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**CONSCIENCE COLLISIONS:
The Search for Public Policy Solutions to the Problem
of Doctrine in Medicine**

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Trinity College, Hartford, CT
Fall 2015 – Spring 2016*

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INTRODUCTION:

At only 18 weeks of pregnancy, Tamesha Means' water broke. She was immediately rushed to Mercy Health Partners, a Catholic health care organization in Muskegon, Michigan, where doctors gave her medication for her pain and sent her home. What the doctors failed to tell Means is that she was miscarrying and her pregnancy was over, and that failure to evacuate her uterus put her at risk for a life-threatening infection and loss of fertility. When her condition did not improve, she made another visit to the emergency room and was again sent home, still unaware of the severity of her condition. After returning to the hospital for a third time and only to have physicians prepare to send her home once again, Means began to deliver her unviable fetus and was finally treated for the massive infection caused by her miscarriage.¹

Why did physicians at Mercy Health Partners knowingly send home a very sick patient, refusing to provide her with miscarriage management treatment that would be standard medical procedure in a case like this one? Because Catholic hospitals operate under the *Ethical and Religious Directives for Catholic Health Care*, which prohibit abortion, sterilization, and contraceptive services. State and federal institutional conscience exemptions, provided by laws called conscience clauses, give Catholic hospitals nearly unbridled authority to decide how medicine is practiced in their facilities – even if that practice directly defies standards of medical care. As the Catholic Church is one of the oldest and most vocal opponents of abortion, exempting Catholic hospitals from providing elective abortions is logical and reasonable. However, the waters become very muddy with situations like Tamesha Means' miscarriage, in which the death of the fetus is inevitable but may not be immediate.

¹ "Tamesha Means v. United States Conference of Catholic Bishops," *American Civil Liberties Union*, June 30, 2015, Accessed February 19, 2016, <https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops>.

Many Catholic hospitals and health care organizations classify assisting miscarriage completion as a direct abortion, even if the treating physician does not agree with the doctrine under which the hospital operates. If left untreated, however, incomplete miscarriages and other pregnancy complications can be fatal to the mother. In a recent study, researchers found that 52% of physicians working in Catholic hospitals reported that their institution's religious policies conflicted with their medical practices.² Perhaps more troubling are the findings of a different study that reported that women believed that there would be no difference in access to care between a Catholic hospital and a non-Catholic hospital.³ Shortages of care exist in hundreds of hospitals across the country, and most women are unaware of these restrictions. For these reasons, conflicts in care created by doctrine in Catholic hospitals require immediate attention.

Conflicts in care are an interdisciplinary issue: they arise at the intersection of law, policy, medicine, bioethics, and religion. Therefore, an interdisciplinary approach is required in order to understand these conflicts and propose solutions. The primary research objective of this thesis is to identify the factors that allow conflicts in care to exist by examining the points at which competing rights clash. In exploring the implications of conscience collisions and Catholic health care, this thesis will examine the history of reproductive rights, conscience legislation, the history of Catholic health care, data about physician conflicts in care, Catholic bioethical principles, and medical bioethical standards.

Ultimately, this interdisciplinary analysis will reveal two flashpoints for conflicts in care.

The first is related to the way in which conscience legislation is written, which has been

² Debra B. Stulberg, Annie M. Dude, Irma Dahlquist, Farr A. Curlin, "Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies," *American Journal of Obstetricians and Gynecologists* 207, no. 1 (July 2012): 4, [http://www.ajog.org/article/S0002-9378\(12\)00420-6/pdf](http://www.ajog.org/article/S0002-9378(12)00420-6/pdf) (accessed April 19, 2016).

³ Maryam Guiahi, Jeanelle Sheeder, Stephanie Teal, "Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care," *Contraception* 90, no. 4 (October 2014): 429-434, [http://www.contraceptionjournal.org/article/S0010-7824\(14\)00358-8/pdf](http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/pdf) (Accessed April 19, 2016).

expanded over the last twenty years to protect an increasingly long list of individuals from participating in a very broad range of procedures. Through conscience legislation, the federal and state legislatures have continued to restrict medical authority in reproductive health care, more so than in any other medical practice. The second flashpoint is due to fundamental disagreements between Catholic doctrine and modern medical practice, enshrined in the standards that govern the practices of Catholic hospitals. The incompatibility of Catholic conscience provisions with medical practices may appear to be insurmountable, but solutions are attainable, as demonstrated by certain areas of potential common ground between secular medicine and religious authority. A key objective of this discussion is to identify a policy solution that affords women appropriate care while attempting to protect Catholic conscience. Such a solution will require compromise on the part of both medical professionals and Catholic providers, but it should not require a compromise in quality of patient care.

This thesis does not intend to suggest that Catholic hospitals provide lesser quality care than non-sectarian hospitals. In fact, some literature suggests that Catholic hospitals have better outcomes overall than non-Catholic hospitals. Further, this thesis will not suggest that conscience laws do not hold value, nor will it suggest that the Catholic identity of Catholic health care institutions does not deserve protection. Any such suggestion would be averse to the principles of the First Amendment, and perhaps even averse to the more general principles of American society. However, in light of the urgency created by conflicts in maternal health care, church officials, medical authorities, and policy makers must arrive at some solution. To begin, this thesis will explore the history of abortion and reproductive rights in the United States, as these events provide the foundation on which all ensuing abortion and reproductive issues have developed.

CHAPTER ONE:

The Abortion Controversy and the Role of Bishops in Public Policy

This chapter will provide background information that is essential for contextualizing the issues to be discussed later in this thesis. First, a short history of abortion in the United States will be given, highlighting particular events that led up to the decriminalization of abortion in *Roe v. Wade*. The discussion of *Roe* and the events that preceded the decision reveal important themes about the nature of pro-life movement, as well as the role the Catholic Church has played in shaping both the pro-life movement and public policy.

Abortion in the United States

Women have been having abortions as long as history has been recorded, regardless of the procedure's legal status or its concealment from public view. According to Kristen Luker, author of a seminal work on abortion, there was essentially no regulation of abortion in the United States until the end of the nineteenth century, at which point all states had passed laws that forbid abortion at any stage of pregnancy.⁴ These laws did little to restrict the demand for abortion, though, and women found ways to get the procedure in spite of its prohibition. The reason that criminalizing abortion did not decrease the rate of abortion is simple: these laws did nothing to prevent accidental pregnancies, which are one of the common reasons why women seek abortions in the first place. Rates of illegal abortion were particularly high during the Great Depression, since many women could not afford children who resulted from unintended pregnancies.⁵

The illegality of abortion did however have serious effects on the safety of the procedure. A ten-year study conducted in Philadelphia in the early twentieth century indicated that 20

⁴ Kristin Luker, *Abortion and the Politics of Motherhood* (Berkeley: University of California, 1984), 15.

⁵ Luker, 50.

percent of maternal deaths were the result of a botched abortion, either self-induced or abortionist-induced.⁶ Therapeutic abortions performed by physicians were available, too, but in limited supply; the aforementioned abortion laws permitted the procedure when it was deemed necessary to preserve the life of the mother.⁷ In fact, Leslie J. Reagan explains that therapeutic abortions provided a “legal loophole” during the time when abortion was illegal, because of the fact that there was disagreement among medical professionals at the time about what criteria should be used in deciding the necessity of an abortion.⁸ Therefore, determining what constituted a threat to maternal health was nearly completely at the discretion of physicians.

Access to abortion depended on the beliefs of a woman’s doctor, as well as on her connectedness and financial status.⁹ If a woman was lucky enough to find a physician who was sympathetic to the necessity of abortions, her chance of obtaining the procedure was much higher. As private health insurance was and still is unavailable to indigent populations, the criminality of abortion disproportionately affected poor women and women of color.¹⁰ These women often took the matter of ending a pregnancy into their own hands: self-induced abortion techniques included ingesting chemicals and introducing objects such as coat hangers into the uterus.¹¹ In an attempt to offset the dangers of self-induced abortions, a number of physicians

⁶ Luker, 49.

⁷ Luker, 54-57.

⁸ Leslie J Reagan, *When Abortion Was a Crime Women, Medicine, and Law in the United States, 1867-1973*, (Berkeley: University of California, 1997), 61-62.

⁹ Luker, 57.

¹⁰ Heather D. Boonstra, Rachel Benson Gold, Cory L. Richards, Lawrence B. Finer, *Abortion in Women’s Lives* (New York, NY: Guttmacher Institute, 2006), 4,

<https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/05/04/AiWL.pdf>.

¹⁰ Luker, 50.

¹¹ OBOS Abortion Contributors, "History of Abortion in the U.S.," *Our Bodies Ourselves*, March 28, 2014, <http://www.ourbodiesourselves.org/health-info/u-s-abortion-history/>.

provided illegal abortions, and some religious organizations even offered women information about where they could seek a safe, illegal abortion.¹²

Though it is tempting to separate birth control from abortion due to the intense stigma surrounding the latter, efforts to provide women with safe, reliable birth control are intimately connected with the abortion movement. In a publication given at the International Summit for Reproductive Choice, Beverley Winikoff argues that separating birth control from abortion creates a dangerous dichotomy, which implies that women avoid unwanted pregnancy either by using contraception or by getting an abortion, though the two are not mutually exclusive.¹³ To assume that women who use birth control do not get abortions and vice versa completely misrepresents the reproductive decisions that women actually make. Access to contraceptives decreases the need for abortion, whereas women without access to contraceptives may only have one option to control their fertility – abortion. Acknowledging the relationship between these abortion and contraceptives is essential to understanding policy disputes over abortion in the United States as well as to making informed decisions about reproductive rights policy.

Furthermore, many parties that have historically opposed abortions have also opposed birth control. During the first half of the 20th century, the use of birth control was outlawed in the United States, in large part due to the Comstock Act of 1873 and the act's namesake, Anthony Comstock. The Act forbade the production, distribution, and dissemination of information about birth control and abortions, and it carried a penalty of up to five years in prison and a \$2000 fine.¹⁴ In addition to political and legal opposition to contraceptives, as one might expect, religious institutions have also played an important role in shaping the reproductive rights

¹² *Our Bodies Ourselves*.

¹³ Beverly Winikoff, "Is One of These Things Not Just Like the Other?" *Conscience*, September 12, 2014, <http://consciencemag.org/2014/09/12/is-one-of-these-things-not-just-like-the-other/>.

¹⁴ Encyclopedia Britannica Online, s.v. "Comstock Act United States (1873)," Accessed February 06, 2016, <http://www.britannica.com/event/Comstock-Act>.

controversy. The Catholic Church is one of the oldest opponents of birth control and abortion; Church doctrine teaches that sex is only for procreation and any thought or action otherwise is a sin.¹⁵ These opponents believed that allowing women to control their fertility – and to enjoy sex purely for its own good – would lead to a degradation of society’s morals. In spite of strong opposition from a variety of sources, women still sought to control when they got pregnant, both before conception with birth control and after conception with abortion.

Margaret Sanger is widely known as the “heroine” of women’s rights, since she was the key figure responsible for making birth control accessible in the United States, as well as for spearheading the development of oral birth control methods.¹⁶ Sanger was trained as a nurse, and she was drawn to activism after witnessing the horrors of unwanted pregnancy in her work.¹⁷ Sanger recognized that women desperately needed a way to control their fertility, and her relentless efforts yielded results that would improve the female condition forever. In 1937, the American Medical Association condoned the incorporation of birth control into physician’s practices, and a year later a federal judge overturned the contraceptive obscenity ban.¹⁸ While bans on contraceptives themselves remained in place in many states, the number of contraception clinics nationwide increased from 55 clinics in 1930 to more than 800 in 1942.¹⁹

In addition to her attempts to legalize preexisting birth control methods such as condoms and diaphragms, Sanger also sought to implement new methods. With the help of Dr. Gregory

¹⁵ Jonathan Eig, *The Birth of the Pill: How Four Crusaders Reinvented Sex and Launched a Revolution* (New York: W. W. Norton & Company, 2014), 14.

¹⁶ Eig, *The Birth of the Pill*.

¹⁷ Jon Knowles, "Margaret Sanger - 20th Century Hero," *Planned Parenthood Federation of America*, August 2009. Accessed February 6, 2016, https://www.plannedparenthood.org/files/7513/9611/6635/Margaret_Sanger_Hero_1009.pdf.

¹⁸ Knowles, "Margaret Sanger - 20th Century Hero."

¹⁹ Megan Gibson, "The Long, Strange History of Birth Control," *Time*, February 2, 2015, Accessed February 6, 2016, <http://time.com/3692001/birth-control-history-djerassi/>.

Pincus, Sanger was able to provide a birth control method that is 99% effective: the pill.²⁰ The pill (and other contraception) revolutionized the female condition because in several important ways, it made women equal to men. First, like men, women were able to enjoy sex without the consequences of unintended pregnancy. Second, gaining the ability to control their fertility allowed women to advance in society in ways they never had before. Many women were unable to pursue higher education because of pregnancy, and those who were fortunate enough to receive degrees were often unable to move up the ladder because of pregnancy later on. With the advent of safe, effective birth control methods, women were able to control their life trajectories by postponing motherhood, either temporarily or indefinitely. The core triumph of Margaret Sanger and her colleagues was to afford women *control* and *choice*.

Despite these advances, the American legal system still had to catch up with regards to legal protections for reproductive rights. The legal progress began in 1965, when the Supreme Court said in *Griswold v. Connecticut* that a ban on birth control for married couples was unconstitutional, as was prohibiting physicians from telling their patients about birth control.²¹ Writing for the majority in *Griswold*, Justice Douglas also set forth a penumbral right to privacy, which creates “zones of privacy” by combining the protections of the first, third, fourth, fifth, and ninth amendments. Marital privacy and the privacy of doctor-patient relationship fall within these penumbral zones of privacy, said the Court. Then, in *Eisenstadt v. Baird* in 1972, the Court extended the right to possess and use contraceptives to unmarried people.²² Finally, women gained the right to an abortion in 1973 with *Roe v. Wade*, but not before about a decade of aggressive reform efforts by pro-choice advocates.

²⁰ Eig, 1-11.

²¹ *Griswold v. Connecticut*, 381 U. S. 479 (1965).

²² *Eisenstadt v. Baird*, 405 U. S. 438 (1972).

In the 1960s, activists began campaigning for the reform of abortion laws at the state level. There is divergence among authors about where exactly the first changes took place, but all agree that the laws had the same purpose and function: to liberalize abortion. As previously mentioned, a significant problem with earlier abortion laws was that they were vague and produced disagreement among medical professionals. The reformed laws explicitly set forth the “indications” for a therapeutic abortion, or in other words, exactly what constituted a threat to maternal health.²³ Other new laws also allowed abortions when a pregnancy was the result of rape or incest. Over the next decade, some states began reforming or even repealing their abortion laws altogether. In 1970, Hawaii legalized the procedure through 20 weeks of pregnancy for state residents, followed by New York, where non-therapeutic abortions were legalized through the 24th week of pregnancy.²⁴ Then, in 1973, the Supreme Court released its landmark decision *Roe v. Wade*, which made abortion legal nationwide.

Roe v. Wade and the Galvanization of the Pro-Life Movement

In the 1973 landmark case *Roe v. Wade*, the Supreme Court ruled that women have a constitutional right to abortion, which falls within the zones of privacy established in *Griswold*. In the Opinion of the Court, Justice Blackmun writes that “the right of personal privacy includes the abortion decision, but that this right is not unqualified, and must be considered against important state interests in regulation.”²⁵ Blackmun explains that the state has legitimate interests in upholding medical standards, preserving maternal health, and protecting fetal life. The state may have compelling interests in protecting both maternal and potential life, and although the

²³ Luker, 78.

²⁴ “*Our Bodies Ourselves*.”

²⁵ *Roe v. Wade*, 410 U.S. 113 (1973), 154.

lives of mother and fetus are intimately linked, they are separate and distinct and therefore require different protections.

In defining these protections, Justice Blackmun develops what is known as the Trimester Analysis. Since medical research at the time indicated that a woman's mortality is lower in first trimester abortions than it is in normal childbirth, the state has a compelling interest in protecting maternal health only after the end of the first trimester. During the first trimester, *Roe* afforded unfettered access to abortion. However, during the second trimester, "a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health."²⁶ Access to abortion during the second trimester could thus only be regulated, not prohibited. Finally, Blackmun explains that a state's interest in protecting potential life becomes compelling at the point of viability in the third trimester, "because the fetus then presumably has the capability of meaningful life outside the mother's womb."²⁷ A state therefore may prohibit abortions only after the point of viability, which at the time of *Roe* was between 24 and 28 weeks.

Although pro-life and anti-abortion forces first materialized in the United States in the mid-19th century, the pro-life movement did not truly take shape until after the decision in *Roe* was handed down. Between and 1967 and 1973, the pro-life movement was in its "awakening stage," during which activists were mainly focused on state-level issues, according to Scott Klusendorf, a prominent pro-life activist.²⁸ Authors Luker, Jacoby, and Munson agree that *Roe* was the force that galvanized the pro-life movement, uncovering a "vast untapped sea of abortion

²⁶ *Roe v. Wade*, 163.

²⁷ *Roe v. Wade*, 163.

²⁸ John Stonestreet, "A Brief History of the Pro-Life Movement," *Breakpoint*, March 12, 2014, Accessed March 26, 2016, <https://www.breakpoint.org/component/blog/entry/12/24765>.

opponents.”²⁹ According to Luker, more of the people interviewed for her book “joined the pro-life movement in 1973 than in any other year,” and “almost without exception, they reported that they became mobilized to the cause on the very day the decision was handed down.”³⁰ Before *Roe*, Luker writes, many pro-life individuals simply had no idea that anyone could condone abortion, mainly because these individuals had never met anyone who did not share their beliefs. Most of the individuals galvanized by *Roe* were white, female homemakers, most of whom were actively religious.³¹

Many pro-life individuals felt that the *Roe* decision was completely out of the blue, though it was in fact “the result of over a decade of political activity, during which sixteen states, including California, had passed greatly liberalized abortion laws.”³² The pro-choice movement was excited by the decision in *Roe*, though not in the way that the decision seriously invigorated pro-life forces. As discussed above, pro-choice activists began working in the 1950s and 60s to liberalize abortion laws, which were of course opposed by the small number of pro-life activists at that time. Pro-choice efforts began as a reaction to the miserable state of abortion in the United States, and pro-life mobilization responded to those pro-choice efforts. In particular, vigorous policy and legal efforts by pro-life groups, especially American Catholic bishops, began after a series of calls to action by church officials, which will be discussed below. Pro-life activism, in its most aggressive form, was a direct response to *Roe*.

According to Luker, nearly 80 percent of the female pro-life activists she interviewed for her book, *Abortion and the Politics of Motherhood*, were Catholic. This number may seem high, but there are important structural reasons why so many pro-life activists were Catholic. Jacoby

²⁹ Kerry N. Jacoby, *Souls, Bodies, Spirits: The Drive to Abolish Abortion Since 1973*. (Westport, CT: Praeger, Publishers, 1998) <https://books.google.com/books?isbn=0275960447>.

³⁰ Luker, 137.

³¹ Luker, 138-139.

³² Luker, 127.

argues that the institutional structure of the Catholic Church made Catholics poised to join the early pro-life movement in a way that their Protestant counterparts were not, lacking an institutional authority equivalent to the Church and the Pope: “While Catholics and Protestants share certain Christian beliefs, Protestants generally view the traditions of their denominations as something more akin to habits than doctrine.”³³ Luker’s research substantiates this claim, as several pro-life individuals interviewed for her book give Catholic teachings as the source of their pro-life views, with one even citing grade school catechism classes.³⁴ There is a clear connection between Catholicism and being pro-life, a product of the way the Church inculcates its adherents with pro-life values. The unique status of the Catholic Church to frame the abortion issue in doctrinal terms allowed it to launch its “moral crusade” against abortion after *Roe*, as did the social power and prominence held by the Catholic bishops.³⁵

The Bishops and Public Policy

The Catholic Church has been active in the abortion debate since abortion reform efforts began in the 1960s, and since then, they have continued to influence public policy and law. From the end of the 1960s until the decision in *Roe*, the National Conference of Catholic Bishops (NCCB, later combined with the United States Catholic Conference, USCC, and renamed the United States Conference of Catholic Bishops, USCCB) released a series of statements opposing abortion, but their early action remained at the state-level.³⁶ Luker writes that in the California Legislature, testimony against a proposed liberalized abortion bill, the Beilenson Bill, came primarily from Catholic organizations like the Catholic Physicians Guild, as well as from

³³ Jacoby, 29.

³⁴ Luker, 146.

³⁵ Jacoby, 64.

³⁶ Timothy A. Byrnes, *Catholic Bishops in American Politics* (Princeton, NJ: Princeton University Press, 1991), 57.

individual Catholic doctors.³⁷ Before *Roe*, most of the abortion reform action was taking place at the state level, as discussed previously, so it is logical that abortion opponents concentrated on state statutes, too.

When the *Roe* decision was handed down, “Cardinal John Krol, president of the NCCB denounced the decision as “bad logic and bad law” and called it “an unspeakable tragedy for this nation”.³⁸ The NCCB’s committee on pro-life activities issued a call to action and encouraged the exploration of “every legal possibility” to challenge *Roe*, a decision that “withdraws all legal safeguards for the right to life of the unborn child.”³⁹ Soon, the bishops realized that exploring all legal options required a campaign to pass a constitutional amendment protecting a right to life. The first step in this campaign was to establish the National Committee for a Human Life Amendment (NCHLA) in 1974, which was a lobbying group that worked toward the passage of the amendment.⁴⁰ NCHLA was initially funded entirely by the bishops, and the group has remained affiliated with the Church during its activity to the present day.⁴¹

The next step in the bishops’ attempt to establish a pro-life amendment was to send Cardinals to testify before the Senate Subcommittee on Constitutional Amendments in March of 1974.⁴² Interestingly, Byrnes writes that some bishops did not want to draft any specific language for a potential pro-life amendment for fear of isolating abortion as a solely Catholic issue. The bishops’ Senate testimony included the following central arguments:

1. “The right to life is a basic human right which should be protected by law.

³⁷ Luker, 83.

³⁸ Byrnes, 57.

³⁹ Byrnes, 57.

⁴⁰ Byrnes, 58.

⁴¹ "About: Human Life Action." Human Life Action - National Committee for a Human Life Amendment, Accessed March 28, 2016, <http://www.humanlifeactioncenter.org/about>.

⁴² J. Brian Benestad, *The Pursuit of a Just Social Order: Policy Statements of the U.S. Catholic Bishops, 1966-80* (Washington, D.C.: Ethics and Public Policy Center, 1982), 79.

2. Abortion, the deliberate destruction of an unborn human being, is contrary to the law of God and is a morally evil act.”⁴³

The first argument is later buttressed by claims that the right to life is a basic human right acknowledged in the Declaration of Independence, the Constitution of the United States, and the United Nations Declaration of Human Rights.⁴⁴ The second argument is founded in doctrine, though according to Benestad, the bishops’ testimony framed the second argument as a supplement to the first – that, in addition to reasons discovered in basic human rights philosophy, God’s law provides a prohibition of abortion.⁴⁵ The bishops’ testimony “repeated the assertion that these views were as much based on the bishops’ understanding of American law and tradition as they were on Catholic doctrine and moral values.”⁴⁶

Then, in 1975, the bishops released the *Pastoral Plan for Pro-Life Activities*, which Byrnes explains “has been called the most “focused and aggressive political leadership” ever exerted by the American Catholic Hierarchy.⁴⁷ The Pastoral Plan outlined three main pro-life goals of the Church: first, a public information and education program to educate the public about the threat of abortion and the need for legal protections for unborn life; second, to provide pastoral care to women facing difficult child-bearing decisions; and third, a legislative policy agenda in the defense of life.⁴⁸ The introduction of this plan marked the first time in United States history that a “major religious group launched a concerted, nationwide, and overt political

⁴³ *Testimony of United States Catholic Conference on Constitutional Amendment Protecting Unborn Human Life before the Sub-Committee on Constitutional Amendments of the Senate Committee on the Judiciary*, United States Cong. (1974) (testimony of Cardinal John Krol).

⁴⁴ Benestad, 79.

⁴⁵ Benestad, 79.

⁴⁶ Byrnes, 58.

⁴⁷ Byrnes, 58.

⁴⁸ Benestad, 80.

effort on a single topic.”⁴⁹ The Pastoral Plan represented the start of the Church’s involvement in public policy, specifically with regards to abortion. The bishops played a role in the 1976 presidential election by attempting to make politicians publicly state their position on abortion, though their efforts failed to help elect a pro-life candidate.⁵⁰ In light of this failure, “the pro-life movement sought alternative means of undercutting, if not altogether reversing, the *Roe v. Wade* decision.”⁵¹

The first means by which they sought to achieve this goal was to mobilize forces to pass the Hyde Amendment.⁵² In fact, some authors have attributed the passage of the Hyde Amendment almost entirely to the Pastoral Plan and the action of the Catholic Church (Mumford, Miller, Hofman). “During the debates on the Hyde Amendment in the 94th Congress, the Catholic Church played an active role in organizing its parishioners in every congressional district to lobby their congressmen to support the Amendment, pursuant to its *Pastoral Plan for Pro-Life Activities*,” according to Brenda Hofman.⁵³ As discussed above, the unique position and power of the Catholic Church gave them strong footing to enter the abortion debate and impact policy, which led them to their first policy victory with the passage of the Hyde Amendment and has continued to help in their current efforts.

Today, the bishops remain highly active in American public policy and law, and though their pro-life activities encompass a wide range of issues, abortion is clearly still at the forefront of the bishops’ political action. Curran argues that the media paid more attention to the Church’s

⁴⁹ Paul D. Simmons, “Reviewed Work: *The Politics of Abortion: A Study of Community Conflict in Public Policy Making* by Raymond Tatalovich, Byron W. Daynes,” *Journal of Church and State* 26, no. 1 (Winter 1984): 121–22. <http://www.jstor.org/stable/23917594> (accessed April 16, 2016).

⁵⁰ Brenda D. Hofman, “Political Theology: The Role of Organized Religion in the Anti-abortion Movement,” *Journal of Church and State* 28, no. 2 (Spring 1986): 225–47. <http://www.jstor.org/stable/23917655> (accessed April 16, 2016).

⁵¹ Hofman, 239.

⁵² *The Hyde Amendment forbids the use of federal funds for abortion services, except in cases of rape, incest, or danger to the mother. The law primarily affects Medicaid recipients.*

⁵³ Hofman, 239.

stance on abortion than to any other stance it took on issues of public policy, adding to the politicization of abortion as a whole.⁵⁴ The USCCB website offers a variety of resources about how the bishops remain involved in politics, as well as about how parishioners can join their cause. The bishops maintain a page about public policy, where they post updates about current issues and how they are involved, including proposed amendments, press releases, and letters sent to legislators. They provide information about their continued provision of testimony before Congress on issues ranging from migration to gun violence. On the USCCB's "Issues and Action" page, the bishops explain that they seek to provide information so that "Catholics are better able to evaluate policy positions, party platforms, and candidates' promises and actions."⁵⁵ Specific issues listed include religious liberty, faithful citizenship, marriage and family, cultural diversity, human life and dignity, and youth protection. The page also includes an Action Center, which lists current issues and where followers can sign up for email alerts about action on those issues.

Discussing the role of the Catholic Church in public policy is important in understanding the character and strategy of the Church as an institution. As discussed, the bishops have had a strong influence in the development of abortion policy and therefore have shaped the current legislative efforts to restrict abortion. Religion plays a powerful role in the lives of many still today, both in the United States and elsewhere. Acknowledging the influence of religion generally and the Catholic Church specifically is important as this thesis turns to discuss conflicts that appear at the intersection of religion and medicine and which impact believers and nonbelievers alike. Furthermore, it is important to recognize that by taking control of the

⁵⁴ Charles E. Curran, "The U.S. Catholic Bishops and Abortion Legislation: A Critique from Within the Church," *An Occasional Paper* 28 (2011), <https://www.smu.edu/~media/Site/Provost/Ethics/pdfs/Curran%2028.ashx?la=en> (accessed February 8, 2016).

⁵⁵ "Issues and Action," United States Conference of Catholic Bishops, Accessed March 29, 2016. <http://usccb.org/issues-and-action/index.cfm>.

discussion about abortion immediately after *Roe*, Catholic Church was essential in shaping the pro-life definition of abortion. This definition, which is extremely rigid, becomes vital in examining the provision of maternal health care in Catholic hospitals. This definition and its complete polarization from the pro-choice understanding of abortion is one of the primary reasons why abortion has been and continues to be one of the most contentious topics in American politics and culture.

Abortion today looks vastly different from the time immediately before and after *Roe*, and it is without question that the conditions of abortion in the United States have improved dramatically since the procedure was legalized, in spite of TRAP law restrictions. In 2011, abortion rates were the lowest they have been since *Roe*, at 16.9 abortions per 1,000 women aged 16-44.⁵⁶ According to the Guttmacher Institute, “one-third of abortions occur at six weeks of pregnancy or earlier,” and “89% occur within the first twelve weeks.”⁵⁷ Abortion safety has increased exponentially, particularly as a result of medical abortion, which entails administering the drug mifepristone to induce an abortion, as opposed to performing the procedure surgically. Still, studies show that abortion in all cases is “markedly safer than childbirth,” as “the risk of death associated with childbirth is 14 times higher than that with abortion.”⁵⁸ Guttmacher also reports that women continue to have abortions for a multitude of reasons, including those relating to education, employment, and personal finances.

As this chapter has demonstrated, *Roe* marked a turning point in American social politics to galvanize some of the most aggressive political activism, which still exists today. Advocates

⁵⁶ The Guttmacher Institute, *Facts on Induced Abortion in the United States*, March 2016, accessed April 21, 2016, https://www.guttmacher.org/sites/default/files/pdfs/pubs/fb_induced_abortion.pdf, 1.

⁵⁷ *Facts on Induced Abortion in the United States*, 2.

⁵⁸ Elizabeth G. Raymond and David Grimes, “The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,” *Obstetrics & Gynecology* 119, no. 2 (February 2012): 215, <http://unmfamilyp planning.pbworks.com/w/file/ fetch/82184965/The%20Comparative%20Safety.pdf>.

on both sides of the abortion debate have employed a variety of tactics to advance their agendas, either pro-life or pro-choice, with varying degrees of success. Readers should consider the issues explored in the following chapters within the context of the abortion debate in general, because conflicts in care in Catholic hospitals are in part a product of the activism, legislation, and thinking that has been generated since *Roe*. Next, the discussion will turn to consider the conscience legislation that has proliferated as a result of the abortion controversy, both at the Federal and State levels.

CHAPTER TWO:

Conscience Legislation and Religious Liberty in the United States

In the area of reproductive health care, federal and state laws protecting individual and institutional conscience protections have created concerns for medical practice, because non-medical legislators are making decisions about medical issues. This chapter will explore the proliferation of conscience laws that began after *Roe*, most of which provide protections for healthcare professionals with regards to abortion and contraception services. These policies exist at the federal and state levels, but as an analysis of the conscience laws of every state is beyond the scope of this thesis, the discussion will focus on federal policy.

Federal Conscience Legislation

Conscience clauses originated with opposition to the military draft, by which the federal government allowed individuals to claim conscientious objection to war on religious grounds.⁵⁹ Individuals who opted out of military service were known as “conscientious objectors.” Since the Supreme Court handed down its decision in *Roe v. Wade* in 1973, however, conscience legislation has been enacted to allow medical professionals and other health care providers to refuse to provide certain types of care because of their religious beliefs. Now, conscientious objectors exist in many aspects of public and private life, most notably in the realm women’s healthcare. There are two main types of healthcare conscience protections: individual and institutional. As will be discussed in detail below, individual conscience protections are written as prohibiting employers from discrimination against an individual employee who refuses to

⁵⁹ Claire Marshall, "The Spread of Conscience Clause Legislation," *Human Rights Magazine* 39, no. 2 (January 2013), http://www.americanbar.org/publications/human_rights_magazine_home/2013_vol_39/january_2013_no_2_religious_freedom/the_spread_of_conscience_clause_legislation.html.

provide certain services based on his or her religious or moral beliefs. Institutional conscience protections, on the other hand, allow entire institutions to refuse certain types of care on the basis of religious or moral beliefs. These conscience laws typically protect objections to abortion, contraceptives, and sterilization, though the list of objections has grown since the first conscience laws were passed.

In direct response to the Court's decision in *Roe*, Congress passed the Church Amendments in 1973, authored by Senator Frank Church, which provide two sets of protections. First, the law set forth that individuals or institutions may not be compelled "to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions."⁶⁰ Second, the law prohibits discrimination "in the employment, promotion, or termination of employment of any physician or other health care personnel" if he or she "he performed or assisted in the performance of a lawful sterilization procedure or abortion" *or* if he or she refused to perform or assist in abortion or sterilization procedures because doing so "would be contrary to his religious beliefs or moral convictions."⁶¹ In other words, the law prohibits discrimination against individuals who both provide and refuse to provide abortion or sterilization services. These amendments apply to any individual or institution that receives funding under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act.

In the forty years that have followed, several other pieces of federal legislation have been passed that serve to bolster the opt-out and anti-discrimination aspects of the Church

⁶⁰ Church Amendments, 42 U.S.C. § 300a-7 (1973).

⁶¹ Church Amendments

Amendments.⁶² The Public Health Service Act § 245, passed in 1996, provides that no one may be forced to undergo training for abortion procedures.⁶³ The law states that neither the Federal Government nor any state or local governments receiving federal funding can discriminate against any “health care entity” on the basis of refusal to provide or participate in abortion procedures or to provide or participate in training for abortion procedures. In addition, the law says that no health care entity that refuses to provide abortion training or services will be denied accreditation on the basis of that refusal. A “health care entity” is defined to include “an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.”⁶⁴

Public Health Service Act § 245 allows any individual or institution to refuse to provide abortion procedures as well as training for abortion procedures. This includes graduate medical programs, and as would be expected, the medical specialty most affected by this law is obstetrics and gynecology (OB/GYN). The law was passed shortly after the Accreditation Council for Graduate Medical Education (ACGME) stated in 1995 that it would require all OB/GYN programs to provide abortion training in order to be accredited.⁶⁵ The provisions of Public Health Service Act § 245 make the ACGME’s abortion training requirement effectively null, creating an instance in which the word of a leading medical authority was struck down by a governing body with no medical jurisdiction. More will be said about the interactions of medical authorities with non-medical authorities in chapter seven..

⁶² Congressional Research Service, *The History and Effect of Abortion Conscience Clause Laws*, by Jody Feder, RS21428 (Washington, DC.: Library of Congress, 2005)

<http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>

⁶³ "Overview of Federal Statutory Health Care Provider Conscience Protections," *U.S. Department of Health and Human Services*, <http://www.hhs.gov/civil-rights/for-individuals/conscience-protections/index.html>, accessed April 21, 2016.

⁶⁴ Public Health Service Act §245, 42 U.S.C. § 238n (1996).

⁶⁵ Angel M. Foster, Jane van Dis, Jody Steinauer, “Educational and Legislative Initiatives Affecting Residency Training in Abortion,” *Journal of the American Medical Association* 290, no. 13 (October 1, 2003), <http://jama.jamanetwork.com/article.aspx?articleid=197390>.

Nearly a decade after the passage of Public Health Service Act § 245, Congress attached a conscience clause to the 2005 Consolidated Appropriations Act, known as the Weldon Amendment. It afforded protections for “health care entities” similar to those in previous conscience laws, but it revised the term “health care entities” to include “an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”⁶⁶ The Weldon Amendment had serious implications for federal conscience law because it greatly expanded the list of “entities” to which conscience protections applied. Jodi Feder explains that while previous laws restricted conscience protections to physicians and medical training programs, this amendment expanded protections to include health insurance companies and HMOs.⁶⁷ She predicted that “since an HMO’s refusal to provide abortion-related services would affect a much larger number of patients than would an individual doctor’s refusal to provide such services,” this conscience law could mean that many more individuals are affected by abortion-refusals.⁶⁸

Most recently, the Bush Administration enacted an expansive conscience bill in January of 2009, ironically on the day President Bush relinquished the Oval Office to President Obama.⁶⁹ The law, called the Provider Refusal Rule, again expanded both the list of providers who could refuse services and the services they could refuse, but it has been criticized as vague and overreaching.⁷⁰ The expanded list of care refusals included “counseling, referral, training, and other arrangements for the procedure, health service, or research activity,” and though “health

⁶⁶ Weldon Amendment, Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, 125 Stat 786 (2005).

⁶⁷ Feder, 5

⁶⁸ Feder, 5.

⁶⁹ Saundra Young, "White House Set to Reverse Health Care Conscience Clause," *CNN*, 27 Feb. 2009, http://www.cnn.com/2009/POLITICS/02/27/conscience.rollback/index.html?eref=ib_us.

⁷⁰ Rob Stein, "Obama Administration Replaces Controversial 'conscience' Regulation for Health-care Workers," *Washington Post*, 19 Feb. 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/18/AR2011021803251.html>.

care entity” was again redefined and broadened even further.⁷¹ According to Rob Stein of the *Washington Post*, the new definition of “health care entities” allowed essentially anyone working in proximity to abortion care to claim conscience protection, including receptionists who might refuse to schedule appointments for objectionable procedures or janitors who might refuse to clean an operating room where objectionable procedures were performed. In addition, the law protected more than just abortions – any procedure that any individual deemed objectionable fell within the scope of the law, potentially including sterilizations as well as HIV/AIDS treatments.⁷² President Obama finally rescinded the law in 2011, though still leaving in tact previous conscience protections.

The Provider Refusal Rule drew opposition from some groups and support from others, and each side was interested in protecting different types of rights. On one hand, physicians like Dr. Suzanne Poppema of Physicians for Reproductive Choice and Health praised President Obama’s decision to rescind the law as “placing good health care over ideological demands.”⁷³ Conversely, lawyers from Americans United for Life condemned President Obama’s decision, stating that “enforcement of the basic civil right to provide care for patients without being required to participate in life-destroying and unethical activities should not hinge on who sits in the White House.”⁷⁴ The debate over the law boiled down to a tension between patient rights to health care and the right of religious belief.

Two additional conscience bills are currently before Congress –the Conscience Protection Act of 2016 and the Health Care Right of Conscience Act. The first proposed law would give

⁷¹ Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law; Final Rule, 73 Fed. Reg. 245 (proposed December 19, 2008) (to be codified at 45 CFR pt. 88) <https://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30134.pdf>.

⁷² Stein, Rob.

⁷³ Young, Sandra.

⁷⁴ Denise Burke, and Anna Franzonello, "Healthcare Rights of Conscience: A Survey of Federal and State Law, " *Defending Life* (2012): 547-553, <http://www.aul.org/wp-content/uploads/2012/04/survey-fed-state-law.pdf>.

legal recourse to individuals who believe their conscience has been violated, requiring the Director of the Office for Civil Rights of the Department of Health and Human Services to take complaints and investigate these cases.⁷⁵ The second law is more expansive: first, it would “apply longstanding policy on conscience rights to the Affordable Care Act” by amending the ACA to include a new section titled “Respecting Conscience Rights in Health Coverage.”⁷⁶ This new section would include conscience protections that would prohibit the government from requiring individuals and institutions to purchase or provide health insurance coverage that includes abortion or other objectionable care. Furthermore, it would prohibit the imposition of a fee or tax related to the exclusion of care that is objectionable based on an individual or institution’s religious belief.⁷⁷ Like the Conscience Protection Act of 2016, the Health Care Right of Conscience Act would also give entities claiming conscience violations legal recourse via the Office for Civil Rights of the Department of Health and Human Services.

The introduction of these laws before Congress highlights the perpetually strong advocacy for the expansion of conscience rights. Though neither law has been passed (and probably will not be for a while, considering the gridlock that Congress currently faces), they are part of a larger trend of increasingly broad religious liberty claims. More will be said about these claims and the future of conscience rights later in this thesis.

⁷⁵ Conscience Protection Act of 2016, H.B. 4828, 114th Congress (2016) <https://www.congress.gov/bill/114th-congress/house-bill/4828/text>.

⁷⁶ Health Care Right of Conscience Act, H.R. 940, 114th Congress (2015) <https://www.congress.gov/bill/114th-congress/house-bill/940/text>.

⁷⁷ The Health Care Right of Conscience Act bears particular significance because it is a clear response to claims that have been made against the Contraceptive Mandate of the ACA, which are currently being considered by the Supreme Court in *Zubik v. Burwell*. The case involves seven religious non-profits that claim that signing a form to indicate that their religious beliefs prohibit them from providing contraceptive coverage in their employee health plans is a substantial burden on their religious practice. The government argues that providing free, easily accessible contraceptive coverage constitutes a compelling government interest and therefore, the burden on religious exercise is justified. The religious non-profits have brought their case under the Religious Freedom Restoration Act, which requires that any law that substantially burdens religious exercise be shown to have a compelling government interest, as will be discussed in further in the conclusion of this thesis. The case is still pending before the Court, and a decision is expected some time in the next few months.

State Conscience Legislation

By 1978, nearly all states had enacted conscience legislation of their own, complementing and expanding the federal laws already in place.⁷⁸ Like the federal conscience legislation discussed above, these clauses primarily protect refusals in the realm of health care – abortion, contraception, sterilization, and end-of-life care. The Guttmacher Institute’s research indicates that as of March 1, 2016, forty-five states have passed conscience legislation that allows “some” health care providers to refuse to participate in abortion services.⁷⁹ In addition, forty-three states allow institutional refusals for abortion services, with thirteen limiting protection to private institutions and only one limiting refusal exclusively to religious health care institutions.⁸⁰ Twelve states also have policies that permit refusals to provide services related to contraceptives, though the scope of “entities” covered by the refusal policies vary by state.⁸¹

Conscience laws at the state and federal level have proliferated as a direct result of the legality of abortion. As shown above, these laws have become increasingly broad since the 1970s, strengthening conscience protections for sincerely held beliefs but also necessarily making abortion harder to access. Therefore, finding a way to balance conscience rights and abortion access is a central goal of this thesis, as this tension is augmented within the scheme of the Catholic health ministry’s conflicts in care. In order to understand the context in which these conflicts arise, it is necessary to analyze the *Ethical and Religious Directives for Catholic Health Care Services*. This discussion will reveal the tension that exists between reproductive and conscience rights within Catholic hospitals.

⁷⁸ Feder, 2.

⁷⁹ "State Policies in Brief: Refusing to Provide Health Services," *Guttmacher Institute*, 1 Mar. 2015, https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_RPHS.pdf.

⁸⁰ "Refusing to Provide Health Services," Guttmacher Institute.

⁸¹ "Refusing to Provide Health Services," Guttmacher Institute.

CHAPTER THREE:

Catholic Health Care, the *Directives*, and Conflicting Interpretations

Catholic health care has played an important role in American society since the 19th century, guided by the *Ethical and Religious Directives for Catholic Health Care Services* (henceforth “the *Directives*”), which have evolved over the last seventy years in response to a changing social and medical landscape. The previous chapter explored the secular policies that ensure institutional conscience rights, and this chapter will explore how institutions exercise those rights. An analysis of relevant Catholic ethical directives will provide perspective on how abortions and conscience clauses have produced tension in Catholic hospitals. The discussion will then consider criticisms of the *Directives*, particularly how they are interpreted and applied. Analysis throughout this chapter will highlight key issues that arise as a result of conflict within the American Catholic health ministry, all of which contribute to the questions that are the central focus of this thesis.

Catholic Health Care in the United States and the History of the Directives

Today, more than 600 Catholic hospitals are in operation in the United States, providing health care to 1 in 6 Americans every year.⁸² Catholic health care facilities retain more than half a million full-time employees, as well as nearly a quarter of a million part-time employees.⁸³ As they are affiliated with the Catholic Church, these hospitals seek to infuse their medical practice with doctrinal beliefs that stem from their faith. Among those beliefs are complete prohibitions of direct abortions and sterilizations. As will be discussed in chapter five, scholars have produced

⁸² "The Facts About Catholic Health Care in the United States," *Catholics for a Free Choice*, September 2005, Accessed April 16, 2016,

<https://www.catholicsforchoice.org/topics/healthcare/documents/2005factsaboutcatholichealthcare.pdf>.

⁸³ "Facts and Statistics: Catholic Health Care in the United States," *The Catholic Health Association of the United States*, January 2016, Accessed April 16, 2016, <https://www.chausa.org/about/about/facts-statistics>.

extensive evidence that grounds these beliefs in scripture and church documents. Controversy arises surrounding when and how to apply these beliefs and others in maternal care. The discussion in this chapter will indicate that there is significant disagreement about how Catholic ethics should be applied in Catholic hospitals, even among Catholic hospitals and health organizations themselves.

The first Catholic hospitals in the United States were founded by nuns, whose primary goal was to apply their faith in helping the sick. They developed their own nursing practices despite a lack of formal medical training.⁸⁴ Then, in 1915, the Catholic Hospital Association (now the Catholic Health Association, or CHA) was established in order to unify Catholic health care institutions in the United States.⁸⁵ Although there were a variety of reasons why a unified system was beneficial to Catholic hospitals, including financial concerns, a need for written ethical guidelines was an important goal among Catholic health care providers at the time of CHA's founding.⁸⁶ According to CHA, in 1921, Reverend Michael Burke assembled a set of medical ethical norms to provide direction to Catholic health care facilities and providers in dealing with complicated moral issues.⁸⁷ The list included instructions for beginning-of-life care, forbidding direct sterilization and the destruction of fetal life.

However, as medical science progressed over the years, "the ministry of health care became more complicated and extensive, and a new more complete document was needed."⁸⁸ In response to this need, the first set of *Directives*, called the *Ethical and Religious Directives for*

⁸⁴ Sandra Hapenny, "Divergent practices among Catholic hospitals in provision of direct sterilization," *The Linacre Quarterly*, 80:1 (July 2013): 32-38, DOI: 10.1179/0024363912Z.0000000003.

⁸⁵ "About Our History," *The Catholic Health Association of the United States*, Accessed April 16, 2016, <https://www.chausa.org/about/about/our-history>.

⁸⁶ Kevin O'Rourke, Thomas Kopfen-Steiner, and Ron Hamel, "A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services," *Health Progress* November-December (2001): 18-21, <https://www.chausa.org/docs/default-source/health-progress/a-brief-history-pdf.pdf?sfvrsn=0>. Accessed April 16, 2016.

⁸⁷ O'Rourke, Kopfen-Steiner, Hamel, 18.

⁸⁸ O'Rourke, Kopfen-Steiner, Hamel, 18.

Catholic Hospitals, was published in the *Linacre Quarterly* in 1948, according to CHA. The fundamental problem with this first set of *Directives*, though, was that it was written by a committee of health providers and theologians, not by a central religious authority, which left the document open to considerable interpretation and revision by individual dioceses and hospitals. To create a truly uniform set of health care rules for Catholic providers, the USCCB itself published the second set of *Directives* in 1971, in the hopes that “if the *Directives* were published by a conference of bishops and promulgated by individual bishops,” uniformity in Catholic health ministry could be achieved.⁸⁹ The goal was to have local implementation of a nationally standardized set of *Directives*. This revision occurred just before the Court’s decision in *Roe* and before the bishops truly became active in shaping public policy and law. In fact, Kevin O’Rourke explains that in 1973, the chairman of the National Conference of Catholic Bishops (former name of the USCCB) recommended that all local dioceses adopt the *Directives* as “official law” to ensure that their health care facilities would be shielded under the Church Amendments’ conscience protections.⁹⁰ This recommendation indicates that the Catholic health ministry has historically tried to align the *Directives* with conscience laws to ensure that Catholic hospitals enjoy legal conscience protections.

Societal and medical advancements over the next forty years would require the bishops to revise the *Directives* three additional times. In the third edition of the *Directives*, released in 1994, the bishops sought to give reasons and explanations for the rules it set forth, as opposed to simply stating what should and should not be done.⁹¹ In 2001, the bishops again revised the *Directives* to offer instructions about cooperation and mergers with non-Catholic health care

⁸⁹ O’Rourke, Kopfen-Steiner, Hamel, 19.

⁹⁰ Kevin O’Rourke, “The Ethical and Religious Directives as Particular Law,” *Health Progress* (July-August 2010) 80-81, <https://www.chausa.org/docs/default-source/health-progress/canon-law---the-ethical-and-religious-directives-as-particular-law-pdf.pdf?sfvrsn=0> (accessed April 16, 2016).

⁹¹ O’Rourke, Kopfen-Steiner, Hamel, 20.

organizations, further adapting the document to a changing health care landscape, according to CHA. Finally in 2009, the bishops published the fifth and current edition of the *Directives*, whose only change from the previous edition is to clarify hydration and nutrition procedures for end-of-life care.⁹²

As mentioned above, the Catholic Church has long opposed contraceptives, abortion, sterilization, and euthanasia – any medical practice that would not serve to respect the dignity of human life. The *Directives* are intended to inform institutional conduct, and they are based firmly in the teachings of the Catholic Church. “A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society,” explain the bishops in the preamble to the *Directives*.⁹³ In this way, the bishops recognize the need for balance between their doctrine and modern society. They view the *Directives* as a means of ensuring that Catholic health care is practiced in line with the goals and vision of the Catholic Church, especially since the issues covered by the *Directives* are the source of longstanding moral and policy debates.

An Analysis of Relevant Directives

As previously mentioned, the *Directives* provide instructions about how Catholic health care institutions and providers should address a variety of medical issues, but only those directives that relate to pregnancy care are relevant to this discussion. Part Four of the *Directives*, called “Issues in Care for the Beginning of Life,” provides standards about maternal health,

⁹² O’Rourke, “The Ethical and Religious Directives as Particular Law,” 80.

⁹³ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed., November 17, 2009, <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>, accessed April 20, 2016.

abortion, miscarriage management, and other pregnancy complications. As would be expected based on traditional Catholic values, the *Directives* prohibit abortion. Directive 45 reads:

Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.⁹⁴

The description of abortion as a “procedure whose sole immediate effect” is to end a pregnancy is deliberate, because it distinguishes direct abortion from an abortion or fetal death that might result from another medical treatment. For example, if a pregnant woman discovers that she has cancer, the Catholic Church would permit her to undergo chemotherapy knowing that the treatment will result in the death of her fetus. In fact, Directive 47 expressly permits these types of “operations, treatments, and medications” intended to save the life of the mother, “even if they will result in the death of the unborn child” and cannot be postponed until after the pregnancy is over.⁹⁵ Permission for abortion or fetal death in these cases is derived from the Principle of Double Effect⁹⁶, which permits certain good actions with bad effects so long as the action is well intended. If the intervention is intended to treat a “serious pathological condition,” the unintended death of the fetus is morally permissible.

Directive 48 is often a source of contention within maternal health in Catholic hospitals.

It concerns extrauterine pregnancy, also known as ectopic pregnancy, and states, “In the case of

⁹⁴ *Directives*, Part Four, Directive 45.

⁹⁵ *Directives*, Part Four, Directive 47.

⁹⁶ In *Contemporary Catholic Health Care Ethics* (2004 Georgetown University Press), David F. Kelly explains that Double Effect has four conditions. First, the act itself cannot be morally wrong. Second, the bad effect must not be the cause of the good effect. Third, the bad effect cannot be sought as the end of the act – it cannot be the principle reason for the act. And finally, the good effects must outweigh the bad. The discussion will return to more fully examine Catholic bioethics in chapter five.

extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.”⁹⁷

However, the *Directives* never clearly define “direct abortion” with regards to extrauterine pregnancy. Ectopic pregnancy, in which a fertilized egg implants itself somewhere outside of the womb, usually in one of the fallopian tubes, is extremely dangerous to the life of the mother and can result in death if left untreated.⁹⁸ If the cells are permitted to continue dividing and the embryo therefore continues to grow, the fallopian tube will eventually rupture, producing deleterious effects on the health of the mother. Furthermore, the fertilized egg cannot survive if it is not implanted properly in the womb, so nearly all ectopic pregnancies are completely unviable.

There is debate among Catholic ethicists about which treatments of ectopic pregnancy are permissible within the framework of the *Directives*. For example, the medically preferred treatment for ectopic pregnancy is to administer a drug called methotrexate, which arrests cell division and leads to embryonic death.⁹⁹ Some Catholics believe that since the drug itself is intended to halt cell division, a side effect of which is the death of the embryo, methotrexate as a treatment for ectopic pregnancy is permissible under the *Directives*. On the other hand, others see the drug to be a direct attack on the embryo and to therefore constitute a direct abortion, which is not permissible under the *Directives*.¹⁰⁰ Consequently, differences in treating ectopic pregnancies among Catholic hospitals stem from conflicting understandings of the *Directives* and the doctrine that informs them. Ectopic pregnancy and Directive 48 serve to highlight a broader issue: that the *Directives* are often vague and are open to interpretation by individual physicians and ethicists and therefore the subject of ongoing debate.

⁹⁷ The *Directives*, Part Four, 48.

⁹⁸ Mayo Clinic Staff, "Ectopic Pregnancy," *Mayo Clinic*, Accessed April 16, 2016, <http://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/basics/definition/con-20024262>.

⁹⁹ “Catholic Hospitals and Ectopic Pregnancies,” *Health Care Ethics USA: Ethical Currents* 19, no. 1 (Winter 2011): 27-29, <https://www.chausa.org/docs/default-source/general-files/c6776764f3cc4624a8ea2a31037e9b111-pdf.pdf?sfvrsn=0>.

¹⁰⁰ “Catholic Hospitals and Ectopic Pregnancies,” 2.

Conflicting Interpretations of Directives Concerning Maternal Health

Some Catholics argue that problems in obstetrical and gynecological care arise precisely as a result of varying interpretations of the *Directives* among Catholic hospitals, not as a result of the *Directives* themselves. Ron Hamel of the CHA explains that neither the *Directives* nor Catholic teachings forbid particular treatments for extrauterine pregnancy, so any variation among Catholic hospitals on the procedures that are used to treat ectopic pregnancy is due to interpretations of physicians within those hospitals.¹⁰¹ This claim is supported by Sandra Hapenny's research, which indicates that among the hospitals she studied in seven different states, the provision of direct female sterilization varies greatly, in spite of explicit prohibition of sterilization by the *Directives*.¹⁰² Hapenny goes so far as to claim that her research indicates that "no uniform Catholic practice exists" with regards to direct female sterilization. So while the *Directives* were originally meant to unify Catholic medical practice, the opinion of Catholic health professionals and actual data indicate that no such unity has been achieved. Hapenny is not alone in her accusations. In fact, a study conducted between 2000 and 2003¹⁰³ suggests that more than 9,000 direct sterilizations were performed in Catholic hospitals in Texas, in spite of the fact that these procedures are in direct violation of the *Directives*.¹⁰⁴

Dr. John Haas, President of the National Catholic Bioethics Center, gives several explanations for these violations, all having to do with misinterpreting or incorrectly applying the

¹⁰¹ Ron Hamel, "Early Pregnancy Complications and the ERDs," *Health Care Ethics USA: Feature Article 22*, no. 1 (Winter 2014): 1-13, <https://www.chausa.org/docs/default-source/hceusa/early-pregnancy-complications-and-the-erds.pdf?sfvrsn=0>.

¹⁰² Hapenny, 33.

¹⁰³ "What is Wikileaks," *Wikileaks*, November 3, 2015, <https://wikileaks.org/What-is-Wikileaks.html>. This study was published on WikiLeaks, a platform through which authors can publish potentially scandalous information anonymously to avoid professional or personal harm. According to its website, "WikiLeaks specializes in the analysis and publication of large datasets of censored or otherwise restricted official materials involving war, spying and corruption". Therefore, the authors of this study are unidentifiable.

¹⁰⁴ "Sterilization and Abortion Practices in Texas Catholic Hospitals," WikiLeaks, June 16, 2008, https://wikileaks.org/wiki/Sterilization_and_abortion_practices_in_Texas_Catholic_hospitals.

Directives. First, he says, non-Catholic physicians who might not be familiar with the *Directives* work in Catholic hospitals, and while it is widely known that Catholics oppose abortion, the Church's views on sterilization may be less understood.¹⁰⁵ In addition, Haas explains that some of the bishops who are responsible for enforcing the *Directives* are either given bad advice by misinformed ethicists, or the bishops themselves do not truly understand the Catholic teachings. The problem arises when individual Catholic hospitals write their own protocols, in which they interpret and apply the *Directives* as they understand them. For example, Haas says, there are some instances in which the hospital interprets Directive 53 to allow for a direct sterilization after a cesarean section, should medical opinion indicate that a future pregnancy could be harmful to the life of the mother. This interpretation is incorrect, because Directive 53 indicates "that sterilizations are permitted when their direct effect is the cure or alleviation of a present serious pathology and a simpler treatment is not available."¹⁰⁶ According to Haas, a potentially harmful future pregnancy is not a serious pathology, and therefore, performing sterilizations on women whose lives may be put at risk in the event of a future pregnancy constitutes direct sterilization and is therefore prohibited.

Hapenny also points to the fact that there are often no repercussions for violations of the *Directives*, and there is no system through which violations can be reported. Kevin O'Rourke of CHA explains that although the *Directives* are approved as the "national code" for Catholic health care providers, but without a statement from the Holy See, "the USCCB does not have the right to legislate formally for individual dioceses."¹⁰⁷ In other words, the *Directives* must be implemented and regulated at the local level by individual orders and bishops. The *Directives* are

¹⁰⁵ Ann Carey, "'Shocking Lack of Understanding'," *Our Sunday Visitor Catholic Newsweekly*, July 13, 2008, <https://www.osv.com/OSVNewsweekly/ByIssue/Article/TabId/735/ArtMID/13636/ArticleID/4365/Shocking-lack-of-understanding.aspx>.

¹⁰⁶ Carey, "'Shocking Lack of Understanding'."

¹⁰⁷ O'Rourke, "The Ethical and Religious Directives as Particular Law," 80.

implemented through individual hospital policies, and they are overseen by local bishops. From the arguments of O'Rourke, Hapenny, and Haas, the absence of higher-level uniform application and maintenance appears to be the primary source of disagreements that arise about how to interpret and apply the *Directives*.

Haas explains that he has helped to rewrite some hospital protocols so that they (in his opinion) appropriately interpret the *Directives*. For some hospitals, though, it is too late: there are a number of instances in which a failure to comply with the *Directives* resulted in the loss of employment for an individual, and even the loss of Catholic status for an institution. For example, in 2010, St. Joseph's Hospital in Phoenix, Arizona, had its Catholic affiliation revoked after senior administrator Sister Margaret McBride approved an abortion for a woman whose pulmonary hypertension was exacerbated by her pregnancy, which at the time of the abortion was 11 weeks along.¹⁰⁸ The woman would have died as a result of this condition had her pregnancy not been ended.¹⁰⁹ In addition to resulting in the hospital's loss of Catholic status, McBride was excommunicated over the incident. While violations of the *Directives* often go unpunished, as Hapenny points out, punishment can be very severe when it is administered.

The Catholic Health Association supported the decision of McBride and St. Joseph's, claiming that the hospital did not violate the *Directives* by saving the life of the mother. "They carefully evaluated the patient's situation and correctly applied [the Directives] to it, saving the

¹⁰⁸ Dan Harris, "Bishop Strips Hospital of Catholic Status After Abortion," *ABC News*, December 22, 2010, Accessed February 12, 2016, <http://abcnews.go.com/Health/abortion-debate-hospital-stripped-catholic-status/story?id=12455295>.

¹⁰⁹ P.G. Pieper, E.S. Hoendermis, "Pregnancy in women with pulmonary hypertension," *Netherlands Heart Journal*, volume 19, number 12 (2011): 504-508, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3221745/>. According to physicians writing for the *Netherlands Heart Journal*, pulmonary hypertension is a rare condition that can affect women of childbearing age. Women with the condition are advised against pregnancy, though some become pregnant in spite of the fact that the condition can become deadly during pregnancy. Therefore, the danger associated with pulmonary hypertension during pregnancy is directly caused by the pregnancy itself, as opposed to being proportionally dangerous independent of pregnancy.

only life that was possible to save”, said Carol Keehan, president and CEO of CHA.¹¹⁰ The bishops, on the other hand, released a statement in which it condemns ending pregnancies for conditions that are caused or exacerbated by a pregnancy, as is the case with pulmonary hypertension. If “a pregnant woman is experiencing problems with one or more of her organs, apparently as a result of the added burden of pregnancy,” ending the pregnancy would constitute a direct abortion, according to the bishops’ statement.¹¹¹ In other words, deciding to abort as treatment for pulmonary hypertension is unacceptable, since pulmonary hypertension itself puts strain on the heart and should therefore be treated by addressing the heart’s immediate problems. The bishops thus endorsed the actions of Bishop Olmstead in revoking St. Joseph’s Catholic affiliation and excommunicating Sister McBride.

The controversy at St. Joseph’s underlines an important disagreement that arises in the context of abortion and Catholic medicine: if a woman will die as a result of a pregnancy complication, resulting also in the death of the fetus, is it then acceptable to save the life of the mother? Varying interpretations of Directive 47 are the cause of this dispute, in spite of the bishops’ attempt to provide clarity about what constitutes a “direct abortion.” There is continued disagreement about what constitutes a “serious pathological condition” – does a pregnancy complication constitute a serious pathological condition? What types of pregnancy complications constitute a serious pathological condition? Critics say that the choice is clear, since no intervention will result in two deaths and will preclude the possibility of that woman producing viable life in the future. Hardline Catholics seem to have backed themselves into a moral corner with this question, insisting on the need to save a fetus in every circumstance. The same question

¹¹⁰ Jerry Filteau, "Catholic Health Association Backs Phoenix Hospital," *National Catholic Reporter*, December 22, 2010, Accessed February 12, 2016. <http://ncronline.org/news/catholic-health-association-backs-phoenix-hospital>.

¹¹¹ United States Conference of Catholic Bishops Committee on Doctrine, “the Distinction Between Direct Abortion and Legitimate Medical Procedures” (press release, June 23, 2010), <http://www.usccb.org/about/doctrine/publications/upload/direct-abortion-statement2010-06-23.pdf>.

applies to cases of ectopic pregnancy, in which, as discussed above, the embryo is not viable due to implantation outside of the womb and the mother will die without intervention. Underlying all of these questions are further questions about who should have the authority to make these decisions: should it be physicians and medical authorities? What role, if any, should Catholic theologians and health ministers play in making these decisions? These questions will be fully addressed in chapters four and six.

Discrepancies in interpretation and application of the *Directives* inform our understanding of the conflict between Catholic doctrine and reproductive health care in several important ways. First, they reveal a systematic inconsistency in how the *Directives* are applied, which has implications beyond the provision of sterilizations. As a result, the American Catholic health care system faces potentially detrimental consequences, both internally and externally. Internally, these hospitals jeopardize their Catholic identity, which as will be further discussed in chapter five, is a vital part of the operations of a Catholic hospital. Second, Catholic hospitals harm their own credibility as health care providers by allowing inconsistencies in care among different facilities to flourish. The presence of discord among representatives within the Catholic health ministry undermines integrity of the system as a whole and furthers the very conflicts upon which these representatives disagree. Moreover, even though members of the Catholic health ministry argue that disagreements arise only in interpreting the *Directives*, not because of the *Directives* themselves, the fact that the *Directives* are so unclear as to allow for conflicting interpretations indicates that they are fundamentally flawed. Shortcomings in interpretation of this document are necessarily created by the shortcomings of the document itself. If the *Directives* were clear, interpretations would not vary. However, simply providing clarity for existing topics in the *Directives* will not solve conflicts in maternal health care, since this

doctrine fundamentally misconstrues abortion and women's health issues, as will be discussed in the following chapter.

As the ensuing discussion explores the provision of maternal care in Catholic hospitals, as well as both Catholic and non-Catholic perspectives on the duty of hospitals, it will become clear that the issues within the Catholic hospital system require immediate attention, for the sake of patient safety as well as Catholic identity. Furthermore, these disagreements often become the starting point for potentially dangerous conflicts that can jeopardize maternal health care. Now that the discussion has explored why these conflicts arise, the next chapter will examine data concerning how and when issues arise in miscarriage management in Catholic hospitals, providing the framework for later analysis of internal and external implications for the hospitals themselves.

CHAPTER FOUR:

Conflicts in Maternal Health Care in Catholic Hospitals

Collisions between Catholic conscience and maternal health care have already been examined by a number of researchers, and by interviewing OB/GYNs who work in Catholic hospitals across the country, these researchers have been able to elucidate the nature of conflicts in maternal health care and how they arise. The conclusions of each research team are largely compatible, though their differences highlight important themes. Still, all of the research agrees about two important items: that these conflicts do actually occur and that they are produced in part by the presence of doctrine in Catholic hospitals. Throughout, the discussion will include analysis of problems that arise as a result of the conflicts in care, as well as connections to the doctrinal and policy aspects of conscience collisions.

Conflicts in Care: the OB/GYN Experience in Catholic Hospitals

“She was very early, fourteen weeks. She came in...and there was a hand sticking out of the cervix. Clearly the membranes had ruptured and she was trying to deliver...There was a heart rate, and [we called] the ethics committee, and they [said], “Nope, can’t do anything.” So we had to send her to the [university hospital].... You know, these things don’t happen often, but from what I understand it, it’s pretty clear. Even if mom is very sick, you know, potentially life threatening, can’t do anything.”¹¹²

This grim account represents one of many conflicts in care that have occurred in a Catholic hospital or healthcare facility. There are three sets of rights at issue in this case and in others like it: the rights of the patient, the rights of the physician, and the religious authority of the institution. The patient’s rights involve a right to the best medical care available, as well as a respect for the patient’s informed consent and autonomy to make decisions about her treatment.

¹¹² Lori R. Freedman, Uta Landy, and Jody Steinauer, "When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals," *American Journal of Public Health* 98, no. 10 (2008): 1774-1778.

The rights of the physician relate to his or her training and professional medical opinion about how a situation should be handled, though most of the time, physicians work to protect the rights of their patients. The institution's rights equate to how the religion and morals of the institution inform Catholic medical policy, as well as respect for religious exercise. With the development of conscience laws and other policies protecting religion, religious rights have gained a special status in the American political and legal system.¹¹³ This status is the reason why religious claims have considerable clout against patient rights in conflicts involving life and death matters. It is important to keep in mind that conflicts in care arise as a result of the intersection of these three distinct sets of rights. Medical authority disagrees with religious authority, and caught in the middle of all conflicts that arise are the rights and best interests of the patient. The rights themselves will be examined in depth in later chapters, while the discussion in this chapter will focus on what conflicts in care are and when they occur.

An important point to remember going forward is that conflicts in maternal health care in Catholic hospitals typically affect women who are intentionally pregnant. They have not chosen to experience pregnancy complications, nor have they chosen to relinquish their autonomy to Church doctrine. Their loss, which typically occurs around 20 weeks of gestation, is an undesired tragedy. Miscarriage management is required to safely treat these women and preserve future fertility. Further, Catholic hospitals are sometimes the only facility in proximity to a patient, so some women end up in Catholic emergency rooms without realizing that they may not be able to receive the care they need or desire.¹¹⁴ Or, “patients entering a Catholic-owned hospital may be aware that abortion services are not available there, but few prenatal patients conceive of

¹¹³ A discussion of these additional policies protecting religion is not relevant to this thesis, though the most notable example is the Religious Freedom Restoration Act, which is a federal law that prohibits the government from enacting laws that substantially burden religious exercise, unless that the law serves a compelling state interest.

¹¹⁴ Lori Freedman, *Willing and Unable: Doctors' Constraints in Abortion Care*, (Nashville: Vanderbilt University Press, 2010), 120.

themselves as potential abortion patients and therefore are not aware of the risks involved in being treated there”, explain Freedman, Landy, and Steinauer.¹¹⁵ Elective abortions are not part of this discussion; the pregnancy complications discussed below require abortion care to resolve the issues they cause.¹¹⁶

Circumstances under Which Conflicts Arise

Miscarriage, also known as spontaneous abortion, is a loss of pregnancy that occurs within the first 20 weeks of gestation. It occurs in about 15-20% of pregnancies, and the chance of miscarriage is augmented by unhealthy lifestyle choices and increases with maternal age.¹¹⁷ Common causes of miscarriage include abnormal fetal development, improper implantation of an embryo, or problems with the mother’s reproductive system, but the exact cause is not always clear. Miscarriages are classified in a variety of categories, but the three most relevant and often mentioned in the literature are inevitable or incomplete miscarriage, ectopic pregnancy, and molar pregnancy.

Inevitable or incomplete miscarriage is marked by back pain, abnormal bleeding, and an open cervix (this is what happened in the account at the beginning of the chapter). It is called “inevitable” because of the occurrence of an open cervix or rupture of membranes, which make the loss of pregnancy unavoidable.¹¹⁸ As discussed previous chapters, an ectopic pregnancy occurs when the embryo implants itself somewhere other than the uterus, usually in one of the fallopian tubes. Ectopic pregnancies are never viable, require immediate medical treatment, and

¹¹⁵ Freedman, Lori R., Uta Landy, and Jody Steinauer, 1778.

¹¹⁶ Miscarriage management techniques are identical to abortion procedure techniques; both involve methods to safely evacuate a woman’s uterus. The difference lies in the presence of choice or not – women who require miscarriage management face severe infections and even death if they do not receive the proper care.

¹¹⁷ “Miscarriage: Signs, Symptoms, Treatment and Prevention,” *American Pregnancy Association*, August 2015, Accessed February 19, 2016, <http://americanpregnancy.org/pregnancy-complications/miscarriage/>.

¹¹⁸ “Miscarriage,” *American Pregnancy Association*.

if left untreated are potentially fatal to the mother.¹¹⁹ Finally, molar pregnancy is an abnormality in the placenta involving rapid cell growth. Something goes wrong during fertilization, and molar pregnancies seldom produce a viable embryo.¹²⁰ While more complex conditions can occur, these explanations should provide sufficient background to understanding the conflicts in care discussed here.

Conflicts in Care: an Examination of Two Qualitative Studies

When conflicts in care did arise, many of the physicians in Lori Freedman's research reported that there was discussion about whether or not to transport the patient from the Catholic hospital in question to a facility where she could get immediate care. In the account given at the beginning of this chapter, the patient was transported 90 miles to receive full care. Decisions about patient transport usually are made based on how stable or unstable the patient is, but typically, physicians were uncomfortable with transport regardless of the stability of the patient. Miscarriages carry great risk of infection, which can lead to a loss of fertility or even maternal life:

“Obstetricians know that once an infection sets in inside the uterus, you're behind the clock in terms of trying to get the baby out, and if you've got a situation where you don't want the mother to be so infected that it compromises her fertility in the future. And if we wait until they have a high fever and they're really sick, you risk the woman's health and potential fertility.”¹²¹

Some OB/GYNs also opposed transporting miscarrying patients because doing so would add to the emotional trauma of a miscarriage, as well as because of a sense of professional duty.

¹¹⁹ Mayo Clinic Staff, "Ectopic Pregnancy."

¹²⁰ "Molar Pregnancy: Symptoms, Risks and Treatment," *American Pregnancy Association*, August 2015, Accessed February 19, 2016, <http://americanpregnancy.org/pregnancy-complications/molar-pregnancy/>.

¹²¹ Lori R. Freedman and Debra B. Stulberg, "Conflicts in Care for Obstetric Complications in Catholic Hospitals," *AJOB Primary Research* 4, no. 4 (August 2013): 1-10, https://www.aclu.org/sites/default/files/assets/conflicts_in_care.pdf.

Transporting a patient to another facility because of the Catholic prohibitions on care is “egregious,” according to Dr. L, and is unfaithful to the hospital’s “original commitment to put the woman’s health first.”¹²²

In another instance, Dr. P greatly objected to transporting a woman with a molar pregnancy but had no other option, as the ethics committee would not allow him to perform an abortion to end the doomed pregnancy. The case was somewhat complicated, because it involved a twin pregnancy, one fetus and one “mole”. However, in the vast majority of cases, the healthy fetus will be absorbed by the molar growth and will not survive.¹²³ Therefore, the molar pregnancy made the healthy fetus effectively unviable. Still, “the clergy who made the decision Googled molar pregnancy,” and from this online research, the ethics committee found that “there’s a chance that she could actually have a viable pregnancy [because] there have been cases where a child was born.”¹²⁴ In spite of what was medically indicated, Dr. P was not allowed to evacuate the patient’s uterus, and the patient was transferred to another hospital.

How is it logical to allow a Google search to overrule the medical judgment of a trained OB/GYN? This case points to a potential problem with the composition of ethics committees: who sits on these committees and what qualifies them to be a committee member? An article published in the Catholic Health Association’s journal, *Health Progress*, claims that physicians and nurses constitute the majority of Catholic hospital ethics committee members.¹²⁵ The case above seems to contradict this finding, if a decision about how to handle a clearly unviable pregnancy required a Google search, concluding with care that was contrary to medical opinion.

¹²² Freedman and Stulberg, 5.

¹²³ “Molar Pregnancy,” *American Pregnancy Association*.

¹²⁴ Freedman and Stulberg, 5.

¹²⁵ Francis Bernt, Peter Clark, Josita Starrs, and Patricia Talone, “Ethics Committees in Catholic Hospitals,” *Health Progress* 87, no. 2 (March 2006): 18-25, <https://www.chausa.org/docs/default-source/health-progress/ethics-committees-in-catholic-hospitals-pdf.pdf?sfvrsn=0>.

Medical judgment was disregarded in favor of protecting the hospital's Catholic identity. Or, at the very least, this case indicates that even though medical professionals may sit on ethics boards, the word of the clergy often wins out over medical judgment. Moreover, the fact that Catholic hospitals permit transport of patients to receive this type of reproductive health care signals acknowledgement on the part of Catholic administrators that this care is necessary: they know that women will die or face serious harm without proper treatment for these conditions. If these ethical boards and religious providers did not understand or acknowledge that fact, there would be no reason for them to think that these patients needed to be transported. The scientific and medical facts of these situations are understood and acknowledged, but the facts are subordinate to religious belief.

It is worth noting that in some cases where transport was not an option, some physicians made decisions to evade the *Directives* altogether and act according to their medical judgment. These physicians knew that loss of pregnancy was inevitable, so they chose to act in what they saw as the best interest of the patient without getting ethical approval. In Freedman, Landy, and Steinauer's 2008 article, Dr. G recounted an instance in which the patient's cervix was open and the pregnancy was clearly over. Procedure dictated that she should have performed an ultrasound to check for fetal heart tones, but knowing that "it would have muddied the water in this case," Dr. G proceeded with the evacuation of the uterus.¹²⁶ She knew that there would have been heart tones, and such a finding would have prohibited Dr. G from providing what she thought was proper care, as she worked in a Catholic hospital. When a nurse asked her if there were heart tones, Dr. G instructed the nurse to report that "heart tones weren't documented", so the ethics committee could interpret the situation as they saw fit.¹²⁷

¹²⁶ Freedman, Landy, and Steinauer, 1777.

¹²⁷ Freedman, Landy, and Steinauer, 1777.

Another OB/GYN in the same study, Dr. S, took even more extreme measures in order to act in accordance with his medical conscience:

“The pregnancy was in the vagina. It was over...and I needed to get everything out. And so I put the ultrasound machine on and there was still a heartbeat, and the ethics committee wouldn’t let me [evacuate] because there was still a heartbeat. This woman is dying before our eyes. I went in to examine her, and I was able to find the umbilical cord through the membranes and snapped the umbilical cord and so that I could put the ultrasound – “Oh look. No heartbeat. Let’s go”.”¹²⁸

Dr. S’s actions certainly constitute a violation of the *Directives*, and he also likely violated medical ethical standards. However, he felt that the patient’s condition was so dire that he had no other option. He reported that the patient nearly died and spent 10 days recovering in the intensive care unit. After this incident, Dr. S left the Catholic hospital to seek other employment.¹²⁹

The cases of Dr. S and Dr. G underscore another fundamental problem within the scheme of Catholic health ministry. In addition to the previously discussed interpretational inconsistencies among the non-medical Catholic health ministry, this evidence suggests that medical personnel intentionally and knowingly evade the *Directives*. The actions of Drs. S and G would certainly have resulted in termination of employment, if their employers knew of their violations of the *Directives*. With the overwhelming consensus from the physicians surveyed that the *Directives* directly conflict with medical judgment, it is not hard to imagine that other physicians have also taken actions similar to those of Dr. S and Dr. G. If physicians view the *Directives* as ethically inappropriate, and their medical conscience inhibits acting in accordance with them, updating them to align with medical science is clearly logical and necessary.

¹²⁸ Freedman, Landy, and Steinauer, 1777.

¹²⁹ Freedman, Landy, and Steinauer, 1777.

One physician, Dr. J, reported that he was counseled by a nun on the ethics committee at the hospital where he worked about how to present cases to the ethics committee. She advised Dr. J to highlight terms like “inevitable abortion” and “maternal complications,” in order to convince the committee to rule in favor of his medical judgment.¹³⁰ Dr. J reported that the nun’s advice worked well, and in future cases he was able to successfully navigate the ethics committee’s decision-making process. While this seems like good news, it only serves to further highlight the problems within the Catholic health ministry. Using St. Joseph’s hospital in Arizona¹³¹ as a reference point, it can be assumed that the nun involved here also risked censure. Her actions might not have been as severe as the case of Sister McBride’s, but there is no question that she put herself at peril by assisting in the avoidance of the *Directives*. In addition to physicians who attempt to and succeed at evading the *Directives*, even members of the Catholic Church take measures to sidestep their instructions. These are issues that the Catholic health ministry simply cannot ignore.

In a study conducted for Ibis Reproductive Health, researchers found that “most participants felt that norms [for OB/GYN care] were communicated in conversations between peers, by leaders within the department, or through implicit assumptions about what is acceptable in the department or faculty.”¹³² With regard to Catholic facilities, this same study reports that most participants did believe that the *Directives* had an impact on reproductive health care. However, these participants reported that the *Directives* have not been used to create

¹³⁰ Freedman, Landy, and Steinauer, 1777.

¹³¹ As discussed in chapter two, St. Joseph’s hospital was stripped of its Catholic status after Sister Margaret McBride approved what the local diocese deemed a direct abortion. McBride was excommunicated from the Church for her actions.

¹³² Angel M. Foster, Amanda Dennis, Fiona Smith, *Assessing Hospital Policies & Practices Regarding Ectopic Pregnancy & Miscarriage Management* (Cambridge, MA: Ibis Reproductive Health, 2009), 11, http://www.nwlc.org/sites/default/files/pdfs/ibis_rh_-_nwlc_qualitative_study_report.pdf.

policies about miscarriage management or the treatment of ectopic pregnancies and have only impacted sterilization, elective abortion, and contraceptive services.

“As one physician in a recently merged facility reported, the *Directives* “don’t apply” when methotrexate, salpingostomy, and uterine evacuation techniques are used to treat ectopic pregnancies or manage miscarriages because these “are not considered elective abortions because ectopic [pregnancies] and miscarriages were not intended nor were they the patient’s choice.””¹³³

As opposed to other instances discussed above and in previous chapters, this hospital has delineated miscarriage management and ectopic pregnancy care from other elective procedures on the basis of patient choice. A possible explanation for this approach is the fact that this hospital was “recently merged,” which presumably means that a non-Catholic hospital merged with a Catholic one, and the two facilities needed to find common ground about the types of care the new merged facility would provide. While this case provides a nice model for how these issues could be handled, unfortunately, it is not the case across the board.

Like the physicians in Freedman’s research, the respondents in Ibis’s study reported that the *Directives* “most [impacted] treatment decision regarding ectopic pregnancies and miscarriage management.”¹³⁴ The Ibis study explains that many of their participants were frustrated by the limitations imposed by the *Directives*, which often precluded certain types of care that would have been the physician’s preferred option. Dr. Y reports that the Catholic hospital where she works “does not keep methotrexate in house, so a carrier must be sent to pick up the medication,” and she believes that this is a measure to deter physicians from using methotrexate in treating ectopic pregnancies.¹³⁵ The Ibis study also corroborates Freedman’s conclusions about patient transport from Catholic hospitals to facilities where they could receive care that is prohibited under the *Directives*. One physician explained that hypothetically, “if we

¹³³ Foster, Dennis, Smith, 12.

¹³⁴ Foster, Dennis, Smith, 13.

¹³⁵ Foster, Dennis, Smith, 14.

have a patient...with no chance to reach 24 weeks and [there is] no chance of viability, I think they should be induced for delivery. If we still have a heartbeat, we can't do that, so I transfer them to another hospital."¹³⁶ Still, the study implies that these transports are relatively rare, and that physicians try to provide proper care at their own hospital.

As opposed to the incidents discussed above in Freedman's findings, the Ibis study reports that most physicians interviewed had no knowledge of a time when a hospital ethics committee became involved with decisions about care for miscarriages or ectopic pregnancies, though "a number of physicians at Catholic facilities expressed concern that they would face consequences if they acted outside of the *Directives*."¹³⁷ In addition, physicians told Ibis researchers that they had heard about a case in which another physician was admonished for violating the *Directives*, though none had any direct involvement with such a case. Although these physicians appear to be somewhat fearful of the consequences of violating the *Directives*, many reported that they believed that medical judgment would prevail should they be faced with a conflict in care. The Ibis study also says that none of their participants "reported that they changed their practice patterns with respect to ectopic pregnancy and miscarriage management after a hospital merger," though many expressed concerns over the availability of other reproductive health services, such as tubal ligations, abortion services, and contraceptive services.¹³⁸

Perhaps the most important observation by the Ibis study is how the presence of the *Directives* affected trust among hospital employees. "Some physicians did suspect that their behaviors were being carefully watched by" other staff, "to ensure that they were abiding by the

¹³⁶ Foster, Dennis, Smith, 16.

¹³⁷ Foster, Dennis, Smith, 13.

¹³⁸ Foster, Dennis, Smith, 17.

Directives.”¹³⁹ The Ibis researchers astutely point out that this type of distrustful monitoring among medical faculty surely influences standards of care in the hospitals where it occurs. One can imagine that it could undermine the teamwork mentality that is necessary to ensure the delivery of the highest levels of care, and it could prevent staff members from developing meaningful, trusting relationships with one another.

Although the two research teams discussed above had slightly different findings, there is agreement among the studies that the *Directives* can and do influence reproductive health services in Catholic hospitals. Differences in their conclusions about the influence of ethics committees, for example, could be explained by differences in sampling: this research was based on personal experiences, and each research team interviewed different physicians with different experiences. Nonetheless, all of the above data indicate that there are systematic conflicts within the Catholic health ministry, including those that can produce extremely harmful and potentially fatal conditions. The discussion has highlighted aspects of conflicts in care that harm all involved – physicians, nurses, members of the Catholic health ministry, and, of course, patients. These conflicts must be addressed.

Physicians and Catholic Employers

The accounts above might lead some to say that Catholic hospitals should hire only Catholic physicians in order to avoid conflicts over the *Directives*. However, this is a fallacious argument on all fronts. First, it does not follow that being Catholic means that a physician will necessarily adhere to the *Directives*. In fact, Freedman and Stulberg reported that OB/GYNs in Catholic hospitals were no more likely to report that religion was important in their lives than

¹³⁹ Foster, Dennis, Smith, 21.

OB/GYNs in secular hospitals.¹⁴⁰ Even Catholic nuns who are employed by Catholic hospitals do not follow the *Directives*, so there is no guarantee that a physician who identifies as Catholic will adhere to their rules. Second, the scenarios above would not be resolved by limiting Catholic hospitals to hiring Catholic physicians, because patients would still be unable to receive proper care in many situations. Furthermore, there are plenty of reasons why physicians who do not themselves adhere to Catholic doctrine could find themselves working for a Catholic hospital or health care facility. The data in Freedman's 2010 book indicates that some physicians do not realize how the religious restrictions affect care until a conflict arises.¹⁴¹ In fact, she asserts that miscarriage management is a rather uncontroversial part of obstetrics outside of Catholic hospitals, so OB/GYNs trained in routine miscarriage management may not anticipate a problem, even if they are aware of the Church's total prohibition on elective abortion. In their 2013 article, Freedman and Stulberg report that "many physicians...reported positive feelings toward their Catholic hospital employer or workplace for a variety of reasons," in spite of restrictions on care they faced.¹⁴² One study published in *Health Care Management Review* indicates that Catholic hospitals are rated slightly better overall than their secular counterparts.¹⁴³ Catholic hospitals provide good medical care and can be great places to be employed.

Availability of academic resources, proximity to family, community ties are all very legitimate motivations to explain why a physician may choose to work at a Catholic hospital as opposed to a non-religious one. Or, a physician may have chosen to work at a hospital that merged with a Catholic facility. According to MergerWatch, a liberal organization that advocates

¹⁴⁰ Freedman and Stulberg, 2.

¹⁴¹ Freedman, *Willing and Unable*.

¹⁴² Freedman and Stulberg, 4.

¹⁴³ Ann Kutney-Lee, G.J. Melendez-Torres, Matthew D. McHugh, Barbara Mann Wall, "Distinct Enough? A National Examination of Catholic Hospital Affiliation and Patient Perceptions of Care," *Health Care Management Review* 39, no. 2 (2014): 134-144, doi: 10.1097/HMR.0b013e31828dc491.

for patients' rights, "there have been more than 140 agreements between religious and non-religious hospitals since 1997."¹⁴⁴ In 2011, 10 of the nation's 25 largest health care networks were Catholic, and one in nine hospital beds was located in a Catholic facility, and the federal government has classified 30 Catholic hospitals as the "sole provider" for their community.¹⁴⁵ Catholic hospitals have a large presence in the United States, so there is a high likelihood that a physician could end up working in a Catholic health care facility, simply based on the widespread presence of Catholic health ministries.

Furthermore, Catholic hospitals should aim to hire the best physicians, regardless of their religious or spiritual background. Failing to do so would mean that an institution would sacrifice the highest standard of medical care as a result of discrimination based on physicians' backgrounds. In fact, respect for belief and conscience is what these institutions (as well as individuals) request, so that same courtesy should be extended to non-Catholic physicians who seek employment at the hospital that best suits them. For these reasons, the argument that Catholic hospitals should only seek to employ Catholic physicians, and vice versa, is not persuasive.

Conclusions So Far

This thesis has explored the policy, Catholic doctrine, and medical standards that all play a part in maternal medicine in Catholic hospitals. Expansive federal legislation, buttressed by state legislation, has allowed doctrine to flourish in Catholic hospitals while often constraining

¹⁴⁴ "About Hospital Mergers," *MergerWatch*, Accessed February 18, 2016, <http://mergerwatch.squarespace.com/about-hospital-mergers/>.

¹⁴⁵ Lois Uttley, Sheila Reynertson, Lorraine Kenny, and Louise Melling, *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care* (New York: American Civil Liberties Union & MergerWatch, 2013) Accessed February 18, 2016, <https://www.aclu.org/report/miscarriage-medicine?redirect=religion-belief-reproductive-freedom/miscarriage-medicine-growth-catholic-hospitals-and-threat>.

the judgment of medical authorities. There is no doubt that abortion and conscience legislation has greatly impacted the provision of women's health care in the United States, with regard to miscarriage management as well as most other women's health items. The most acute restrictions of medical authorities, however, are produced by the doctrine itself, as demonstrated by the physician experiences discussed in this chapter. After exploring the conflicts in care that arise in maternal health care in Catholic hospitals, it is clear that the implementation of Catholic doctrine in medicine has fostered fundamental misunderstandings about abortion and miscarriage management.

Though the treatment required in each is largely identical, these two terms are not synonymous. Their meaning diverges in two places: maternal agency and threat to maternal life. "Abortion" in the traditional sense involves a mother's choice to end her pregnancy. Sometimes a mother may choose to abort because of a fetal anomaly or a predicted dangerous pathology, but elective abortions are typically not urgent and are often not medically necessary, beyond what the mother desires for herself. Miscarriage management, on the other hand, involves little to no choice on the part of the mother to end her pregnancy. Rather, a mother experiences a tragic pregnancy complication that leads to a loss of fetal viability, though sometimes, she requires miscarriage management procedures to ensure that her pregnancy passes fully and safely. She does not choose to have a miscarriage or pregnancy anomaly. She is electively pregnant and never imagines that she would ever need anything resembling abortion care.

In this way, the Catholic health ministry has fundamentally misunderstood the nature of conflicts in maternal health care. By equating miscarriage management with elective abortions, both in the vagueness of the *Directives* and in the way they are implemented, they have created miscarriage management conflicts. However, as seen above, there is recognition of the need for

miscarriage management care, as some Catholic hospitals transport their patients to other hospitals or even simply approve the objectionable procedures in their own facilities. If the Catholic health ministry totally denied the severity of miscarriage complications, we would expect to see fatalities from these restrictions of care, though research indicates that no maternal deaths have been reported in the United States as of yet. This acknowledgment of the medical necessity of miscarriage management can be taken as a good omen, though, as it creates a window for compromise. Chapter seven will explore this opportunity for compromise in depth, but in order to fully understand the perspectives of the parties involved, the discussion will first consider the Catholic and physician perspectives on conscience.

CHAPTER FIVE:

Catholic Perspectives and Preserving Catholic Identity

Conflicts in care represent the point at which Catholic doctrine collides with medical opinion, with patient rights caught in the fray. Varying understandings and interpretations of Catholic doctrine exist within the American Catholic health ministry, though all draw their beliefs from the same grounding principles. This chapter will first explore the foundations of Catholic bioethics, as well as why conscience protection is intimately connected to Catholic identity and bioethics. Then, the discussion will turn to examine why maintaining Catholic identity is important to Catholic health care institutions. The ideas discussed will demonstrate how it is possible to make compromises while still preserving Catholic identity, in addition to how Catholic identity requires respecting the values and ideas of others.

Catholic Bioethics

According to David Kelly, bioethics as a discipline developed in the last four decades of the 20th century as “what had been the largely intrareligious study of the morality or ethics of medical practice became “bioethics’.”¹⁴⁶ Kelly claims that while secular philosophers would like to believe that they created an entirely new field of study, contemporary bioethics is completely based in religious moral doctrine that had been established for hundreds of years. Until the 1960s, Catholic theologians and philosophers, along with Jewish scholars, were essentially the only people interested in bioethics. The Catholic tradition had a particularly profound impact on the development of modern bioethics because “Catholics adopted a natural law approach to morality, claiming that moral judgments were based on reason and hence applicable to all

¹⁴⁶ David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington, D.C.: Georgetown University Press, 2004), 3.

humans.”¹⁴⁷ Religious doctrine provided a good foundation upon which philosophers were able to cultivate the bioethical principles that are nearly ubiquitous in contemporary health care.

“Catholic moral theology has traditionally argued that ethics (what we ought to do) must be based on anthropology (who we are)”, explains Kelly.¹⁴⁸ Respect of human dignity is the foundation of the Catholic prohibition against abortion, as well as the Church’s prohibitions on euthanasia, its denunciation of war, and its efforts to fight poverty.¹⁴⁹ It is the founding principle for Catholic bioethics. “For the Church, there is no distinction between defending human life and promoting the dignity of the human person,” according to the United States Conference of Catholic Bishops.¹⁵⁰ If human life and dignity are the same in the eyes of the Church, then it is clear why fighting for the dignity of impoverished persons is made equivalent to protecting the life of an unborn child. Cardinal Bernardin famously equated war with abortion, explaining that if the Catholic protection of innocent life prohibits attacks on civilians in warfare, it must also necessarily prohibit attacks on life in the womb. Therefore, he says, “War and abortion are linked at the level of moral principle.”¹⁵¹ Any activity that does not support human life and dignity is unacceptable on its face. “The right to life is the first and most fundamental principle of human rights that leads Catholics to actively work for a world of greater respect for human life and greater commitment to justice and peace.”¹⁵²

There are two approaches within the Church to human dignity issues, though. Timothy Byrnes argues that some bishops believe that while all pro-life issues are important, “abortion

¹⁴⁷ Kelly, 4

¹⁴⁸ Kelly, 10.

¹⁴⁹ "Human Life and Dignity," United States Conference of Catholic Bishops, <http://www.migrate.usccb.org/issues-and-action/human-life-and-dignity/index.cfm>.

¹⁵⁰ “Human Life and Dignity.”

¹⁵¹ Brenda D. Hofman, “Political Theology: The Role of Organized Religion in the Anti-abortion Movement”. *Journal of Church and State* 28 , no. 2 (1986): 225–47, <http://www.jstor.org/stable/23917655>.

¹⁵² “Human Life and Dignity.”

should be the American church's first political priority."¹⁵³ On the other hand, others argue that focusing primarily on abortion will undermine the effectiveness of the Church's overall pro-life goals. The website of the nation's most prominent Catholic ethical group, The National Catholic Bioethics Center, seems to indicate that the NCBC is most aggressive on anti-abortion pro-life issues. The NCBC's most recent press release features four news updates, all of which are related to anti-abortion activities.¹⁵⁴ Earlier NCBC releases feature the occasional gay marriage or euthanasia story, but a majority of each document discusses the status of abortion in the United States. On the other hand, groups like the USCCB and CHA seem to be more even in their pro-life coverage, offering materials on a wide range of pro-life issues in addition to abortion. While abortion is certainly the most visible pro-life Catholic issue, it does not totally dominate the activity of Catholic groups in the United States. In addition, Catholic physicians and medical professionals describe conflicts with a variety of issues in medicine, including but certainly not limited to abortion issues. Still, abortion and issues relating to abortion motivate pro-life advocates in government at all levels, in advocacy groups, and in medicine.

Abortion becomes a paradox within the framework of Catholic bioethics: doctrine states that any activity that is contrary to the dignity of any human life is unacceptable. However, the abortion decision necessitates a disregard for at least one human life. By choosing to protect the fetus first and foremost, the mother is necessarily disregarded. To say that the fetus is innocent and therefore deserves more protection than the mother is to assume that in every circumstance, the mother's poor decisions have created a situation in which abortion is considered. This is simply not true, as demonstrated by conflicts in care and fundamental misunderstandings about miscarriage management, discussed above. Furthermore, applying this line of reasoning in

¹⁵³ Timothy A. Byrnes, *Catholic Bishops in American Politics* (Princeton, NJ: Princeton University Press, 1991), 6.

¹⁵⁴ "Bioethics and Public Policy Report," *National Catholic Bioethics Center*, November 2015, <http://www.ncbcenter.org/document.doc?id=912>.

conflicts in care is inherently contradictory, because by necessitating that the fetus must never be killed directly, no intervention can ever be taken to save the mother, even though the fetus cannot live if the mother dies. Any attempt at resolving this intrinsic disagreement in Catholic bioethics is beyond the scope of this thesis, but following the examination of conflicts in care, it should be clear that some compromise must be reached within the Catholic health ministry with regards to how to handle miscarriage complexities. In addition, the protection of Catholic identity in medicine hinges on finding such a compromise.

Catholic Perspective on Conscience in Medicine

In an article that appeared in *The Pulse of Catholic Medicine*'s February 2016 edition, Brian Bamberger, M.D., M.P.H., recounts his struggle to protect his Catholic conscience and identity throughout his medical training:

“To be honest, I lived in fear throughout most of medical school. Medical education itself is a high stress environment... There’s a fear of failure... Yet, my greatest fear was if I could fully live out my Catholic Faith while training to be a physician. Would I violate my conscience? Would I be expected to participate in interventions I knew were contrary to Church teaching? Worse yet, would I have the courage to proclaim our Catholic Faith clearly when confronted by a classmate, supervising resident or attending physician?”¹⁵⁵

Bamberger’s fears about violating Catholic conscience are unsurprising, even in spite of both state and federal conscience legislation that protects providers as well as institutions. However, Bamberger’s fear of standing up to his non-Catholic colleagues to defend his conscience is more unique and interesting. Fear of confrontation, especially in the workplace, is understandable, as one might not want to risk jeopardizing workplace relationships, censure, or even loss of employment. The addition of Catholic conscience to the equation offers an important

¹⁵⁵ Brian Bamberger, "Be Not Afraid: Evangelization Through Residency Interviews," *The Pulse of Catholic Medicine*, February 2016, 16-17, <http://cathmed.org/assets/files/ThePulse-Feb2016.pdf>.

perspective. Before an interview, Bamberger counseled himself, “Don’t be labeled a religious fanatic” because he feared the negative connotation that many non-religious individuals attach to religiosity.¹⁵⁶ In spite of his concerns, Bamberger reports that he has found that most residency programs explained that they would respect his conscience and allow him to practice in accordance with his faith, should he work in their program.

Bamberger is not alone in his concerns about conscience protections, though, nor is he even particularly aggressive in his conscience beliefs. Virtually every pro-conscience advocacy group claims that there are not enough conscience protections for health care providers, and many advocate for new conscience legislation. A video produced by the USCCB asserts that “the freedom of conscience is at the heart of who we are as Americans,” and that although the freedom of conscience has long been protected in the United States, it is now “under attack.”¹⁵⁷ The video profiles a nurse, Cathy, who claims to have been coerced by her employer into assisting in a 22-week abortion. Cathy alleges that her employer threatened to revoke her nursing license if she did not comply. “If Congress does not act, doctors and nurses across the country will be forced to violate their conscience, or to leave health care altogether – that’s discrimination”, according to the video. The narrator then urges viewers to support the Abortion Non-Discrimination Act (ANDA), which would expand the list of health care providers and entities that could claim conscience objection to abortion services.¹⁵⁸ Other pro-life pro-conscience groups also support the ANDA on their websites, such as the Human Life Action, a project of the National Committee for a Human Life Amendment. “A campaign is underway to

¹⁵⁶ Bamberger, 16.

¹⁵⁷ “Stand With Cathy for Conscience Rights,” a video from the United States Conference of Catholic Bishops, 1:33, *Conscience Protection Videos*, performed by Cathy Cenzone-DeCarlo, Accessed March 4, 2016, <http://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/videos.cfm>.

¹⁵⁸ According to Congress.gov, the Abortion Non-Discrimination Act (ANDA) is a bill that was introduced in the Senate in January of 2015 that amends the Public Health Service Act to expand the list of individuals who may object to providing abortion-related services. Perhaps more importantly, though, the ANDA “creates a cause of legal action” for violations of the Act, which allows complainants to seek litigation in federal court.

force Catholic hospitals and other health care institutions to perform or promote abortion,” says Human Life Action, and this campaign of governmental discrimination that would be stopped by the ANDA.¹⁵⁹

These groups classify conscience protections as protection against discrimination. Framing the issue in such a way is powerful – more powerful than merely asserting conscience rights alone. Their claim is that if the law does not protect the freedom of conscience, then it is discriminating against certain religious and moral beliefs. In addition, language to describe the importance of conscience rights is very intense, perhaps reflecting an attempt to drum up attention, but also reflecting sincere beliefs. Cathy described her experience assisting in an abortion to be contrary to “every moral fiber of [her] being.”¹⁶⁰ The CHA’s 2015-16 Advocacy Agenda explains that the CHA supports “measures that allow us to maintain our Catholic identity and protect and defend human life from conception to natural death.”¹⁶¹ The protection of conscience is intimately connected to the protection of Catholic identity, and it is imperative to remember the sincerity of these beliefs when evaluating them against rights with which they conflict. This conscience flows out of beliefs about the sanctity of life that are part of doctrine that is hundreds of years old, engrained in followers by church teachings.

The Importance of Catholic Identity

As discussed in previous chapters, the identification of Catholic hospitals as Catholic played an important role in the development of the American Catholic Health Ministry and can be revoked if an institution fails to adhere to Catholic values. In 2008, a group of Dutch

¹⁵⁹ "Abortion Non-Discrimination Act (ANDA)," *Human Life Action*, <http://www.humanlifeactioncenter.org/issues/abortion-non-discrimination-act-anda>.

¹⁶⁰ *Stand with Cathy for Conscience Rights*.

¹⁶¹ "Advocacy Agenda 2015-2016," *Catholic Health Association of the United States*, April 8, 2015, <https://www.chausa.org/advocacy/advocacy-agenda-2013-2014>.

researchers completed a study to better understand how and why Catholic health organizations articulate their Catholic identity.¹⁶² They interviewed Catholic health providers from five American Catholic health care organizations (HCOs) – three hospitals, one health system, and one health association. In coding their transcripts, the researchers identified seven “considerations” (or themes) among the responses of their interviewees. Three of these themes are relevant to the discussion of this chapter: inspiration, ethics, and strategy.

The inspiration of a Catholic HCO is related to the organization’s purpose, as well as to articulating why the organization does what it does. Knowing what inspires the organization and why is essential to the function of Catholic health ministry. “A shared inspiration can strengthen the internal cohesion of an organization”, the authors explain, though they do acknowledge that a mission based on Catholic values will have a greater impact on Catholics than on non-Catholics.¹⁶³ A clearly expressed purpose is not something unique to a Catholic HCO, but is rather ubiquitous among most HCOs (and other non-health organizations). Strategy, according to what these authors understand it to mean, seems connected to their interpretation of inspiration: “an articulated Catholic identity can guide the organization in times of great changes...or of deep crises.”¹⁶⁴ Catholic identity is expressed through identifying the organization’s inspiration, and then it is implemented as a strategy for dealing with difficult situations, including ethical dilemmas.

In discussing what their interviewees said about ethics, the authors explain that Catholic identity can be a source of moral guidance. Further, “articulating the organization’s Catholic identity expresses that the institution and all who work there are bound by the ethical views and

¹⁶² Martien A. M. Pijnenburg, Bert Gordijn, Frans J. H. Vosman, and Henk A. M. J. ten Have, "Catholic Healthcare Organizations and the Articulation of Their Identity," *HEC Forum* 20, no. 1 (2008): 75-97, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797850/>.

¹⁶³ Pijnenburg, Gordijn, Vosman, and ten Have, 79.

¹⁶⁴ Pijnenburg, Gordijn, Vosman, and ten Have, 81.

guidelines of the Catholic Church.”¹⁶⁵ The authors go on to discuss instances in which HCOs found compromises when dealing with matters that conflicted with Catholic bioethics, often because administrators recognized that it was in the best interest of the HCO to find a way to accommodate each party. For example, one interviewee explained that the hospital he or she worked for made compromises about how to meet the ACOG/ACGME requirement for ob-gyns to incorporate abortion training, recognizing that if they did not, “then we have the problem for the future that we would have no ob-gyns anymore that got their education in Catholic medical schools.”¹⁶⁶ There were also questions about cooperation in evil¹⁶⁷, but the interviewee explained that they were able to reach an agreement that also satisfied the archbishop who oversaw their organization. This example and analysis furthers the claim that not all Catholic HCOs operate under the same terms; some are more conservative and some are more liberal. In this instance, this HCO was able to find a compromise that satisfied their medical duties but also protected their Catholic identity.

Another important theme in the interviews was a discussion about the language used in defining Catholic identity and mission. “There is a tension between an explicitly religious or a more neutral vocabulary”, because some fear that using overtly religious language will turn away non-Catholic individuals.¹⁶⁸ Kami Timm, a nurse writing for the Catholic Health Association, identifies the same issue, arguing that Catholic HCOs should pay more attention to how they market themselves: “Do we emphasize being Catholic or being a provider of excellent health

¹⁶⁵ Pijnenburg, Gordijn, Vosman, and ten Have, 80.

¹⁶⁶ Pijnenburg, Gordijn, Vosman, and ten Have, 80.

¹⁶⁷ The National Center for Catholic Bioethics explains that the principle of cooperation in evil limits the amount that a person may cooperate in an evil act, regardless of whether or not he or she is aware that he or she is cooperating in evil. An example of cooperating in evil could be referring a woman to an abortion clinic, knowing that she is going there to abort her child.

¹⁶⁸ Pijnenburg, Gordijn, Vosman, and ten Have, 81.

care services? What visual images do we use when we represent ourselves to the public?”¹⁶⁹ The discussion of how particular language reflects on Catholic HCOs represents two things. First, it signifies that the Catholic Health Ministry is thinking about its public image, and that there is concern about how religious language and imagery might impact how the public views their medical competencies. Second, it represents a concerted effort by some in the Catholic Health Ministry to appeal to the masses, not just Catholics. Some Catholic health professionals clearly recognize that in the end, they provide a service and run a business, and they understand that if they want to continue to exist, they must adapt in certain ways.

The need for a positive public image is a recurring theme in Timm’s article, though she advocates for a strong religious presence in Catholic HCOs. The piece opens with her reflection on an interaction with two individuals who claimed to be “recovering” Catholics. Timm is troubled by the idea of “recovering” from Catholicism, but she respectfully asks herself what it could mean to these individuals: “Do they regard it as progress that they have replaced the "oughts" and "ought nots" of Catholicism with the freedom to do what they want, when they want, with whom they want? Do they mean that they have disaffiliated with a church which did not meet their needs as a modern-day woman or man?”¹⁷⁰ This is a response to a classic criticism of religion, that it is antiquated and became less relevant with the advent of modern technology and science. Though Timm might not agree with these individuals’ choice to “recover” from Catholicism, she thoughtfully considers what their motivations might be. She uses this reflection as a springboard for her claims about how “our organizations need to carry our identity in their

¹⁶⁹ Kami Timm, "An Examination of Conscience: The Catholic Identity of Catholic Health Care," *Health Progress* 93, no. 1 (January/February 2012): 7, <https://www.chausa.org/publications/health-progress/article/january-february-2012/an-examination-of-conscience-the-catholic-identity-of-catholic-health-care>.

¹⁷⁰ Timm, 7.

core.”¹⁷¹ In a way, “recovery” from Catholicism serves to enhance the identity of other Catholics, like Timm, because it allows her to reexamine her own ideas about faith and reasons for implementing faith in health care.

Later, she asks, “Is there a pervasive, welcoming feeling when someone enters our buildings? Do visitors have a sense of being on holy ground?”¹⁷² This line of questioning indicates that Timm advocates for ensuring that patrons are aware of a hospital or organization’s Catholic identity, but that they do not feel unwelcome if they themselves are not Catholic. Still, Timm is clearly committed to the application of Catholic doctrine to Catholic health care, explaining that the hospital where she works had recently done an evaluation of how well their health care standards adhered to the Directives. She returns to ideas about being welcoming and creating a good image, which suggests that she understands the goals of a Catholic hospital to be greater than simply articulating Catholic identity. In the final section of her article, she says, “We have the potential to stand up and unabashedly state “we are Catholic health care,” but it will come only after a thorough and honest examination of conscience and an intense effort to ensure we are on the correct path in all areas.”¹⁷³ The fact that Timm discusses seeking “the correct path in all areas”, rather than just the correct path in Catholic affairs, is important because it signals her tolerance and understanding of opposing views in health care and other disciplines.

Although Timm is a clear advocate of Catholic principles in health care, she also takes care to recognize that Catholic identity should not alienate those for whom they care. Even when examining the “recovery” from Catholicism, Timm is respectful of the choices of these individuals. In fact, protecting human dignity seems to necessarily include being welcoming and conscientious. The Catholic Health Association’s “A Shared Statement of Identity” states that

¹⁷¹ Timm, 7.

¹⁷² Timm, 10.

¹⁷³ Timm, 11.

the Catholic Health Ministry must respond to “God's call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable.”¹⁷⁴ It is true that Catholics are motivated by the word of God, but their end goals still include compassion, aid, and understanding. Therefore, Catholic identity requires respect of other beliefs and uplifting anyone with whom you come into contact.

The two articles examined in this section demonstrate that there are ways to protect Catholic identity in health care while still respecting the desires and opinions of non-Catholics, though compromise is clearly required from both sides. A non-Catholic doctor might argue that the medical community has already made many sacrifices by way of conscience clauses, however. In addition, the convictions possessed by Catholic health care providers seem to be at odds with the medical oaths and promises these providers must make, like the Hippocratic Oath, which stresses patient rights to care, not physician rights of conscience. Physician perspective and medical ethics will be examined in depth in the following chapter, where the discussion will examine the rights that compete with Catholic conscience.

¹⁷⁴ "A Shared Statement of Identity," Catholic Health Association, <https://www.chausa.org/mission/a-shared-statement-of-identity>.

CHAPTER SIX:

Physician Perspectives on Conscience

The discussion will now turn to examine the physician perspective on conscience, which will include both physicians who oppose and physicians who support conscience objection in obstetrics and medicine generally. To start, it is necessary to define the basic principles of modern medical ethics, which dictate the practice of medicine both nationally and internationally. The discussion will demonstrate that these medical ethical principles underlie objections to conscience rights, as well as concessions made by those who support conscience rights. Further analysis will consider what secular medical authorities have to say about conscience in health care, as well as an examination of the positions of the Christian Medical and Dental Associations (CMDA) and the Catholic Medical Association (CMA).

Although the opinions of the CMDA and the CMA largely echo those of other religious bodies discussed in previous chapters, they are relevant to the discussion of this chapter because they are exclusively physician membership groups. Their perspectives on conscience will shed light on the difficulties faced by, for example, a Christian ob-gyn, who feels conflicted between her medical education and Christian values. This discussion aims to provide a foundation for the final chapter of this thesis, in which potential solutions and plans of action will be explored.

A Brief Overview of Modern Medical Ethics

While David Kelly argues that all bioethics developed out of Catholic and Jewish theology, as discussed in Chapter Four, most secular medical bodies agree that Western medical ethics originated with Hippocrates, an Ancient Greek physician (John R. Williams, Avraham Steinberg, Stephen Garrard Post). Hippocrates is credited with the creation of the Hippocratic

Oath, which has changed over time but whose core ethic remains as “the physician’s pledge to do what he or she thinks will benefit the patient”¹⁷⁵. The Hippocratic Oath is recited at nearly every medical school graduation in the United States today and continues to hold significance in the medical community.¹⁷⁶ However, in the 1960s, technological advances confounded the practice of medicine in ways that Hippocratic principles could not address alone.¹⁷⁷ These advances led to the evolution of medical ethics from an individually focused Hippocratic approach to the more community-based approach seen today. Modern medical ethics continues to stress patient rights and physician duties, just in different terms.

Current medical ethics are built upon four key principles: respect for autonomy, beneficence, nonmaleficence, and justice.¹⁷⁸ In moral terms, respect for autonomy involves allowing rational agents to make voluntary and informed decisions about care.¹⁷⁹ Beneficence states that health care providers have a duty to help their patients and must take actions that benefit patients. Nonmaleficence holds that providers must not harm their patients, regardless of whether harm is direct or indirect. Finally, justice requires a fair distribution of goods and services in health care. All four principles inform medical decisions in important ways, but autonomy is particularly relevant to this thesis, because it provides the foundation for informed consent: “Informed consent is the process by which the treating health care provider discloses appropriate information to a competent patient so that the patient may make a voluntary choice

¹⁷⁵ Post, 1488-1494.

¹⁷⁶ Peter Tyson, "The Hippocratic Oath Today," *PBS*, March 27, 2001, <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.

¹⁷⁷ Robert Veatch, "The Changing Health Care Scene: Introduction." *Source Book in Bioethics: A Documentary History* (Washington, D.C.: Georgetown University Press, 1998) 409.

¹⁷⁸ Thomas R. McCormick, "Principles of Bioethics." *Ethics in Medicine: University of Washington School of Medicine*, October 1, 2013, <https://depts.washington.edu/bioethx/tools/princpl.html>.

¹⁷⁹ A “rational agent” refers to a patient whose capacity to make reasoned decisions is not diminished, as opposed to a patient who, perhaps as the result of some pathology or injury, is unable to make autonomous decisions about his or her care. For example, patients who are braindead are not considered to be rational agents, and the respect for autonomy shifts to whoever is making decisions in their stead, usually a spouse or family member.

to accept or refuse treatment.”¹⁸⁰ It requires physicians to provide patients with all information relevant to the patient’s condition, so that the patient might make the best, most informed decision. Implicit in this idea of autonomy and informed consent is that decisions are made within the parameters of the patient’s desires and beliefs. If it were not, informed consent would not exist. The primacy of informed consent can contribute to many physicians’ opposition to conscience clauses and helps explain why many physicians who support conscience understand a need for compromise between patients’ rights and conscience.

Medical Associations: Purpose and Mission

The American Medical Association, the American College of Obstetricians and Gynecologists, the Catholic Medical Association, and the Christian Medical and Dental Associations are all non-profit groups that offer membership to physicians and medical students, and in some cases, other health professionals. Understanding the interests and goals of each group is imperative, as they inform the policy positions taken by each group. The AMA states that its mission is to “promote the art and science of medicine and the betterment of public health.”¹⁸¹ ACOG calls itself “the premier organization for obstetricians and gynecologists and providers of women’s health care”, stating that it is “dedicated to the advancement of women’s health care through practice and research.”¹⁸² Both the AMA and ACOG use medical and scientific standards as a point of departure, which is depicted by each group’s stress on “science” and “practice and research” as key parts of their mission. The AMA explains that its mission

¹⁸⁰ McCormick, “Principles of Bioethics.”

¹⁸¹ “AMA Mission & Guiding Principles,” *American Medical Association*, <http://www.ama-assn.org/ama/pub/about-ama.page>, Accessed March 22, 2016.

¹⁸² “The American College of Obstetricians and Gynecologists Strategic Plan,” *American Congress of Obstetricians and Gynecologists*, July 12, 2009, <https://www.acog.org/-/media/About-ACOG/StrategicPlanCollege.pdf?dmc=1&ts=20160321T1050254025>, Accessed March 22, 2016.

includes “setting standards for medical education, and advancing medical science to serve as the premier voice for the core values of the medical profession.”¹⁸³ Similarly, ACOG stresses “life-long learning” and “scholarship in medical science.”¹⁸⁴

The AMA and ACOG are both heavily involved in setting medical standards and making decisions about American medical practice, with ACOG focusing on the practice of obstetrics and gynecology. The AMA produces and maintains the Current Procedural Terminology, or CPT, which is “the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.”¹⁸⁵ It also holds conferences and consortiums focused on improving patient care and continuing medical education. Similarly, ACOG’s website offers extensive resources on obstetrics and gynecology, including the Obstetric Care Consensus Series, which are “documents [that] provide high-quality, consistent, and concise clinical recommendations to practicing obstetricians and the maternal-fetal medicine (MFM) subspecialists.”¹⁸⁶

Furthermore, both the AMA and ACOG are associated with other medical organizations that set standards for the practice of medicine. The AMA is associated with the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other accreditation bodies that govern medical education and practice in the United States¹⁸⁷. ACOG is affiliated with the American Board of Obstetrics and Gynecology (ABOG),

¹⁸³ “AMA Mission & Guiding Principles.”

¹⁸⁴ “The American College of Obstetricians and Gynecologists Strategic Plan.”

¹⁸⁵ “About CPT®,” *American Medical Association*, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page>, Accessed March 22, 2016.

¹⁸⁶ “Women’s Health Care Physicians: Obstetric Care Consensus Series,” *American Congress of Obstetricians and Gynecologists*, <http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series-List>, Accessed March 22, 2016.

¹⁸⁷ “Member Organizations,” *Accreditation Council for Graduate Medical Education*, <https://www.acgme.org/What-We-Do/Overview/Member-Organizations>, Accessed April 04, 2016.

which is the organization that certifies obstetricians and gynecologists in the United States¹⁸⁸. In other words, in order to practice as an ob-gyn in the United States, physicians must receive accreditation from ABOG. All of the aforementioned organizations – AMA, ACOG, ACGME, ABMS, and ABOG – work together to ensure that Americans receive the best medical care available, making decisions based in science, medical research, and secular bioethics.

By contrast, the primary goal of both the CMDA and CMA is to infuse medicine with Christian values. The CMDA states that it “motivates, educates and equips Christian health care professionals to glorify God by: serving with professional excellence as witnesses of Christ’s love and compassion to all peoples and advancing biblical principles of healthcare within the Church and to our culture.”¹⁸⁹ Along the same lines, the CMA’S stated purpose is to encourage “steadfast fidelity to the teachings of the Catholic Church, to uphold the principles of the Catholic faith in the science and practice of medicine.”¹⁹⁰ It is necessary to differentiate the CMDA and the CMA from ACOG and the AMA, because the former have a very specific, religious purpose, as opposed to a focus on medical standards and research. CMDA is an interest group that takes *Christian* positions on issues within health care, while AMA and ACOG offer recommendations and seek to influence policy based on medical research and scientific evidence.

CMDA membership is open to “all Christian healthcare professionals”, and the “the greatest [membership] benefit of all is helping to further His kingdom as we change hearts in healthcare.”¹⁹¹ Members of the CMA “are challenged...to demonstrate how Catholic teachings

¹⁸⁸ "Home Page," *American Board of Obstetrics and Gynecology*, <https://www.abog.org/new/default.aspx>, Accessed April 04, 2016.

¹⁸⁹ "Our Mission & Vision," *Christian Medical & Dental Associations*, <http://cmda.org/about/page/our-mission-vision>, Accessed March 22, 2016.

¹⁹⁰ "Mission," *Catholic Medical Association*, <http://www.cathmed.org/about/mission/>, Accessed March 22, 2016.

¹⁹¹ "Members: Frequently Asked Questions," *Christian Medical & Dental Associations*, <http://cmda.org/members/FAQ>, Accessed March 22, 2016.

on the human person, human rights and the common good intersect with and improve the science and practice of medicine, and to defend the sacredness and dignity of human life at all stages.”¹⁹² The goals of the CMDA and CMA, which emphasize Christian values over scientific evidence, are therefore distinct from the more traditional medical organizations that actually regulate the profession.

The American Medical Association: Physician Exercise of Conscience

Within its Code of Medical Ethics, the AMA gives a clear statement on the Physician Exercise of Conscience: “Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination.”¹⁹³ Reference to “ethical norms” is not surprising, nor is the mention of “fidelity to patients” and “patient self-determination”. The AMA is referring to some of the most basic principles of physician ethics, informed consent and autonomy, discussed above. However, their statement goes on to recognize that physicians and other health care providers operate both within the parameters of medical practice and within their individual systems of belief and values. The AMA contends that “physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities,” but that the “physicians’ freedom to act according to conscience is not unlimited.”¹⁹⁴

The AMA’s statement on conscience places emphasis on the physician’s duty to thoughtfully consider how his or her actions (or refusals) might affect patient care, as well as how they could affect his or her colleagues. In addition, the AMA requires physicians to “uphold

¹⁹² "History," *Catholic Medical Association*, <http://cathmed.org/about/history/>, Accessed March 22, 2016.

¹⁹³ "Opinion 10.06 - Physician Exercise of Conscience," *American Medical Association*, June 2015, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1006.page>, Accessed March 22, 2016.

¹⁹⁴ "Opinion 10.06 - Physician Exercise of Conscience.”

standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.”¹⁹⁵ This statement is likely a direct response to Catholic refusals, which, as discussed in previous chapters, include refusals to refer patients to other physicians for objectionable care. Overall, the AMA makes important accommodations for physician conscience, but they are steadfast in their commitment to patient care and medical ethics.

The ACOG: the Limits of Conscientious Refusal in Reproductive Medicine

Like the AMA, the American College of Obstetricians and Gynecologists has a clear statement on physician conscience, released by their Ethics Committee. However, ACOG’s position is much less flexible, and it goes into more detail about how and why conscience refusals are limited within reproductive medicine: “Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities.”¹⁹⁶ This position effectively states that no conscience refusal is acceptable, because conscience refusals necessarily involve an imposition of one’s beliefs onto another individual. ACOG’s reference to racial and socioeconomic disparities reflects an understanding that good health care, particularly women’s health care, has historically been unavailable to certain groups.¹⁹⁷ A desire to ensure that such disparities do not impact care is a manifestation of the medical ethical principle of justice, discussed above.

¹⁹⁵ "Opinion 10.06 - Physician Exercise of Conscience."

¹⁹⁶ "The Limits of Conscientious Refusal in Reproductive Medicine," *American College of Obstetricians and Gynecologists*, <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine>, Accessed March 22, 2016.

¹⁹⁷ See Chapter One, "History of Abortion in the United States."

ACOG goes on to say that refusals that are not in the patient's best interest should be respected only if the physician can fulfill his or her primary duty to the patient. This concession could be read to mean that ACOG would allow conscience refusals in conjunction with a referral to another physician who could provide the objectionable care. This reading is likely accurate, as ACOG explains later in its statement that physicians with moral and religious constraints should "ensure that referral processes are in place."¹⁹⁸ This compromise between patient rights and conscience reflects ACOG's desire to defend autonomy and informed consent, showing respect for conscience while maintaining standards of care.

Regarding institutions specifically, ACOG states that "institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services."¹⁹⁹ For both individual and institutional conscience, ACOG places the burden of upholding care on the source of the refusal; it is the responsibility of the physician or institution to ensure that a refusal does not compromise medical practice. At the end of its statement, ACOG offers medical and policy proposals on conscience refusals. "Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services," recommends ACOG. The College acknowledges the role of respect for conscience in ethical medical practice, but it believes that it cannot simply trump the provision of medically indicated and desired procedures and care.

¹⁹⁸ "The Limits of Conscientious Refusal in Reproductive Medicine."

¹⁹⁹ "The Limits of Conscientious Refusal in Reproductive Medicine."

The Christian Medical and Dental Associations: Freedom of Faith and Conscience

In contrast to the positions of the AMA and ACOG, the CMDA believes that conscience in health care should receive a high level of protection. The introductory statement on their “Freedom of Faith and Conscience” page begins with a series of questions:

“As a Christian healthcare professional, have your colleagues ever looked down at you for refusing to prescribe the morning after pill? Or have you ever been punished for maintaining your religious beliefs instead of believing in evolution? Or have you ever been harassed by an attending trying to force you to perform an abortion?”²⁰⁰

These questions raise similar concerns to those voiced by Brian Bamberger, as discussed in Chapter Four. Fear of loss of professional respect is a reoccurring theme among individuals who support conscience objection, and so is a fear of being forced to perform procedures that one finds objectionable. The statement goes on to say that “abolishing the right of conscience is dangerous,” not only for the individuals who refuse based on conscience, but also for the country as a whole and every patient.²⁰¹ The statement indicates that the “danger” in repealing conscience laws lies in the fact that in a survey of faith-based doctors, “95 percent of them said they would quit medicine before violating their conscience”. The CMDA suggests that without conscience protections, physicians will quit in large numbers, and there will not be enough physicians.

In its “Healthcare Right of Conscience Ethics Statement”, the CMDA offers further information on its position on conscience. It frames the health care professional’s right of conscience as a right to refuse care that “they believe to be morally wrong and/or harmful to the patient or others.”²⁰² By framing it as a prevention of harm in addition to a moral wrong, CMDA

²⁰⁰ “Freedom of Faith and Conscience,” *Christian Medical & Dental Associations*, <http://cmda.org/issues/detail/freedom-of-faith-and-conscience>, Accessed March 22, 2016.

²⁰¹ “Freedom of Faith and Conscience.”

²⁰² “Healthcare Right of Conscience Ethics Statement,” *Christian Medical & Dental Associations*, <http://cmda.org/resources/publication/healthcare-right-of-conscience-ethics-statement>, Accessed March 22, 2016.

almost makes conscience refusal a part of professional responsibility. Still, CMDA says that any refusing health care professional is obligated to transfer the patient's records to "the healthcare professional of the patient's choice."²⁰³ This record transfer suggestion is representative of CMDA's respect for patient autonomy and informed consent, and the compromise they offer indicates that CMDA believes that conflicting interests can and should be balanced. With regards to institutional conscience, CMDA says that institutions "have the right to refuse to provide services that are contrary to their foundational beliefs", but that refusing institutions "have an obligation to disclose the services they would refuse to give."²⁰⁴

The assertion that institutions should publicize their refusals is presumably related to a belief that refusals should come with alternatives, just as with physician duty to transfer records. So, although conscience protections should exist both at the individual and institutional level, CMDA believes these protections involve responsibility on the part of the refusing party to ensure that care is still available. This evidence supports a conclusion that CMDA is informed by both Christian values and secular medical ethics, in spite of distinctly Christian goals. In this way, the position of the CMDA is in fact similar to that of ACOG, as both recognize a need for balance between conscience and care. Emergency situations put a strain on this balance, however, as life and death situations require expedient decision-making that could be hindered by any deference to conscience.

The Catholic Medical Association: "Declaration of Faith" and Commentary on Conscience

Unlike the AMA, ACOG, and CMDA, the Catholic Medical Association (CMA) does not have a statement or webpage dedicated solely to their stance on conscience in medicine.

²⁰³ "Healthcare Right of Conscience Ethics Statement."

²⁰⁴ "Healthcare Right of Conscience Ethics Statement."

However, references to conscience rights and how CMA members should understand their rights appear throughout the organization's website. For example, on the webpage titled, "What CMA Does for Members", CMA explains that "we defend your right to follow your conscience and Catholic teachings so you can protect your integrity and help build a culture of life."²⁰⁵

Elsewhere, the CMA provides information about options for legal advocates who work to protect conscience, in addition to giving examples of federal legislation that provides protections for refusals.²⁰⁶ The CMA also takes specific positions on health care legislation, stating that one of its highest priorities is working "to ensure that any national health-care reform legislation provides...respect for the conscience rights of health-care professionals."²⁰⁷

In the CMA's "Declaration of Faith of Catholic doctors and students of medicine, on the sexuality and fertility of human beings", item four states:

"The foundation for the dignity and freedom of the Catholic doctor is exclusively his or her conscience, enlightened by the Holy Spirit and informed by the teaching of the Church, and that he or she has the right to act according to said conscience and in keeping with medical ethics that have established the doctor's right to oppose all acts that are against one's conscience."²⁰⁸

This statement is consistent with the opinions on conscience of other Catholic bodies and organizations discussed in previous chapters. The statement, published in January of 2015, includes standard denunciations of abortion, euthanasia, and sterilization, which violate the Catholic bioethical principles discussed in the previous chapter.

Two additional items in the Declaration of Faith are relevant to understanding the CMA's position on conscience. Item five calls on Catholic doctors to "recognise [sic] the priority of

²⁰⁵ "What CMA Does for Members," *Catholic Medical Association*, <http://cathmed.org/membership/what-cma-does-for-members/>, Accessed March 24, 2016.

²⁰⁶ "Educational Resources: Introduction to Conscience Rights," *Catholic Medical Association*, 2016, <http://cathmed.org/students/student-resources/introduction-to-conscience-rights/>, Accessed March 24.

²⁰⁷ "Health Care Reform: Overview," *Catholic Medical Association*, <http://cathmed.org/resources/health-care-reform/overview/>, Accessed March 24.

²⁰⁸ "Declaration of Faith," *Catholic Medical Association*, <http://cathmed.org/resources/cma-statements/declaration-of-faith>, Accessed March 24.

God's law of the law of nations and...the current need for providing alternatives to the anti-human ideologies and dictates imposed by some contemporary societies."²⁰⁹ In effect, the CMA tells its members that God's law transcends secular law, and that it is their duty to combat ideas that are "anti-human" in the eyes of the Church. Still, item six tells members to "believe that, while not imposing their beliefs and opinions, Catholics, including doctors and students, have a right to perform their professional activities in accordance with their conscience."²¹⁰ Here, the CMA acknowledges the need for some kind of balance between physician conscience and respect for the beliefs of others, though earlier statements do not indicate that there is flexibility to provide such a balance. If doctors have a right to "oppose all acts" that violate his or her conscience and must hold God's law higher than secular law, how is a physician able to refrain from imposing his or her beliefs on patients or colleagues?

Discussion: Comparisons and Some Conclusions

Each of the medical associations discussed takes a clear stance on conscience rights, either in support or opposition, and each also makes some kind of concession to the other side. The way each organization is informed in developing its position on conscience clauses is important: the AMA and ACOG are largely dictated by medical ethical principles, like autonomy and informed consent, but they understand that moral objections may arise to certain types of care, indicated by their allowance of some conscience refusals. On the other hand, the positions of the CMDA and CMA are primarily informed by Christian values, though they clearly incorporate medical ethical principles by instructing members to ensure referrals or to not impose their beliefs. Members of the CMDA and CMA are physicians in addition to being

²⁰⁹ "Declaration of Faith."

²¹⁰ "Declaration of Faith."

Christians, so it is logical that they infuse their work with medical ethical principles in addition to Christian values.

However, in spite of some concessions, these organizations still vigorously defend their positions, through social, political, and legal channels. The AMA and ACOG both have their own political action committees, (PACs), which are fundraising organizations that support particular candidates and initiatives that are aligned with the PAC's interests and goals.²¹¹ Both organizations also have litigation and advocacy branches, which work to influence policy and law at the state and federal levels. Recently, the AMA and ACOG joined an Amicus Curiae – “friend of the Court” – brief filed in favor of the petitioners in *Whole Woman's Health v. Hellerstedt*, a case involving abortion regulation laws in Texas.²¹² ACOG's advocacy resources include legislative priorities such as protecting the patient-physician relationship, continued implementation of the Affordable Care Act, and protecting access to care for low-income women and adolescents.²¹³

The CMDA's Public Policy page offers updates on focus issues at the state and federal levels, which include physician-assisted suicide, religious freedom, and, of course, freedom of conscience.²¹⁴ Over the last 20 years, it has joined in case briefs for nearly sixty court cases at all levels of the judiciary, with topics ranging from embryo research to First Amendment

²¹¹*Encyclopaedia Britannica Online*, s.v. "Political Action Committee (PAC)," by Michael Levy, <http://www.britannica.com/topic/political-action-committee>, Accessed March 25, 2016.

²¹² *Whole Woman's Health v. Hellerstedt* is a Supreme Court involving Targeted Regulation of Abortion Provider (TRAP) Laws in Texas, which impose unnecessary “health” regulations on abortion clinics with the aim of limiting access to the procedure. The AMA and ACOG filed a brief on behalf of the petitioners, in which they argue that the regulations are medically unnecessary and do not serve health of women in Texas. Arguments were heard on March 2nd, 2016, and a decision expected in late June of 2016.

²¹³ "Legislative Priorities," American College of Obstetricians and Gynecologists, <http://www.acog.org/Advocacy/ACOG-Legislative-Priorities>, Accessed March 25, 2016.

²¹⁴ "Ministry: Public Policy," Christian Medical & Dental Associations, <http://cmda.org/about/page/our-mission-vision>, Accessed March 22, 2016.

freedoms.²¹⁵ The CMA has a page dedicated to health care reform, a topic that is central to the organization's mission because "decisions made now will fundamentally shape how Americans interpret human and constitutional rights to life, religious and civic liberty, and freedom of conscience."²¹⁶ In addition, the CMA also files amicus briefs in Supreme Court cases defending conscience rights and religious freedom, including a brief in *Hobby Lobby Stores, Inc. v. Kathleen Sebelius*.²¹⁷

So even if the AMA, ACOG, CMDA, and CMA give theoretical concessions to their opposition on conscience, the extent of their advocacy indicates that these concessions are not necessarily applied in reality. Considering how firm each group is in its position on conscience, it is unclear how a physician can be a card-carrying member of, for example, the AMA and the CMDA, or both the ACOG and the CMA. Given the priority and supremacy of Catholic doctrine in particular, bolstered by constitutional claims of religious freedom, there appears to be an irreconcilable conflict. The requirements of religious conscience put physicians on a collision course within the confines of their profession's ethical standards. Still, the point at which these and other groups are willing to compromise in theory can assist in the discussion about how to resolve the issue of conscience collisions. In the next chapter, these points of compromise will be evaluated in order to formulate some potential solutions to the medical conscience problem. It will demonstrate that a balance can be struck between medical and Catholic interests, and that the opportunity to seek such a balance is within reach of Catholic institutions at this time.

²¹⁵ "Court Action - Christian Medical Association," Christian Medical & Dental Associations, January 2016, <http://cmda.org/library/doclib/CMA-court-briefs-summary020916.pdf>, Accessed March 25, 2016.

²¹⁶ "Health Care Reform: Overview."

²¹⁷ "Amicus Curiae Briefs," Catholic Medical Association, <http://cathmed.org/resources/amicus-curiae-briefs/>, Accessed March 25, 2016.

CHAPTER SEVEN:

Looking Forward: Challenges, Compromises, and Solutions

This final chapter seeks to explore how challenges to Catholic conscience have unfolded thus far, both in the courts as well as in hospitals and HCOs themselves. An examination of legal challenges will reveal that although parties opposed to conscience in health care are aggressive and unyielding in their efforts, the courtroom is not the place to resolve these conflicts. Rather, positive change has been found in cooperation and compromise between local dioceses, hospital administrators, and local governments. In addition, since court challenges have the power to enact broad, sweeping change, Catholic institutions have an opportunity at this point in time to create change that protects their identity and interests. After considering the factors that contribute to the pervasive conflicts that exist in maternal health care in Catholic hospitals, it has become clear that the most appropriate solution is for the USCCB to revise the *Directives* in accordance with medical judgment and federal policy.

Legal Challenges to Catholic Conscience

Both individuals and organizations have begun to take legal action against Catholic hospitals and even the USCCB. In 2010, after the incident described in the introduction to this thesis, Tamesha Means of Michigan filed suit against the United States Council of Catholic bishops, claiming that the bishops' policies (namely, the *Directives*) "caused her to receive improper treatment and information regarding her miscarriage."²¹⁸ However, Means' suit was dismissed in 2015 because the Court was not allowed to exercise "personal jurisdiction" over the

²¹⁸ Tamesha Means v. United States Conference of Catholic Bishops et al. (United States District Court for the Western District of Michigan Southern Division June 30, 2015) (ACLU, Dist. file).

USCCB, and because Means failed to bring a complaint that the Court could arbitrate.²¹⁹ In other words, the district court said that the suit concerned church matters and did not present a question that the legal system was equipped to answer.

Rebecca Chamorro, also represented by the ACLU, filed suit against Dignity Health in California after it became clear that she would be denied a tubal ligation following her cesarean section scheduled for January of 2016.²²⁰ This delivery was Chamorro's third child, and after informing her obstetrician that she and her husband do not want any more children, the obstetrician advised Chamorro that she should have a tubal ligation immediately following her delivery. The hospital where Chamorro was to receive care, Mercy Medical Center Redding (MMCR), denied her obstetrician permission to perform the sterilization, as it would be a direct violation of the *Directives*. MMCR is the only hospital within 70 miles of Chamorro's home that provides labor and delivery services.²²¹ According to the ACLU, prohibiting Chamorro's tubal ligation is discriminatory, because MMCR has allowed other women to undergo the procedure upon proving that future pregnancies would result in physical harm. The ACLU further alleges that the hospital's refusal violates California law, which requires that if a hospital performs sterilizations, "then it may not require the individual seeking the sterilization to meet nonmedical qualifications."²²²

In yet another case, the ACLU itself filed a complaint against Trinity Health Corporation for failing to provide emergent care to miscarrying women. It alleges that refusals based on the *Directives* violate the Emergency Medical Treatment and Active Labor Act, which requires any

²¹⁹ Tamesha Means v. United States Conference of Catholic Bishops et al.

²²⁰ Rebecca Chamorro and Physicians for Reproductive Health v. Dignity Health (Superior Court of the State of California for the County of San Francisco December 28, 2015).

²²¹ Azeen Ghorayshi, "Pregnant Woman Sues Catholic Hospital For Not Letting Her Get Tubes Tied," *BuzzFeed*, December 30, 2015. <http://www.buzzfeed.com/azeenghorayshi/pregnant-woman-sues-catholic-hospital>, Accessed February 21, 2016.

²²² Chamorro v. Dignity Health.

health care facility that receives Medicaid funding to treat patients with emergency medical conditions.²²³ The Act also prohibits transferring or discharging patients who have not been stabilized. The ACLU claims that the *Directives* have led Trinity Health system hospitals to “repeatedly and systematically” deny care to miscarrying women, and as a result, patients “have become septic, experienced hemorrhaging, contracted life-threatening infections, and/or unnecessarily suffered severe pain for several days at a time”.²²⁴

These cases signal important changes in the way Americans are thinking about the status of Catholic hospitals, as well as the status of religion in general. As demonstrated by this thesis, the cases of Means and Chamorro are not unique; they represent a pervasive issue in Catholic health care facilities across the country. Organizations like the ACLU work specifically to enact change on certain agenda items, and they are aggressive in their attempts to do so. Thus far, the lower courts have been reluctant to accept the arguments put forth by the ACLU, but all advocates need is one sympathetic judge to advance their case. These issues are not going away, and the American Catholic health ministry would be wise to address them immediately in order to create a solution that protects their interests.

Court decisions impact the jurisdiction over which they preside. Hypothetically, one of these challenges could reach the Supreme Court, which would mean that a decision on Catholic conscience could affect the entire country. This is the type of issue that all parties have an interest in proactively addressing, because a decision in either direction has potential to cause harm to one or more of the parties involved. For example, if a court rules against the Catholic HCOs, they might not be able to protect their distinctive identity. Chapter five explored the importance of Catholic identity and Catholic conscience, demonstrating that an inability to

²²³ American Civil Liberties Union v. Trinity Health Corporation (United States District Court for the Eastern District of Michigan October 1, 2015).

²²⁴ American Civil Liberties Union v. Trinity Health Corporation

protect these interests is damaging to Catholic individuals as well as institutions. On the other hand, if a court rules in favor of the Catholic HCOs, women's reproductive health care could be seriously compromised. Chapter four explored the scenarios that arise as a result of restrictions on reproductive care, though there are additional areas of health care that could become problematic. For these reasons, it is in the best interest of all parties involved for legislators, medical authorities, and the Catholic Church to arrive at a mutually agreeable solution before these claims advance any further.

A Cooperative Solution to the Problem of Doctrine in Medicine

The discussion throughout this thesis has examined several flashpoints that contribute to conflicts in maternal health care in Catholic hospitals, though analysis has revealed that the most aggressive cause of the conflicts is the presence of religious doctrine in medicine. Conscience legislation is certainly problematic, but in order to address the specific issues that arise within the scheme of the Catholic health ministry, it is necessary to ameliorate the specific cause of those issues. In light of the way that the Catholic health ministry has fundamentally misconstrued miscarriage management via the *Directives*, the most robust solution to conflicts in care is to revise the *Directives* in order to correct this misunderstanding. This revision by the USCCB should take place in consultation with medical authorities, like the AMA and ACOG, and with policy experts, in order to ensure that patient rights are fully represented and that the Catholic health ministry is exercising its conscience rights within the scope of existing legislation.

A revision of the *Directives* to alleviate the conflicts discussed in this thesis could happen in one of two ways. First, the USCCB could amend Directive 47, which allows for treatments that will cause abortion in the case of a "proportionately serious pathological condition of a

pregnant woman” for which treatment “cannot be safely postponed until the unborn child is viable.”²²⁵ Directive 47 could be revised to define “serious pathological condition” as including miscarriage complications, molar pregnancies, ectopic pregnancies, and other relevant pregnancy complications that may require miscarriage management care. This revision would also address the issues caused by Directive 48, which gives vague prohibitions for “direct abortion” in the case of ectopic pregnancies.²²⁶

The second and perhaps more effective way that the USCCB could revise the *Directives* would be to create a new Directive altogether that addresses pregnancy complications and miscarriage management and how to treat them. If written, the new Directive should distinguish miscarriage management from direct abortion on the premises that miscarriages are not elected and that the fetus is inevitably unviable. Emphasis on the fact that these complications almost never allow fetal life to continue could alleviate any conscience pressures, as the Catholic prohibition on abortion is based on the assumption that abortion causes death to an otherwise potential life. Recognizing the mother’s lack of agency in any decision about the death of her fetus could also serve to protect conscience, as the mother could then qualify as “innocent life” to be protected. Finally, the new Directive should acknowledge the medical necessity of miscarriage management, perhaps even stressing the importance of providing patients with the highest quality medical care to which they as human beings are entitled.

²²⁵ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed., November 17, 2009, <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>, Part Four, Directive 47.

²²⁶ The *Directives*, Part Four, Directive 48.

CONCLUSION

This thesis has explored conscience conflicts in Catholic hospitals, specifically those that arise with miscarriage management, in great detail. The discussion has attempted to give equal weight to the individuals and institutions on each side of the controversy, exploring the nuances of each argument. Points of friction have been identified, and though a number of these points are unresolvable because of their place within the framework of the Catholic health ministry and American public policy, other points are accessible for compromise. Finally, this thesis considered the future of conscience rights within the American political and legal landscape, arriving at a recommendation that would require the cooperation of legislators, medical authorities, and most importantly, the Catholic health ministry.

Regardless of what you believe about the motives and sincerity of individuals who claim religious conscience objection, it is imperative to acknowledge the ultimate effect of these objections: they infringe on the rights of private citizens. Within the reproductive rights debate, they deny women the right to make choices about health care and by extension, they deny women the dignity of equality. These are issues that are distinctly *feminine*: they do not affect male patients simply due to rudimentary biology. They affect only women and are therefore reducible to questions about equality and dignity. Moreover, the debate over conscience rights comes down to protecting belief and emotional wellbeing versus protecting a woman's right to receive proper care and stay alive. Religious liberty is certainly deserving of protection, but we must ask ourselves if we are willing to allow one person's religious or moral belief to impact another person's quality of life. It is for these reasons that reproductive rights advocates will continue to fight for the rights of all women to have control over their bodies, their health care, and ultimately, their lives.

Conflicts in care in Catholic hospitals represent a microcosm within the larger context of religious freedom and women's rights, but this thesis has tried to demonstrate how themes of these specific conflicts can be used to understand reproductive rights and religious liberty more generally. At this point in time, Catholic hospitals have an opportunity to shape the discussion and influence policy issues that will not fix themselves. They should seize the chance to be a part of deciding how these conflicts are resolved, through which they could ensure that their own interests are protected, rather than simply asserting doctrine and avoiding taking responsibility for these issues.

Medical authorities and policy makers have a duty to address these issues, too. Although secular medical authorities have their hands tied in many ways with regards to conscience in medicine, physicians and other health care providers have a duty to seek the highest quality of care for their patients. Policy makers are partially responsible for the creation of conflicts in care in Catholic hospitals, as they maintain the policy that allows doctrine to flourish in medicine. By cooperating with the Catholic Church to revise the *Directives*, medical authorities and policy makers could help to solve a set of problems that have the potential to expand. Conscience collisions are characterized by a clash of rights of several parties; therefore, all of those parties have an interest and a duty to find a solution.

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