



Conscience and conscientious objection in nursing: A personalist bioethics approach

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Abstract

The ability of nurses to act as moral agents in accordance with their conscience is both an essential human freedom and an important part of professional ethics. Recent developments in Canada related to Medical Assistance in Dying have revealed new and important challenges related to conscientious objection – challenges that may require rethinking of how nurses do professional ethics. Notably, the inclusion of a personalist bioethical approach is needed to introduce and explicate what conscience is for nurses to be able to apply it to nursing practice. In this article, we explore the importance of conscience and conscientious objection as ethical concepts to support nurses in addressing issues of conscience amid ethically challenging situations. We discuss how a personalist basis for conscience can support nurses to inclusively engage with one another across diverse moral perspectives.

Keywords

Conscience, conscientious objection, ethics, euthanasia, nursing, personalism

Introduction

Conscience and conscientious objection hold an important place in nurses' professional ethics. Conscience is the application of moral knowledge to situations that require moral decisions about how someone should act. At times, moral decisions consist of refraining from doing something because it would be unethical to act in a certain way. Morality and ethics refer to what is good to do.¹ In nursing (and healthcare in general), conscientious objection is the term used to describe a situation in which a nurse voices an objection to providing or participating in an aspect of practice that they deeply, morally disagree with based on their conscience.¹ Moral decision-making is contingent on freedom, meaning that moral acts are specific kinds of acts. The specificity of moral acts is contingent on their being freely chosen and requires one to have a degree of moral awareness and understanding.

Within and across nursing practice, nurses are called to be moral agents who act ethically on behalf of patients and for communities.² Because nursing is a profession that works closely with patients and

primarily seeks to make their worlds better, conscientious objection, at face value, may be seen as something that is contradictory to nursing. For example, when nurses make a conscientious objection to participating in or carrying out an aspect of patient care that they deeply, morally disagree with, this may seem to be at odds with their goal of providing care to patients. However, this is only the case if the professional assumption grounding nursing ethics is that it is solely what patients request or choose that guides ethics for nursing care. When this happens, the focal point of nursing ethics solely becomes patient wishes and autonomy. It may, therefore, be difficult for nurses to know where their own moral compass fits in relation to the nurse–patient relationship, because in this instance the wishes of the patients (made known through the relationship nurses have with patients) become the point of departure for nursing ethics.

This relational emphasis in nursing can be seen in the relational approach to ethics that has been widely taken up in Canadian nursing. Proposing that the unique, fundamental access point of nursing is one of relationality, Bender³ states that nursing is a ‘relation-sensing performance’ in which ‘nurses create worlds where they can make a difference – where they can make things better’ (p.7) for their patients. However, in the broader context of nursing ethics, a relational approach may not explicitly foreground nurses’ conscience as part of the multi-modal, moral knowledge development needed to fulsomely inform the moral actions of persons within relationships. When this happens, nurses’ moral decision-making practices may be neglected because nurses (and patients) need to conscientiously orient themselves to being moral persons to participate in ethical relationships. As such, a relational approach may have unique limitations in situations of moral gravitas for nurses – such as Canadian nurses’ involvement in the context of Medical Assistance in Dying (MAiD), in which nurses play a central, moral role in not only the lives of their patients but also their own.

If fundamental, ethical concepts for nurses, such as conscience, are not an explicit part of ethical frameworks guiding nursing care, nurses’ ethical needs to reflect on and respond to their conscience may not be addressed and may result in nurses experiencing moral injury. Moral injury ‘occurs when we perpetrate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs’ (p. 400).⁴ This is particularly true in situations of moral gravitas or seriousness such as MAiD. In this article, we are going to make the argument that nurses’ understanding of conscience is essential for them to act freely in relation to moral decisions. This freedom to make a conscientious decision is particularly critical in situations where the risk of moral injury is high. We will make this argument by first addressing what is known about conscience and conscientious objection in Canada in relation to MAiD. Then, we will show how the lack of knowledge around what conscience is in Canadian nurses can complicate their ability to make a conscientious decision in practice. This ability is compounded by the lack of bioethical frameworks utilized in nursing ethics that focus on conscience. We assert that in the context of nursing in the current ethical landscape of MAiD, a personalist bioethical approach is needed to further articulate the relevance of conscience to MAiD itself and to nurses’ moral decision-making. While we focus on the ethical situation of Canadian nurses, we anticipate that the issues raised here will be relevant for nurses in other countries where euthanasia is either enacted or under consideration.

Conscience in practice

Conscience is recognized as essential for moral decision-making in theology, philosophy and in some approaches to bioethics.^{1,5} Healthcare is a moral endeavour in which healthcare professionals (HCPs), such as nurses, do what they perceive to be ethical and in the best interest of their patients.^{1,6} As such, nurses will inevitably draw upon their conscience as part of moral decision-making in practice. While central to moral decision-making, little research and training exist regarding nurses’ and HCPs’ understanding and use of conscience, and this may leave them feeling ill-equipped to address issues of conscience in healthcare practice.⁷

Research that does exist shows that nurses and other HCPs report conscience as an influential aspect of their ethical practice.^{8–10} When able to use their conscience in practice, HCPs have reported decreased stress over practice situations that trouble their conscience and increased ability to stay true to their personal, professional and patient-oriented approaches to care while also voicing ethical concerns over patient issues that may otherwise go unnoticed.^{11–15} HCPs also report making a conscientious objection that enables them to maintain their autonomy, which is in keeping with professional standards.¹⁶

Conversely, nurses who are not able to voice their conscientious concerns in practice report lack of professional support to do so, stress related to issues that trouble their conscience, and burnout. Furthermore, those who have expressed their conscientious concerns report being met with silence by colleagues and clinical leaders and stigmatization if they bring up controversial ethical issues that challenge the professional or social status quo.^{9,12,13} Despite this body of evidence, and an increasingly ethically complex clinical landscape, little progress has been made to support nurses' use of conscience in healthcare. There, therefore, exists a need for an approach to nursing ethics that includes conscience to inform nurses' theoretical basis for practice. To address this knowledge gap, we need to turn to other ethical approaches that attend to conscience as a formative concept. One such approach is the personalist bioethical perspective. To illustrate the theoretical gap that personalist bioethics could fill, we will first discuss how conscientious objection has been taken up for nurses in Canada and the lack of knowledge that exists regarding conscience in this context.

Significance of conscientious objection in Canada

Nursing is a profession rooted in ethics that aims to do what is good and beneficial for patients.¹⁷ To date, nursing conscientiously is almost exclusively focused on enabling patients' choices rather than refraining from acts that they find objectionable. For example, patient overtreatment has been an endemic and enduring source of nurses' moral distress. Yet, one rarely hears of situations in which nurses withdraw their participation in that care. Such an act might be perceived as the abandonment of patients or the failure of duty to employers. As such, nurses are encouraged to turn towards strategies that seek to advocate for their patients' well-being (e.g. advance care planning). As such, conscientious objection for nurses' ethical concerns have been less visible within the moral landscape of nursing care. It is only when situations of moral gravitas, such as MAiD, enter the healthcare arena that this relative invisibility has been seen to become somewhat problematic because it impacts both nurses' and patients' well-being.

The relative invisibility of conscientious objection recently changed dramatically in Canada with the decriminalization of MAiD in 2016.¹⁸ MAiD takes on two forms in Canada: (a) clinician-administered MAiD and (b) self-administered MAiD.¹⁹ Nurses play important roles in MAiD in Canada. Registered nurses assist with coordinating and organizing MAiD-related services and nurse practitioners can independently perform roles of assessing for MAiD eligibility and providing MAiD.^{18,19} Though MAiD has been decriminalized for patients who meet eligibility criteria, it remains a highly contentious act. Recognizing this contention, Canadian legislation protects the right to conscientiously object to participating in MAiD.¹⁸

Conscientious objection is protected because it is an expression of conscience, which refers to the substantive character of moral acts requiring freedom to be carried out.^{5,7,20} Given this, conscience is considered a fundamental freedom in the Canadian Charter of Rights and Freedoms.²¹ Nurses' freedom to act upon their conscience is also internationally recognized as being a human right in the Universal Declaration of Human Rights and Freedoms.²² Similarly, the International Council of Nurses endorses this declaration.²³ In the Canadian context, nurses who decide that they cannot participate in MAiD are free to declare themselves as conscientious objectors while ensuring that they continue to honour the responsibilities outlined in the Canadian Nurses' Association Code of Ethics (e.g. non-abandonment).²

Challenges in accommodating conscience and conscientious objection

Although conscientious objection and freedom of conscience are nationally enshrined and provincially and territorially protected, it may be difficult for individual nurses who are conscientious objectors within a system that is at the same time committed to the accessibility of MAiD for the Canadian population.¹⁸ Accessibility to MAiD across Canada's diverse geography ideally requires nurses willing to participate in the process. For example, patients often inquire about MAiD through nurses, nurses may be required to start the intravenous lines, and nurses play important roles in supporting patients and families through the process. As such, nurses who are conscientious objectors may be placed in a morally problematic situation if accessibility to MAiD requires that they provide the contact number for the MAiD coordination service. For some nurses who are conscientious objectors, this is problematic because it can place them in close proximity to ensuring the act that they perceive to be unethical is still carried out by someone else.^{24–26} These important nursing roles pose challenges for nurses caught between their fundamental commitments to patients and their own moral commitments as conscientious objectors.

Stepping away from these nursing roles in MAiD also has the potential to cast a shadow on nurses' relationships with their colleagues and fellow nurses. Preliminary research findings in Canada reveal that stigma, professional isolation, and negative impacts on employment opportunities can result when nurses conscientiously object to MAiD.^{10,24} Even though the Canadian MAiD legislation states that 'nothing in this Act affects the guarantee of freedom of conscience and religion' (preamble), nurses who conscientiously object have, at times, experienced the contrary, encountering lack of support from practice leaders in making their conscientious objections known.^{18,24}

Furthermore, many nurses remain undecided about their moral convictions in relation to MAiD, dwelling in a grey zone of indecision as they experience and try to make sense of it.^{27,28} Some will participate in MAiD to determine whether they are capable of accommodating this within their moral sense-making. As they do so, some will continue to participate but others may withdraw from participation. To protect the rights of both patients and nurses in this new ethical landscape, it is critical to ensure that nurses are well prepared as moral agents.^{2,26,29}

Yet, nurses may not be able to act with moral agency owing to the lack of awareness that some of them have over what conscience and conscientious objection are and what the relationship between nursing, ethics, and moral decision-making is.²⁴ The almost exclusive focus in nursing on doing what is right in relation to patients may fail to consider the fundamental moral question of whether the nurse believes MAiD is an ethical act. Being professionally embedded in relational ideals may create and perpetuate the notion that nurses' moral actions may only be evaluated in lieu of their relationship with patients and patient's requests (such as a request for MAiD). Nurses should respect and value their patients' perspectives. However, nurses' professional moral horizons need to encompass what they perceive to be moral as well in order for them to freely act with the moral agency and integrity necessary for both their personal and professional lives.

However, the lack of knowledge and support some nurse leaders have in relation to conscience and conscientious objection reveals a potential gap between practice and the ideals embodied within the Charter and the Canadian Nurses Association (CNA) code of ethics and practice.^{24,28,29} And while this gap affects the ability of nurses to make conscientious objections in care settings, it more importantly shines a light on the fact that conscience itself is neglected in nursing when it comes to making conscientious objections. To address this gap, more attention needs to be paid to the place of conscience in nurses' moral decisions and to its status as an essential component of nurses' ability to make ethical decisions. One way to do this would be to engage more broadly with ethical frameworks in which an appreciation of conscience is found.

Addressing the challenges to conscience and conscientious objection

Approaches that may help to illuminate the role of conscience in nursing care are phenomenology and personalist bioethics. Nursing has deep affiliations within phenomenology, and some 20th century phenomenologists have focused specifically on the role of conscience in the development of morality. For example, Edith Stein³⁰ and Karol Wojtyła³¹ investigate conscience as a central part of what it means to be human from phenomenological standpoints. They assert that it is only by acknowledging the need to develop our moral knowledge and acting according to our consciences that we can fully know who we are as moral persons while engaging with others in the communities in which we live.^{30,31} There are multiple ways of developing our moral knowledge requisite for acts of conscience – for example, engaging in relationships and conversations with others; formal and on-going knowledge through ethical courses; reflecting on our experiences in alliance with these other modes of understanding; engaging with art and other inter-subjective interactions.^{31,32}

While phenomenology provides one way forward for nurses to gain an experiential understanding of their conscience in relation to moral decision-making and ethical actions, nurses would also benefit from other philosophical approaches to knowledge of ethics and conscience. Such knowledge can be derived from bioethical approaches that intersect with moral philosophy, which employs critical thinking to enhance our understanding of the use of science and grounds our understanding of ethics.^{33,34} One such approach can be found in personalism and the personalist approach to bioethics.

Personalism and bioethics

Bioethics is the term for a relatively new, 20th century inter-disciplinary field. Aimed at merging knowledge from various intellectual traditions to support people as patients and professionals in healthcare contexts, bioethics principally works to keep the humanities in the sciences to fulsomely round out an integrated approach to health science research, education and practice.¹ Sometimes confused with being exclusive to the medical profession and reliant on the principlist approach to ethical decision-making, bioethics is, instead, highly relevant to any profession engaged in any aspects of ethical healthcare.³⁵ Unique in its specifically inter-disciplinary approach, bioethics is robust because it draws on multiple frameworks for moral decision-making (principlism being only one of many). However, few bioethical frameworks are rooted in a multi-disciplinary approach that triangulates moral philosophy and theology – disciplines in which conscience is typically appreciated – with science. One exception is the personalist bioethical approach rooted in the philosophy of personalism.¹

Personalism emerged in the first half of the 20th century as a response to social, cultural and philosophical questions of modernity arising in the post-World War era. Personalism's primary focus is the centrality and inalienable dignity of the human person.³⁶ Primary personalist thinkers focus on defining the human person as the central locus of interest to transcend the political dualisms of individualism and collectivism, as well as the notion that truth only exists in scientific and specifically positivist approaches to knowledge. Despite being criticized by some as lacking in a unitary, systematic approach to philosophy – with concomitantly set practical applications to social, political and ethical issues – personalism has much to offer across all these applications. Given this, personalism is an ethical approach suited to diverse perspectives and contexts. The pioneers of personalism came from various philosophical traditions and united through their contributions and to one central endeavour: to offer a re-conceptualization of the human person as the unique point of departure for all human thought and activity.³⁶

Through the work of contemporary personalists, personalism is emerging as a philosophy with more focused practical, social and bioethical applications. The primary endeavour that personalists aspire to is characterized by the following elements: an ontological or metaphysical worldview; an anthropological

perspective of the human person emphasizing their affectivity, subjectivity and corporeality; an interpersonal and communitarian focus; an ontological understanding of the human person as a physical, psychological and transcendent being; a focus on the primacy of action, love and freedom as the sources of self-determination; an acknowledgement of good and evil (evil being the absence of good); and the narrative-driven character of human existence.^{1,7,36} Personalists embrace transcendence by acknowledging that being human involves facing the facts of life, suffering and death in relation to life's 'ultimate questions' (p. 221), which are of a universally relevant nature.³⁶

To do so, personalists draw on philosophy, theology and science to round out their approach to bioethics while retaining their originality by virtue of their unique focus on the value of the human person. This focus is further shaped by the personalist notion that everyone is equal in dignity by virtue of their shared humanity and that for each person (whose purpose is greatly concerned with truth and the moral life) moral questions are paramount. Personalists, therefore, hold that, to make a moral decision, people need to appreciate the essential and contributing role of the conscience, distinguishing it as central to the work and aims of bioethics.

Conscience in personalism

Conscience has been well articulated in the context of personalist philosophy and personalist bioethics.¹ Specifically, in the approaches of personalist philosophers Jacques Maritain and Karol Wojtyla to moral philosophy, the person and moral acts are seen as offering a relevant conceptualization of conscience to contemporary ethics. Both maintain a Thomistic foundation for conscience, grounded in Aquinas' seminal explication (more on this shortly). Drawing on Maritain and Wojtyla's personalism, we summarize Aquinas' conceptualization of conscience in relation to the human person for contemporary contexts. It is important to note in doing so that conscience is a complex phenomenon. Conscience is a pervasive term that has not been comprehensively fleshed out in nursing or healthcare to date, and to do so is beyond the scope of one paper.²⁰ Instead, our purpose here is to introduce some of the essential points on conscience that some personalists expound in order to show what is requisite for humans to freely discern how to make moral decisions. In the personalist framework, the defining characteristics of conscience are that it is a mechanism by which we are accountable to ourselves, other-oriented, characterized by both discernment and action, and dependent on personal freedom.

In this moral philosophical approach, the human person is defined as corporeal-spiritual and other-oriented. This means that we are concerned with knowing who we are in relation to others and, in a certain affective sense, to ourselves as well. As located in the world in a subjective sense, all meaning comes to us and through us out to others, and therefore we need to be attuned to others as part of the objective reality of our existence. As persons who have a corporeal-spiritual ontology, we can make meaning of who we are and the acts we do or omit. As such, there is a logical integration of science, philosophy and theology as substantive approaches to truth in both personalism and its approach to bioethics. Personalists, therefore, understand moral action as universal responses to common and transcendental values, like truth and goodness.^{1,7,37,38} To bring the good about in our lives and the lives of others, we need to act, and this is a unique feature of being human: to have agency to perform all kinds of acts but especially moral acts that require reflection and discernment. To determine what is moral and then to act on it is the work of conscience.

The work of conscience occurs at the level of conscientia^{7,20} – which is to say that substantive acts of conscience are not merely emotive or intuited.⁵ Moral intuitions can be described in Thomistic terms as synderesis, or the most basic sense of what is right or wrong.^{1,5,7,20} In Thomistic philosophy, synderesis is synonymous with first principles: universal conceptualizations of morality which arise naturally in human

life, are held in common by all humans, and which can transcend cultures.²⁰ Recent research findings in moral psychology align with some of these philosophical assertions.³⁹ For example, findings from research in moral psychology show that although there are cultural differences in valuing specific moral concepts, an appreciation for morality itself is cross-cultural.³⁹ Further differences between degrees of moral engagement have been shown to exist between moral reasoning and intuitions, with moral reasoning involving deliberation and intuitions involving immediate, emotional responses.³⁹

The difference between intuitions and reasoning in Thomistic-personalist philosophy is that intuitions alone do not constitute substantive moral acts of conscience.^{5,7} Such acts require degrees of moral knowledge, which involves the study and acquisition of multifaceted evidence to answer questions such as the following: ‘Is x an act that is good in and of itself to do?’ ‘What do I mean to bring about with this act and how will I do this?’ ‘What are the consequences of such an act and what will they mean for myself and the others involved in this act?’ ‘Are there other acts that would be more beneficial and /or less harmful to do?’ ‘Why or why am I not choosing those options?’¹

Asking such reflective questions is the work of conscience, a faculty which personalists Maritain and Wojtyla assert is innate to being human.^{37,40,41} And since all humans are equal, conscience is a phenomenon that can be recognized across human communities and cultures.^{20,24} But because acts of conscience require degrees of moral knowledge – the mechanism by which moral acts can be understood, experienced and evaluated – understanding of and respect for conscience can vary across people, communities and cultures.

Variation can depend on the degree to which one has spent time cultivating his or her conscience by developing personal knowledge of morality and ethics. This is what we refer to as degrees of moral knowledge: moral decisions which necessitate in-depth and reasoned reflection above and beyond *synderesis* or intuitive responses.^{5,42} The difference between intuition and concrete acts of conscience is that intuitions are not in-depth moral articulations. Rather, they refer to emotional responses which could and sometimes should change in light of deeper thinking and experiences.⁵ The relevance of this philosophical approach to conscience is evidenced in some of our research on nurses’ conscientious objection in the Canadian context. While nurse participants in one study varied in their conceptual understanding of conscience and conscientious objection, they used their conscience and made conscientious objections through moral responses to refrain from doing acts that they could not reconcile with their conscience.²⁴ Despite varying degrees of moral knowledge, their conscientious objections emerged from moral reflection.²⁴

But knowing is not always enough to act. Acts of conscience can require moral courage and a commitment to freely generate a moral act or restrain from committing an immoral one.^{1,43} Freedom in relation to conscience consists of being proportionately able to inform and use our conscience to choose to do what is right, responsibly willing it into action and accepting the consequences of our actions.^{1,20} For example, nurses may need to make a conscientious objection to MAiD given the serious moral implications of assisting someone to die. And nurses need to be free to do so, since measures which impede human freedom related to moral acts can unethically constrain people (such as nurses) from expressing their self-determination or authentic autonomy in balance with other’s rights and what is right or wrong to do.

Deliberation of moral acts is key to one’s moral life because it allows one to exercise their freedom authentically. Authentic freedom consists of using freedom as a vehicle to reasonably respond to a commitment to morality that transcends self-oriented acts based solely on personal preferences, desires or emotive responses.^{5,20,40,41} Rather, authentic freedom is about aligning oneself to commit to what one ought to do. And morality is for everybody to aspire and commit to, as part of being in communities that should work to achieve the good both individually and collectively.³⁷ This common good requires a conscientious encounter with morality (the transcendent good abstracted into specific situations) in which a person can choose to accept the demands and challenges of acting or refraining from acting accordingly. By acting in accord with transcendent moral values, our sense of self as a moral person can be more fully expressed in a process of moral ‘becoming’ (p. 37)⁴⁰ – a becoming that emerges through our moral

knowledge and actions and reveal to us and to others who we are as moral persons.^{40,41} This revelation is proportionate to the extent that conscience plays a formative role in our lives. For our conscience to be formed and developed, we need interior freedom (personal disposition) and exterior freedom (protection by law) of expression. These freedoms are necessary for moral acts requisite for authentic self-determination (responsible autonomy). Without them, aiming for the good may be lost or replaced with harmful acts (acts that do not bring about the common good), causing a deterioration of the moral fabric of communities and generating moral injury. For example, if nurses do not have the support and knowledge necessary to understand, express and address their issues of conscience in their workplace communities, this could result in their categorically insufficient ability to make moral decisions – which is the lack of moral knowledge necessary to make a conscientious decision about whether to engage in an act or not. And this is directly related to the substantive moral content of acts of MAiD, which are acts of moral gravitas and therefore bear being deeply, conscientiously thought out and discussed. No doubt many patients engage in this type of moral reflection as they consider whether or not to choose MAiD; however, there has been less emphasis on nurses' freedom to do the same.

For nurses to consider what moral acts conscientiously mean to them in the context of MAiD – and other serious ethical issues – they need approaches to ethics that take conscience into consideration. Personalist bioethics is one such approach. Expanding nurses' ethical approaches to conscience in care can create opportunities for nurses to inclusively discuss challenging ethical issues they encounter in practice. Doing so can foster a sense of respect and openness among nurses who engage with ethical issues as professionals and moral persons. Striving to be moral people is something nurses can share in common – which they can conscientiously strive to be for themselves, with each other and patients.

Conclusion

Appreciating conscience and conscientious objection in the context of MAiD for nursing today involves rethinking how nurses morally identify with who they are, each other and in relation to their patients. Such identification is essential to create workplaces that are ethically inclusive towards all of those who choose to be involved, or not involved, with MAiD. Peter et al.⁴⁴ point out that nurses' ability to hold their moral identity relies, in part, on the extent to which other nurses 'recognize each other more and through the recognition of the importance of nursing work within society' (p.332). Given the inherent moral nature of nursing, this work is best understood through an ethical perspective that appreciates the fundamental, moral ontology of nurses as persons who are an integral part of nursing itself. As such, nurses can realize their experiences of being conscientious professionals as one that is respectfully attuned to themselves and towards their fellow nurses as moral persons in relation to patient- and system-level changes that affect their conscience. Incorporating a personalist approach to bioethics for nurses to appreciate conscience and issues related to conscience is a necessary step in supporting nurses' freedom of conscience as moral agents in contemporary professional contexts. Doing so would break new ground for nurses' conscience rights today.


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