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Beliefs, Boundaries, and Self-Knowledge in Professional Practice

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INTRODUCTION

"Of More than One Mind: Obstetrician-Gynecologists' Approaches to Morally Controversial Decisions in Sexual and Reproductive Healthcare," usefully describes how a selection of obstetrician-gynecologists (ob/gyns) think and act when navigating between their responsibilities as medical professionals, their patients' healthcare goals, and the moral ground of their own conscience.[1] The issues raised by this study are important to many aspects of medical practice; but from our pedagogical perspective this study is of particular importance for how students learn about patient-physician communication, moral discernment, professional boundaries, and related expectations within medical education. When helping students learn how to listen and communicate effectively in professional practice, it is very helpful to have knowledge of how clinicians, patients, and families actually do communicate with one another: What kinds of things are communicated in the clinical encounter? How are they communicated? Why are they communicated? How are power differentials within the patient-physician relationship negotiated? What is left un-said, un-asked, or un-explained in the clinical encounter — and why? The research by Curlin, Dinner, and Tessler Lindau responds to these important questions.

It should be noted that this study does not claim to map generalizable patterns of behavior, but instead provides insight into the subtle dynamics of the clinical encounter. Most physicians interviewed for the study subscribed to what Curlin, Dinner, and Tessler Lindau call the "mainstream approach." This approach is in keeping with guidance provided by the American College of Obstetricians and Gynecologists (ACOG).[2] We will focus on the issues raised by the participants who subscribed to various "alternatives" to the mainstream approach — alternatives that at times go beyond conscientious objection to intentionally influencing their patients' decision-making process.

We organize our comments within two main themes. First, we discuss how we can best talk about the issues raised by Curlin and colleagues. How should the issues be characterized, and by whom? What language should be used? Which concepts are the most helpful to discuss the role of personal conscience in the healthcare professions? Which concepts are not as useful? We then broaden the discussion about the role of personal beliefs in the clinical setting. Second, we point to background issues in medical education today that shed additional light on the relationship between personal morality and professional responsibility. The background issues revolve around some potentially mixed messages being passed on to students, interns, and residents in contemporary American medical education.

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FRAMING THE DISCUSSION

There are two main issues we will discuss in this section. First, we consider which language and concepts are most helpful to think about the role of a physician's conscience in the clinical encounter, and second, we will enlarge the discussion by including nonreligious beliefs as equally important within the patient-physician relationship.

In their introduction, Curlin, Dinner, and Tessler Lindau situate their study directly within the context of an ongoing debate among bioethicists about clinical decision making. The debate is about the proper place to come down between "the two poles of overweening paternalism and unmitigated patient autonomy."[3] While this approach is in keeping with much of the literature on the role of personal conscience in healthcare, we believe that the authors' decision to frame their study in these terms sets the stage for endless discussions (or perhaps merely assertions) about conflicting principles in complex situations, rather than helpful dialogue about the lives involved.

We find it more helpful to take a step back from "respect for patient autonomy" to its parent concept of "respect for persons." This conceptual shift replaces the need to balance competing rights within the patient-physician relationship with the moral space necessary for a dialogue between patient and provider, the end or goal being increased mutual understanding instead of resolution of conflicting principles. Moving beyond the task of protecting patient autonomy from the threat of physician paternalism, or, alternatively, defending physicians' rights to follow the guidance of their conscience from the demands of patient autonomy, to a context of respect for *both* patient and provider, allows for a helpful re-imagining of the relationship — from that of a battleground to that of a meeting ground where open and honest dialogue can occur between the parties.

Despite attempts to limit the role that a provider's conscience plays in clinical care, the reality is that there will always be occasions when physicians consciously or unconsciously follow the guidance of their personal beliefs when working with their patients. The study by Curlin, Dinner, and Tessler Lindau investigates the religiously based dimensions of this dynamic. The quotations provided reveal varying levels of intention, awareness, and action on the part of the respondents who objected to the "mainstream approach" — most of whom did so out of religious beliefs and convictions.

Focusing attention on religious beliefs and the role of a physician's conscience is one way to frame the discussion about personal moral beliefs in the practice of medicine. We find it more interesting to broaden the discussion by looking more closely at how less-apparent beliefs influence behavior. We all have many different kinds of beliefs, biases, and prejudices — only some of which are conscious — that guide our everyday behavior.[4] The beliefs we hold might be religious in nature, but they often are not. For instance, at some level most of us believe that we will live to see tomorrow and as a result we do not act today as though this were our last day of life. Or, imagine an ob/gyn raised by his family to believe that "poor people should not have children that they cannot support." Might that belief — directly or indirectly, consciously or not-quite-consciously — influence the way he practices medicine? The physician may even consciously claim such a belief as a part of his conscience.[5] Is a "secular" belief, bias, or prejudice that leads a physician to try to influence his patients to prevent or end a pregnancy any less worthy of inquiry than a "religious" belief, bias, or prejudice that leads a physician to try to influence her patients to give birth?

Religiously informed moral beliefs are perhaps the most easily ascertained (and therefore studied), but to focus exclusively on them misses much of the complexity of how inner lives guide outer actions. The authors of this study rely on bioethics literature regarding the role of physicians' personal moral beliefs that calls for transparency and/or disclosure on the part of physicians. This advice presumes that physicians are fully aware of all of their beliefs, and of how they influence their relationships with patients. Indeed, some physicians may steer their patients toward specific choices by presenting their moral preferences as medical advice. They may not be aware that they are acting out of personal moral, rather than professional medical, convictions. For this reason we support respecting providers' appeals to conscience if those appeals are well-

reasoned within a moral framework (one not based in fear, hatred, prejudice, violence, et cetera), consciously held, and openly shared as soon as conflicting goals of care become apparent. But we also want to draw a line as clearly as possible between a physician acting in accordance with the leadings of his own conscience and covertly or openly imposing his moral beliefs on his patients — for example, by remaining silent about options for care, steering patients toward particular decisions, or interpreting the "best interest" of his patients in a way that he feels justifies his acting as a moral therapist. If, however, a patient wants to discuss the moral dimensions of her care with her physician, the patient-physician relationship will best be served if her physician is clear about his beliefs on the matter at hand, shares them with his patient, does not appear to be standing in judgment, and does not try to guide the patient to a particular decision out of moral rather than medical concerns.

Like calls for transparency, appeals to concepts such as acting in the patient's best interest or keeping the patient's welfare as a primary goal are open to considerable interpretation. Such appeals are often made with the assumption that their meaning is completely evident. The minority of practitioners in the study who object to the mainstream approach most likely feel quite strongly that they are in fact acting in the patient's best interest and promoting her welfare by guiding her away from what they see as an immoral or dangerous course of action that may cause grave spiritual harm to her (in addition to causing spiritual harm to the physician herself).

IMPLICATIONS FOR MEDICAL PROFESSIONALISM EDUCATION

Our observations emphasize the importance of teaching medical students, interns, and residents the reflective skills necessary to increase their self-knowledge throughout their educational and professional careers. Before a physician can be transparent about her personal beliefs within her professional relationships (be they religious or nonreligious beliefs), she will first need to learn how to become aware of and reflect on what it is that she actually believes, why she believes as she does, how her beliefs might influence the way she practices medicine, and whether she wants to retain, amend, or lay down any of her previously held beliefs. This reflective process can be taught and modeled by skillful educators. Beyond moral beliefs that arise from a physician's conscience, such reflective skills will also help the clinician become aware of unrecognized biases, prejudices, attitudes, or generalizations that might influence the way she relates to particular patients.

The study by Curlin and colleagues also points to a need for medical educators to model behavior for students that will help them learn how to engage in open and respectful dialogue with their patients around passionately held moral beliefs. Such learning takes both courage and a willingness to try to understand the patient's life experience, beliefs, and choices without seeking to change the patient to fit the provider's belief system.

Unfortunately, we see some aspects of contemporary medical education that may be actively working against these educational goals. We will turn now to look at three "mixed messages" we sometimes see being delivered in contemporary medical education. These mixed messages may inhibit students from learning about themselves and from learning the skills necessary for respectful dialogue with their patients about matters of conscience and personal belief.

The first mixed message that students, interns, and residents may experience is that, on the one hand, they are told that they don't have to do anything that their attending physician tells them to do if they think it is wrong or immoral; students are expected to learn how to develop their own conscience and use it as one source of guidance about what is best in any given clinical situation. But what happens to that same learning when professional medical organizations and medical educators teach that patient autonomy is a higher value than a physician's moral convictions? To us that teaching seems to give students the mixed message that they should listen to and follow their conscience while they are in an educational context, but after they become physicians they need to leave their conscience at the door of the clinic, or at least learn to subvert the

guidance of their conscience during interactions with patients. By expecting medical students to develop and follow their inner moral guide or conscience, and expecting practicing physicians not to, medical education is setting physicians up for failure in knowing how to navigate the complexities revealed in the study by Curlin, Dinner, and Tessler Lindau.

Another mixed message is delivered when medical educators stress the need for medical students and residents to learn about, develop, incorporate, and act out of virtues and values integral to medical professionalism. It may become clear to students that some virtues and values — or perhaps particular interpretations of those virtues and values — are considered desirable while others are not. Students quickly discern when to keep quiet about their personal beliefs if they find themselves outside the dominantly held interpretation of values. This learned silence may then be carried into their medical practice and may lead to some of the covert behaviors and attitudes revealed in this study. Likewise, the disconnect between what students are taught about medical professionalism and students' observations of how medical professionals actually behave may lead students to dismiss all values education as irrelevant or hypocritical.[6]

A third potentially mixed message may occur when medical schools teach students that they should support their future patients' religious/spiritual lives because it is believed that doing so will enhance their patients' health and well-being. Yet at the same time students and physicians who have an active religious or spiritual life may get the message that their own religious beliefs or spirituality should not inform the way they practice medicine.

These potentially mixed messages, absorbed during medical education, coupled with shifting relationships of power in the move from student to practicing physician, can result in unhealthy, fractured identities for physicians and confusion about the role of personal beliefs and conscience in the practice of medicine. Most physicians will find a way to live their professional lives in keeping with their conscience. The effect of mixed messages in medical education may be to drive conscience-led decision making underground in the clinical setting. This move underground may then lead to the surreptitious and unreflective imposition of a provider's beliefs on patients' decision making.

CONCLUSION

The study by Curlin, Dinner, and Tessler Lindau provides a glimpse of how some ob/gyns approach moral and medical decision making with (or for) their patients. We have made two points: First, the choice of language and concepts will influence how the discussion of this study unfolds, and, second, the results of the study have great importance for medical education. A principle-based approach with the goal of clear resolution for all complex situations of the sort described in this study will lead to a continuation of a debate that is centered on conflict. In contrast, we suggest that pursuing the goal of increased respect and understanding between patient and provider would better facilitate fully informed and mutually agreed upon decisions.

We believe that teaching medical students to rely primarily on moral principles to frame ethical and moral discussions does them a disservice. At least equally important is the ability to enter into dialogue with patients in a way that is transparent, honest, respectful, open to hearing the truth of their patients' lives, and true to their own deeply held moral convictions. This ability to enter into respectful dialogue presumes our other educational goals: reflective skills that allow ever increasing self-knowledge; and experiences in medical school and residency that model for students and residents the respect that we hope they will show to their future patients.

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NOTES

1. F.A. Curlin, S.N. Dinner, and S. Tessler Lindau, "Of More than One Mind: Obstetrician-Gynecologists' Approaches to Morally Controversial Decisions in Sexual and Reproductive Healthcare," in this issue of *JCE*.

2. "The Limits of Conscientious Refusal in Reproductive Medicine," *ACOG Committee Opinion* 385 (November 2007), *http://www.acog. org/from_home/publications/ethics/co385.pdf*, accessed 18 April 2008.

3. See note 1 above; see also F.A. Curlin et al., "Religion, Conscience, and Controversial Clinical Practices," *New England Journal of Medicine* 356, no. 6 (8 February 2007): 597-8.

4. For a brief discussion of the possibility of "value neutrality" and "nondirective" counseling in ob/gyn practice see J.M. Thorp, Jr. et al., "Integrity, Abortion, and the Pro-Life Perinatologist," *Hastings Center Report* 25, no. 1 (January 1995): 27.

5. We do not support such a belief or practice, but offer this example to help the reader imagine non-religiously based beliefs that might influence a physician's practice.

6. See for example: A.H. Brainard and H.C. Brislen, "Learning Professionalism: A View from the Trenches," *Academic Medicine* 82, no. 11 (November 2007): 1010-4.