Journal of Intercultural Management and Ethics

JIME

ISSN 2601 - 5749, ISSN-L 2601 - 5749

published by

Center for Socio-Economic Studies and Multiculturalism
Iasi, Romania
www.csesm.org

TABLE OF CONTENT

Editorial……………………………………………………………………………………….3
Iulian Warter

The Personality of Traits in Shaping Leadership Behavior for Local Government Performance in Indonesian Cases: Facet-Level Analysis 5
Yadhi Kowara, Umi Narimawati, Justine Tanuwijaya

Moses and Modern Leadership: Lessons in Purpose-Driven Servant Leadership for The Age of Disruption ………………………….…………………….……..……………..……..25
Hershey H. Friedman, Xianfang Zeng

The Indirect Effect of Active Procrastination in the Relationship Between ChatGPT Use in Academic Contexts and ChatGPT-Related Psychological Distress …………………...…... .45
Tudor-Daniel Huțul, Adina Karner-Huțuleac, Alexia-Gabriela Roman, Ștefana Pintilie, Andrei-Marian Mariș, Cristiana Honțaru, Ion Fărcășan

Conscientious Objection in Medical Practice …………………….……………………....69
Mircea Gelu Buta, Iulia Alexandra Oltean

Barriers and Opportunities in the Employment Inclusion of People with Disabilities. A Qualitative Analysis of Employers' and People with Disabilities' Perspectives ………..….75
Irina-Cristina Pachița, Alois Gherguț

Ethical Perspectives in Sociological Research on Drug Use ……………………….….....93
Cristina Gavriluță, Ramona Ciobanu, Beatrice Gabriela Ioan

CONSCIENTIOUS OBJECTION IN MEDICAL PRACTICE

Mircea Gelu Buta
Professor, MD, PhD, “Babes Bolyai” University,
Cluj-Napoca, Romania
E-mail: butamircea@yahoo.com

Iulia Alexandra Oltean
Lawyer, Bistrița-Năsăud Bar Association, Romania
E-mail: av.iuliaoltean@gmail.com

Abstract

For a fair medical practice, healthcare professionals need, in addition to technical expertise, a well-informed moral character based both on personal virtues and on discernment aimed at understanding the real needs of patients. Although respect for autonomy is important, the excessive emphasis on this principle of medical ethics has paradoxically led to the suppression of the physician’s conscience under the pretext of honoring the patient’s autonomy. However, in the doctor–patient relationship, both are moral agents who must collaborate. Overemphasizing the autonomy of one party risks undermining or suppressing the autonomy of the other. Regarding conscientious objection, it is not a retreat into individualism or moral isolation, but rather the responsible application of moral judgment to specific circumstances, informed both by ethical principles and by the virtuous character of the physician.

Keywords: moral objectivity; relativism; medicine

Introduction

Contemporary society is marked, in addition to significant moral fragmentation, by political polarization. Issues of serious moral significance, such as abortion, surrogacy, assisted reproduction by third parties, castration, physician-assisted suicide, and euthanasia, have been demystified and reinterpreted according to the lifestyles that people choose. When medicine is understood only as an industry in which powerful experts provide technical services to vulnerable subjects with whom they have no relationship of trust, the offer of Christian medicine seems contrary to professional boundaries and patient autonomy, becoming irrelevant.

The Formation of conscience

When we talk about the formation of medical conscience, we are referring to the development of knowledge by which a doctor reflexively judges the morality of his actions. It is not just about theoretical information about good or bad, nor about the scientific objectification of one's moral identity. The mere fact of reading or hearing that a medical procedure is morally wrong or that the authorities consider it proscribed is not enough. For these truths to become part of the doctor's moral conscience, they must be transformed into personal convictions (Hernandez Ojeda, 2025).

Imposing rules or simply transmitting information, no matter how detailed and coherent, cannot effectively form a medical conscience as long as the person concerned does not perceive it as useful both for himself and for the patients he cares for. Achieving harmony between the judgment of conscience and the moral order he serves requires a well-formed conscience on the part of the doctor so that his actions are correctly guided. For example, when in the case of abortion there is a divergence between the objective order indicated by

authority and the judgment of conscience of the doctor, the doctor may remain convinced that the procedure is wrong, even if civil law considers it legal, family and friends encourage him, and health care institutions perceive it as a duty.

There are also situations in which a physician considers that performing an abortion may save the patient's life, despite all the prohibitions imposed by civil law, the opposition of the Church, which regards it as a grave sin, and the discouragement coming from family and friends. In such cases, a physician with a well-formed conscience must follow their inner conviction, even if this means going against authority, by virtue of exercising the right to conscientious objection.

The formation of medical conscience involves the acquisition of perceptive knowledge, that is, knowledge gained when the physician comes into direct contact with reality and perceives it through their senses. These shape moral understanding and form the basis of conscientious deliberation. Such knowledge includes beliefs developed through persuasive argumentation, teachings transmitted by others, adopted codes of conduct, advice and examples from authoritative figures in the field, values conveyed by one's reference group, inherited wisdom, collective imagination, reflective study, and personal life experiences. These deeply personal moral insights may follow a historical trajectory, reflecting the physician's moral knowledge at a given moment in life, with a tendency toward advancement, consolidation, or regression depending on the experiences they have undergone (Hernandez Ojeda, 2025).

Conscience and truth in medicine

The medical act is based on two fundamental concepts: conscience and truth. These not only guide clinical decisions but also define the relationship between physician and patient, directly influencing the quality of care and the respect for human dignity.

Conscience can be defined as that capacity for moral self-evaluation through which a person distinguishes between right and wrong and takes responsibility for their own actions. In medicine, it acquires a professional dimension, being closely linked to the obligation to protect the patient's life and health, since the physician is not merely a performer of procedures, but a moral agent involved in complex decisions. Indeed, the medical act is, first and foremost, a moral one, in which responsibility toward the patient takes precedence over any technical or administrative considerations.

How can a physician determine whether their conscience is correct? When a person acts in accordance with their own conscience, they experience a sense of inner peace. This inner peace arises because there is no conflict between what they think, what they feel, and what they do. The absence of remorse or doubt is a sign that their actions are aligned with their assumed values. On the other hand, the joy that accompanies this state is not superficial, but deep and enduring. It springs from a sense of moral fulfilment and from the conviction that one has done what is right. This joy does not depend on external factors, but on the person's inner balance. However, this should not be confused with fleeting emotions or subjective feelings, as such interpretations risk reducing truth to mere sincerity. In the face of conflicting judgments and opinions, conscience must be grounded in something more enduring than emotion.

An erroneous conscience does not deny the existence of a moral order; on the contrary, it misjudges it. It assumes and affirms an objective moral order, even if it arrives at incorrect conclusions. In contrast, a counterfeit conscience rooted in one's own will rejects the notion of a universal moral law, eliminating any external moral standard in favour of personal desire or autonomy (Reinhard Hütter, 2019).

Since physicians work directly with the health and life of human beings, their judgments of conscience must be informed by an adequate anthropological understanding of

human life and dignity. Such an understanding must take into account the unique value of each human person, the interconnection between physical, emotional, and spiritual well-being, as well as the ultimate purpose of life itself. Without this foundation, their judgments risk becoming superficial or erroneous, guided exclusively by external pressures or incomplete knowledge.

A well-formed judgment of conscience for a physician involves recognizing the inherent dignity of each patient, regardless of circumstances such as age, illness, or social status. It also requires a commitment to seeing patients not merely as biological organisms, but as persons with intrinsic value, aspirations, and relational capacity. This anthropological foundation ensures that the physician's decisions are aligned with the patient's true good, respecting their autonomy and promoting their holistic well-being.

However, it is obvious that, at times, the consciences of two or more individuals may reach opposing judgments regarding the same medical action. In some cases, this divergence may be neutral, while in others it may need to be tolerated. At times, it must be actively rejected when the opposing judgment is considered wrong or even dangerous. For example, two physicians evaluating a shared therapeutic decision may arrive at contradictory conclusions. Consider the case of a 20-week fetus diagnosed with aortic stenosis—a developmental abnormality of the aortic valve that impedes intrauterine growth. One physician might conclude that the best course of action is intrauterine fetal valvuloplasty, aimed at dilating the valve and supporting normal development until birth. Another physician might determine that inducing labor, despite the low chances of survival, is the better option. Meanwhile, a third physician could argue that abortion is the most appropriate choice, due to the low probability of fetal survival (Hernandez Ojeda, 2025).

Contemporary medicine faces multiple challenges that can affect the relationship between conscience and truth. Excessive technologization, economic pressures, and the bureaucratization of healthcare systems can diminish the human dimension of medical practice. In addition, the widespread access to medical information, which unfortunately is not always accurate, alters the physician–patient relationship. In this context, the physician must become a guide to truth, filtering information and adapting it to the patient's level of understanding.

Physician's emotions in clinical practice

Although the medical act is perceived as a strictly rational process, based on scientific knowledge and clinical protocols, the doctor is not a simple technical executor, but a complex person, subject to emotional experiences. His emotions influence both the decision-making process and the therapeutic relationship, being an essential element of modern medical practice. During the medical act, doctors experience a wide range of emotions, among which empathy and compassion are fundamental for an effective doctor-patient relationship, facilitating the understanding of the patient's suffering and increasing adherence to treatment (Mohammadreza Hojat, 2010).

The responsibility of medical decisions generates significant psychological pressure, and diagnostic uncertainty can lead to fear of error (LeBlanc, 2009). Frustration and emotional exhaustion are associated with prolonged exposure to suffering and difficulties in the medical system (Maslach & Leiter, 2016). In contrast, therapeutic success and gratitude from the patient generate professional satisfaction and strengthen the doctor's identity (Shanafelt et al., 2002).

Although the impact of emotions on clinical decisions is undeniable, it must be understood that emotions and moral conscience do not operate independently, but in a dynamic relationship, in which the former can activate moral conscience, and this, in turn, can regulate and orient emotions. For example, empathy may trigger the desire to help the

patient, but moral conscience intervenes to assess the limits of intervention and prevent possible harm, in accordance with the principles of medical ethics (Pellegrino & Thomasma, 1993). Intense emotions, however, can affect the objectivity of medical decisions, favoring the emergence of systematic errors of thought, distortion of information processing, resulting in illogical judgments and/or incorrect decisions. Conscientious physicians try to monitor, without prejudice, their own physical and mental actions in relation to the patients they care for. This self-control allows them to listen carefully to patients' confessions, to recognize their own errors, to refine their technical skills, to make evidence-based decisions, and to clarify their values, so that they can act with compassion, technical competence, presence, and insight. As a link between relationship-centered care and evidence-based medicine, mindful attention should be considered a feature of good clinical practice (Epstein, 1999).

Because chronic stress is associated with decreased cognitive performance and increased risk of medical errors, maintaining emotional balance becomes essential for the quality of medical care. In this regard, doctors have the ability to develop adaptive strategies for managing emotions. Among these, professional detachment allows for maintaining decisional clarity without eliminating empathy (Halpern, 2001).

Peer support and supervision also contribute to processing difficult experiences, and training in "*emotional intelligence*," the ability to recognize, understand, and manage both one's own and others' emotions effectively, is becoming increasingly important (Shapiro, 2011). Mindfulness techniques can also influence the ability to remain present, attentive and balanced during medical work, even in difficult or stressful situations (emergencies, critical patients, high workload). Recognizing the emotional vulnerability of doctors contributes to the development of institutional policies aimed at protecting mental health (Krasner, 2009).

In conclusion, the physician's moral conscience and emotions are not opposite, but complementary dimensions of ethical judgment. Emotions provide sensitivity and motivation, while moral conscience provides direction and discernment. Authentic medical ethics cannot ignore either of these dimensions. Their integration is an essential condition for maintaining professional integrity and ensuring care centered on human dignity.

The Physician's conscience and the patient's autonomy

The evolution of modern medicine has been marked by the transition from a paternalistic model to a patient-centered one, in which the patient's autonomy becomes a fundamental principle. This transformation reflects a profound change in the understanding of the doctor-patient relationship, as illustrated in the typologies proposed by Emanuel and Emanuel (1992).

The emphasis on autonomy has generated significant ethical tensions, especially in situations where the patient's decisions conflict with the physician's moral convictions. The central issue is not the existence of these conflicts, but the risk that, in the name of autonomy, the physician's conscience will be marginalized or even suppressed.

The principle of autonomy derives from the liberal tradition and implies respect for the person's capacity to make informed and voluntary decisions regarding their own health (Beauchamp & Childress, 1979/2019). At the same time, classical medical ethics is based on a set of complementary principles: benefit, avoidance of harm and justice, which limit and contextualize autonomy. In this context, the physician's conscience, as an expression of moral integrity, is essential for the responsible exercise of the profession, and conscientious objection must be understood as a legitimate right within medical practice (Wicclair, 2011).

The conflict between patient autonomy and physician conscience becomes evident in contexts such as abortion, euthanasia, or refusal of treatment. In these situations, physicians may invoke conscientious objection to refuse participation in certain procedures. However, some bioethical positions support the limitation of this right in favor of patient access to

medical services, arguing that physicians have a professional obligation to provide legal and beneficial services to the patient, even if these go against personal beliefs (Savulescu, 2006). However, such an approach risks reducing the doctor to a simple executor, ignoring the moral dimension of the profession (Brock, 2008).

The suppression of a doctor's conscience could have profound implications both at the individual and systemic level. If from an ethical perspective, the moral integrity of the doctor may be affected, from a professional perspective, this may generate the phenomenon of "*moral distress*", in which doctors cannot act according to their ethical convictions, and which, associated with "*burnout*", decreases professional efficiency and, implicitly, the quality of care. Furthermore, limiting conscientious objection affects the moral pluralism of society and may lead to the uniformity of values in the medical profession. Resolution 1763 of the Council of Europe underlines the importance of protecting the right to conscientious objection within the framework of legal medical care (Council of Europe, 2010). Also, the case law of the European Court of Human Rights highlights the need to balance the rights of the patient with those of healthcare professionals (R.R. v. Poland, 2011).

A balanced approach requires recognizing the legitimacy of both principles, i.e. a model in which conscientious objection is permitted but regulated so as not to affect the patient's access to care. The compromise lies in its addressability to another healthcare provider, thus maintaining the balance between patient autonomy and the doctor's moral integrity. This solution takes into account professional principles based on virtues (Oakley & Cocking, 2001).

The conflict between patient autonomy and physician conscience cannot be resolved by unilateral supremacy of one principle. Suppressing the physician's conscience, even in the name of autonomy, undermines the moral foundation of medical practice. A mature bioethics must promote balance, dialogue, and mutual respect, recognizing that both patient and physician are autonomous moral agents. Only through such an approach can the ethical integrity of contemporary medicine be maintained.

Conclusions

The formation of conscience is vital for physicians, as their profession requires making difficult decisions that directly affect the well-being and dignity of patients. The development of their conscience goes beyond acquiring theoretical knowledge of right and wrong. They must cultivate a moral character capable of discerning and doing what is truly good for their patients.

In this context, conscientious objection is not a retreat into individualism or moral isolation; it is the responsible application of moral judgment to specific circumstances, informed both by ethical principles and by the physician’s virtuous character.

References

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of Biomedical Ethics* (8th ed.). Oxford University Press. (Original work published 1979).

Brock, D. W. (2008). Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics*, *29*(3), 187–200. https://doi.org/10.1007/s11017-008-9076-y.

Council of Europe. (2010, October 7). *1763: The right to conscientious objection in lawful medical care.* Parliamentary Assembly.

Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *JAMA: The Journal of the American Medical Association*, *267*(16), 2221–2226. https://doi.org/10.1001/jama.267.16.2221.

Epstein, R. M. (1999). Mindful Practice. *JAMA*, *282*(9), 833. https://doi.org/10.1001/jama.282.9.833.

Halpern, J. (2001). *From Detached Concern to Empathy*. Oxford University Press.

Hernandez Ojeda, J. (2026). Virtue in Medicine: The Foundation Protecting Conscientious Objection from Moral Relativism. *Christian Bioethics: Non-Ecumenical Studies in Medical Morality*, 32(1), 20-34. https://doi.org/10.1093/cb/cbaf014.

Krasner, M. S. (2009). Association of an Educational Program in Mindful Communication with Burnout, Empathy, and Attitudes Among Primary Care Physicians. *JAMA*, *302*(12), 1284. https://doi.org/10.1001/jama.2009.1384.

LeBlanc, V. R. (2009). The effects of acute stress on performance: Implications for health professions education. *Academic Medicine*, *84*(10), S25–S33. https://doi.org/10.1097/acm.0b013e3181b37b8f.

Maslach, C., & Leiter, M. P. (2016). Understanding the Burnout experience: Recent Research and Its Implications for Psychiatry. *World Psychiatry*, *15*(2), 103–111. https://doi.org/10.1002/wps.20311.

Mohammadreza Hojat. (2010). *Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes*. Springer, Cop.

Oakley, J., & Cocking, D. (2001). *Virtue ethics and professional roles*. Cambridge Cambridge Univ. Press.

Pellegrino, E. D., & Thomasma, D. C. (1993). *The virtues in medical practice*. Oxford University Press.

Reinhard Hütter. (2019). *Bound for beatitude: a Thomistic study in eschatology and ethics*. Catholic University of America Press.

R.R. v. Poland App no 27617/04 (ECtHR, 29 March 2011).

Savulescu, J. (2006). Conscientious objection in medicine. *BMJ*, *332*(7536), 294–297. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360408/.

Shanafelt, T. D., Bradley, K. A., Wipf, J. E., & Back, A. L. (2002). Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program. *Annals of Internal Medicine*, *136*(5), 358. https://doi.org/10.7326/0003-4819-136-5-200203050-00008.

Shapiro, J. (2011). Perspective: Does Medical Education Promote Professional Alexithymia? A Call for Attending to the Emotions of Patients and Self in Medical Training. *Academic Medicine*, *86*(3), 326–332. https://doi.org/10.1097/acm.0b013e3182088833.

Wicclair, M. R. (2011). *Conscientious Objection in Health Care*. Cambridge University Press.