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Your Morality, My Mortality

Conscientious Objection and the Standard of Care

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Abstract: Recently the scope of protections afforded those healthcare professionals and institutions that refuse to provide certain interventions on the grounds of conscience have expanded, in some instances insulating providers (institutional and individual) from any liability or sanction for harms that patients experience as a result. With the exponential increase in the penetration of Catholic-affiliated healthcare across the country, physicians and nurses who are not practicing Catholics are nevertheless required to execute documents pledging to conform their patient care to the Ethical and Religious Directives for Health Care Services as a condition of employment or medical staff privileges. In some instances, doing so may result in patient morbidity or mortality or violate professional standards for respecting advance directives or surrogate decisionmaking. This article challenges the ethical propriety of such institutional mandates and argues that legal protections for conscientious refusal must provide redress for patients who are harmed by care that falls below the prevailing clinical standards.

Keywords: abortion; Catholicism; law; medicine; professional ethics; religion

Introduction

Laws that purport to absolve healthcare institutions and professionals from any responsibility for injury or other harm to patients arising out of either the refusal to provide a medically necessary or indicated intervention or the insistence on providing one over the express refusal of a patient or the patient's duly designated proxy, based on religious or moral objections, have proliferated in recent decades—a phenomenon aptly described as "conscience creep."[1] The underlying premise of such laws (or at least the end result) is that the exercise of conscience in this context should be without any adverse consequence to the objector. Syndicated columnist Ellen Goodman initially raised concerns about the validity and acceptability of this premise as a matter of ethics, law, and public policy,[2] and Alta Charo advanced it further in her widely cited article.[3] Although the literature (both supportive and critical) on conscientious refusal to provide legal and medically appropriate measures continues to expand, with the notable exception of law journals, rarely does it directly confront the serious moral and legal implications of the exercise of

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"conscience without consequence," particularly in situations in which the exercise of individual or institutional conscience threatens or directly results in patient morbidity or mortality or imposes a significant hardship, such as a prolonged death or the delay and burden engendered by the need to seek care from a provider who will respect the patient's values and priorities and meet her immediate needs.

This article confronts several interrelated ethical and legal concerns. First, with the significant expansion of religiously affiliated healthcare institutions, in particular, Catholic hospitals that adhere to the United States Conference of Catholic Bishops Ethical and Religious Directives for Health Care Services (hereinafter ERD), an exponentially increasing number of physicians and nurses (many of whom are not Catholic) find that their ability to practice medicine that is consistent with prevailing standards may be constrained in ways that compromise patient care. A second and related matter is that, by institutional fiat, the ERD is claimed to constitute the conscience of the institution, even when the majority of clinical staff, and patients for that matter, are not Catholic. Third, in jurisdictions in which comprehensive conscience legislation has been adopted, patients who are injured as the result of conscience-based refusals to provide treatment have no legal recourse. The same would likely be true for clinicians who refuse to sacrifice the quality of their care to the dictates of the ERD and who subsequently are sanctioned by the institution. This state of affairs has not received the attention it warrants, despite excellent work by a few scholars of law and ethics, whose work this article draws on.

Before undertaking this analysis, it is worth emphasizing that exercises of conscience are not merely refusals to engage in conduct on the grounds of personal or institutional moral or religious principles. Healthcare professionals who provide the very patient care services that are so often the subject of conscientious refusal—whether they be abortion, emergency contraception, or the latest developments in reproductive medicine or respect for advance directive provisions limiting life-sustaining measures, palliative sedation for refractory suffering, or a lethal prescription for terminally ill patients as provided by law in certain jurisdictions—act out of conscience when they do so.[4] In particular, those physicians constituting the distinct minority who demonstrate the moral courage of their convictions by providing the most controversial of these—late-term abortions when the woman's life is imperiled and lethal prescriptions as provided by law at the request of terminally ill patients—do so because they view it as integral to their professional responsibility to meet the needs and respect the informed choices of their patients. Sometimes, provision of these interventions entails great personal sacrifice and even risk, most notably for those who travel long distances on a regular basis in order to provide abortion services when no physicians in the area will.[5] These individuals stand in stark contrast to those who insist that their own exercise of conscience, even when it violates the standard of care and places their patient's life or health at risk, should be without disadvantage of any kind. As a matter of justice and fairness, those individuals and institutions that so vigorously insist that they personally must be held harmless for their conscientious refusals ought to support the same protections for those who step in to provide the type of care that they refuse to provide.

Imposing Theological Standards on Patient Care

The impact of the ERD on patient care was brought to the attention of the public in late November 2013, when the American Civil Liberties Union (ACLU) filed a

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lawsuit on behalf of a mother of three children from Muskegon, Michigan, (Tamesha Means) against the United States Conference of Catholic Bishops (USCCB) and two individuals in leadership positions with Catholic Health Ministries, the organization that operates Mercy Health Partners (MHP), the only hospital in Muskegon County.[6] The gravamen of the complaint is that when Ms. Means presented to the MHP facility in her eighteenth week of pregnancy because her water had broken, the healthcare professionals on the MHP staff failed to advise her that, under these circumstances, the fetus had virtually no chance of survival, and continuing the pregnancy posed serious risks to her health. Such disclosures, the argument runs, were essential to an informed decision by the patient as to whether or not the risks of continuing the pregnancy bore any rational relationship to the potential benefits. The complaint further alleges that MHP staff also failed to advise Means that they would not terminate the pregnancy so long as there was a fetal heartbeat, even if it was medically necessary to save her life, because of the institution's adherence to the ERD.[7] Instead of making these disclosures in a timely manner as the patient's situation warranted, they sent her home with the advice to see her personal physician at an appointment scheduled a week later. Ms. Means returned to MHP two more times during the next 24–36 hours with bleeding and painful contractions before the fetus breached her cervix and died shortly after delivery.

Should this case survive the inevitable round of pretrial motions by the various defendants, the plaintiff can be anticipated to introduce expert testimony at trial that adherence to the prevailing standard of prenatal care for a patient in the clinical circumstances of Ms. Means would have been to at least offer, if not recommend, prompt termination of the pregnancy in view of the serious risks to her and the probability that the fetus would not ultimately survive. The standard of care for patients such as Ms. Means can be formulated as that which a competent, diligent, and reasonably prudent physician would do under the same or similar circumstances in caring for a patient with this medical condition. It is, therefore, a standard set by physicians for physicians, the sources of which may include clinical practice guidelines, protocols or policies by national physician organizations such as the American College of Obstetrics and Gynecology, current medical texts and treatises, and articles in leading professional journals. The overarching consideration in the formulation of such standards is the promotion of the health and safety of the patient. What is novel about this case is the effort to hold the USCCB legally responsible for promulgating the ERD with the expectation, indeed the insistence, that all Catholic hospitals impose the directives as a condition for participation by members of the medical and nursing staff in the care of patients admitted to the institution. In a subsequent section we consider the clinical, ethical, and legal implications of imposing these directives on non-Catholic clinicians and patients when doing so may constitute a material departure from the standard of care that poses a risk of harm to the patient.

The Pertinent Provisions of the ERD: Demands and Prohibitions

Directive number 5 mandates (without exception) that, in order to be employed or granted medical staff privileges by the institution, every physician and nurse must receive instruction about and agree to conform his or her professional conduct to the directives.[8] In a subsequent section, we review the results of multiple studies indicating the frequency of the problems the ERD poses as physicians endeavor to

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treat their patients consistent with prevailing clinical standards. Given the likelihood that many of these physicians are not practicing Catholics, their willingness to submit to such binding theological constraints on their clinical practice is curious. Except in states where conscience legislation provides blanket immunity, one wonders whether these physicians understand that refusing to provide medically necessary treatment because of strict adherence to the directives would not constitute a defense to a malpractice claim. As I argue, similarly, the institution should not be afforded an absolute defense of conscience against claims that the standard of care was breached. The consolation for the institution, when and if assessed with an award of damages, is that this is the price for maintaining its institutional integrity when doing so injures patients to whom it owes a duty of care. Such solace would not be available to non-Catholic healthcare professionals who may be found to have been individually liable. An interesting question is whether institutions adhering to the ERD are willing to indemnify their professional staff for any liability arising out of their commitment to follow the ERD in providing patient care.

Directive 45 precludes abortion under any circumstances, even to save the life of the pregnant woman, whereas directive 47 permits interventions or medications for the purpose of treating a serious pathological condition of a pregnant woman if they cannot be safely postponed until the fetus is viable, even if they may result in the death of the fetus; the justification for this directive is presumably based on the doctrine of double effect. Directive 52 prohibits contraceptive practices while condoning "natural" family planning for married couples. Directive 53 precludes any form of sterilization unless it is for the purpose of treating a serious pathology and no less drastic measure is available.

Other directives address a variety of issues in end-of-life care. Number 24, dealing with advance directives, states: "In compliance with federal law [the Patient Self Determination Act], a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. *The institution, however, will not honor an advance directive that is contrary to Catholic teaching*."[9] There is no suggestion that prospective patients be advised in a timely manner whether provisions in their directive might run afoul of Roman Catholic theology as interpreted by the administrators of the facility, its ethics committee, or the local bishop. A more comprehensive review of the directives that have proven most problematic to patients who seek and practitioners who wish to provide care that is consistent with prevailing clinical standards unencumbered by religious doctrine can be found in a recently issued report by the ACLU and MERGERWATCH.[10]

What is interesting about these directives is that, even if Catholic hospitals that rigorously adhere to them were to restrict their patient population to practicing Catholics, the services would meet neither the needs nor the expectations of many in this group. Public opinion surveys of those who identify themselves as Catholic reveal that 82 percent believe that contraception is morally acceptable and only between 53 and 64 percent agree with the Vatican's position that abortion should always be deemed morally unacceptable.[11]

The Nature of Institutional Conscience

George Annas is curtly dismissive of the idea that institutions such as hospitals can have moral or ethical objections, because they have "no natural personhood."[12]

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Presumably, he would be even more dismissive of the suggestion that they might have consciences and thus be proper subjects for the exercise of conscientious objection or refusal. Annas also notes that hospitals do not practice medicine—physicians do. But as Annas well knows, this does not mean that hospitals do not deliver healthcare, for which they can be held legally accountable when it is negligently provided and results in harm to patients. Indeed, courts have recognized that there are certain nondelegable duties or inherent functions of hospitals, such as emergency, anesthesiology, radiology, and pathology services. The most salient feature of these services is that they are provided by physicians selected by the hospital rather than the patient.[13]

In a disquisition on conscience, Daniel Sulmasy quotes the American College of Obstetrics and Gynecology's definition—"the private, constant, ethically attuned part of human character"—and finds it to be unsatisfactory.[14] He prefers the following characterization: "conscience is the most fundamental of all moral duties—the duty to unite one's powers of reason, emotion, and will into an integrated moral whole based upon one's most fundamental moral principles and identity."[15] Note, however, that both characterizations of conscience use terminology that aptly describes individual human actions but that does not fit comfortably with the idea of institutional conscience. When we consider in a subsequent section the judicial response to conscientious refusals to provide care, we discuss concerns about the dictatorial manner in which the ethical values of the institution are imposed on the clinical staff, thereby creating the risk of a conflict of commitment between the clinician's secular, professional norms and the standard of care on the one hand and the institution's particular religious or ethical principles on the other.

Sulmasy maintains strenuously that institutions can have a conscience, in part because they make and act on decisions for which they can be the subject of praise or blame. They are, he contends, not merely a diverse assortment of professionals. Kevin Wildes is another strong advocate for the legitimacy of institutional conscience, particularly that of Catholic hospitals. Although he does not specifically address the ERD, the thrust of his argument would easily encompass the proposition that this document is an expansive articulation of the mission and vision of every Catholic hospital, and strict adherence to it is essential to the maintenance of the moral identity and integrity of the institution.[16]

In expressing support for the propositions that institutions such as Catholic hospitals can be thought of as having a conscience and that there is benefit to society in recognizing this, Mark Wicclair suggests that it can be important for physicians and nurses (and other healthcare professionals) to be able to pursue their clinical work in a setting in which core values and principles (presumably beyond the generic codes of professional ethics) are shared. Similarly, he suggests that patients might seek to receive care in institutions that are committed to certain fundamental values.[17] However, because of the expansion of Catholic healthcare through acquisition of previously secular or community-operated hospitals, it is less likely than ever before that the typical hospital in a Catholic system is one in which all or even a majority of the healthcare professionals on the staff or patients are practicing Catholics. The data on this trend is compelling: currently, Catholic-affiliated hospitals account for 15 percent of all hospital admissions, 1 in 9 acute care beds, 10 of the 25 largest healthcare systems, and 8 percent of hospitals with a "sole community hospital designation."[18] Conversely, the number of Americans who identify themselves as Catholic has steadily declined and now stands at 24 percent.[19]

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When a Catholic health system absorbs a local community hospital and retains many of the medical and nursing staff of the formerly public or private secular institution, there are competing values and principles that should be taken into account in defining the "conscience" of the institution. Can one credibly assert that it may in any sense be morally legitimate for the "conscience" of a hospital to be completely uninformed by the views of its medical staff and the professional standards they must meet when these conflict with the ERD? What if Catholics happen to be a distinct and insular minority of the population served, and if a majority of the residents expect to have access to the full panoply of legal and medically accepted treatments? It may also be true that a majority of the medical and nursing staff of the institution share this priority. Particularly in such circumstances, control of the corporate legal structure does not necessarily confer the moral authority to impose the ERD by administrative fiat on a religiously diverse clinical staff and community.

Wicclair, in his treatise on conscientious objection in healthcare, characterizes as "conscience absolutism" the view that maintaining one's sense of moral integrity, whether as an institution or individual, always outweighs meeting the needs or respecting the values of patients. This is particularly so when adherence to one's conscience harms or excessively burdens patients.[20] The same characterization would be apt when the core professional values of non-Catholic healthcare professionals are dismissed as having no bearing on the conscience of an institution. In a subsequent section, we consider a legal decision in which the court made precisely this point (albeit as dictum) in a case involving a conflict between Catholic values and a patient's preferences for care.

To avoid such absolutism, in circumstances in which the standard of care and the particular needs of a patient come into conflict with doctrinal considerations peculiar to that institution—a genuine conflict of institutional commitment—the duty to the patient to provide care consistent with the prevailing standard should take priority, especially when any effort to transfer the care of the patient to another facility will place the patient at increased risk of morbidity or mortality or will impose an undue burden on the patient and/or her family. This policy is appropriate, if for no other reason, because of the significant disparity in the harms that will be incurred depending on how the conflict is resolved. If the conscience of the individual professional or institution is followed, the patient's morbidity, mortality, or constitutionally protected liberty interests are imperiled, whereas, if the medical needs or priorities of the patient dictate what is done (or not done), there may be some indeterminate degree of moral distress. The two are hardly commensurate by any reasonable calculation. This is especially so because institutions as such cannot actually experience distress, only the persons whom they engage to carry out their primary mission, which, let us not forget, is the care and treatment of patients, not promotion of any organization's religious or moral principles. Only those individuals who actually subscribe to the underlying philosophy of the ERD might experience some form of moral distress were adherence to the applicable standard of care or prevailing professional values to take precedence. Institutions are already under a general moral obligation to reasonably accommodate those individuals by relieving them from any responsibility to provide nonemergent care that would conflict with their religious or moral values.

Sulmasy acknowledges that "conscientious living is not easy."[21] Indeed, perhaps one reason that strict adherence to conscience might at times be difficult is because

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it can reasonably be expected to call on a person to exercise moral courage and to accept responsibility for contravening prevailing laws, policies, or professional standards in ways that may cause harm to others and for which one can legitimately be held responsible, even if one's acts or omissions are motivated by conscience. The phrase "courage of one's convictions" becomes meaningless in a world in which acting in accordance with personal morality or religious conviction can never, under any circumstances, have adverse consequences for the actor, particularly when doing so injures others. Holding healthcare providers legally accountable for breaching a duty of care for reasons of religious conscience does not run counter to either the free exercise or the establishment clauses of the U.S. Constitution. Rather, it constitutes a neutral and impartial enforcement of a law of general applicability.[22]

Professional Conflicts of Commitment Are Real and Pervasive in Institutions Adhering to the ERD

Recently, physicians practicing in Catholic-affiliated hospitals have been surveyed in an effort to ascertain how frequently the imposition of the ERD constrains their ability to provide care consistent with the needs of their patients and the standards of the profession. One such survey revealed that obstetrician-gynecologists working in Catholic-owned hospitals described a wide range of cases in which they were either precluded by the hospital ethics committee from aborting a nonviable fetus posing an imminent risk to the woman's health or instructed to wait until no fetal heartbeat could be detected, even when there was no clinical justification for such a delay. In other instances, Catholic hospitals sought to transfer medically unstable patients to another hospital rather than violate the ERD.[23] Another, more recent survey revealed similar problems when pregnancy complications arise. More than 50 percent of physicians surveyed reported that they had experienced conflict between providing the care they deemed appropriate for their patients and adhering to limitations posed by institutional imposition of the ERD.[24]

Such conflicts are not restricted to perinatal medicine. Another study found that similar problems have been experienced by primary care physicians working in religiously affiliated hospitals. The results of this study starkly reveal the extent to which institutional policies mandating that physicians conform their clinical practice to religious doctrine seriously undermine the medical ethos that the patient's needs are primary. Study participants were asked to answer the following question:

> What should a physician do if he/she believes that a patient needs a medical intervention and the hospital in which the physician works prohibits that intervention because of its religious affiliation? Response options were: (1) provide the intervention openly, even if doing so risks the physician's job or hospital privileges, (2) provide the intervention discretely in order to avoid risking the physician's job or hospital privileges, (3) encourage the patient to seek the intervention at another hospital, and (4) recommend another treatment option that is permitted at the hospital.[25]

Remarkably and disturbingly, an overwhelming 86 percent of the respondents selected answer number 3, what Annas referred to as "transferring the ethical hot potato."[26] Only 2 percent of respondents would provide the procedure openly,

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and another 2 percent would provide it *sub rosa*. The remaining respondents would recommend another procedure that would not require the patient to seek care elsewhere. The hypothetical clinical scenario raises many questions that are beyond the scope of this article, such as whether the patient would be placed at increased risk by seeking the medically indicated or preferable procedure elsewhere, and how often there really are alternative therapies available at the hospital that meet the patient's medical needs. The procedure in question is left unspecified and may or may not involve a situation like the one Tamesha Means faced. Regardless, it strongly suggests that there may be many situations beyond abortion in which physicians practicing in restrictive settings are "willing but unable" to provide their patients with medically appropriate care.[27] For the reasons previously noted, one might reasonably anticipate that these institutions include a significant percentage of non-Catholic physicians and nurses among their professional staff, and as they become the primary or sole provider of hospital beds in many (especially rural) areas, their patient population will consist primarily of those seeking care consistent with prevailing clinical standards unconstrained by Roman Catholic theology.[28]

Here it is important to note that many of those who defend the imposition of religious limitations on the provision of certain medical interventions often seek to minimize the extent to which the ERD distorts clinical decisionmaking. They also seek to explain away the most egregious cases as instances in which hospital ethics committees or individual bishops have "misinterpreted" the ERD. Such *ex post facto* explanations only serve to further implicate the ERD and the challenges it poses for conscientious professionals seeking to meet their patients' immediate medical needs. When a patient is harmed or must contend with an undue burden in securing medically necessary or appropriate treatment in a timely manner, it matters not whether these were caused by an accurate or erroneous application of religious doctrine.

When the *New York Times* published an editorial entitled "When Bishops Direct Medical Care" following the filing of the suit by the ACLU discussed previously, the Catholic Health Association of the United States (CHA) issued a statement that included the following: "Catholic hospitals in the United States have a stellar history of caring for mothers and infants. Hundreds of thousands of patients have received extraordinary care . . . there is nothing in the Ethical and Religious Directives that prevents the provision of quality clinical care for mothers and infants in obstetrical emergencies."[29] The first portion of the statement is certainly correct. As for the clinical implication of the ERD, the data we have considered suggests that reasonable minds may differ on this point.

A vivid illustration of this is presented by a 2009 case at St. Joseph's Hospital and Medical Center in Phoenix, Arizona, that garnered considerable media attention. St. Joseph's, which was part of Catholic Healthcare West (CHW), the fifth-largest health system in the nation, had as a patient a 27-year-old mother of four with a history of pulmonary hypertension, which carries a serious risk of mortality. She was admitted because of worsening symptoms in the eleventh week of pregnancy, a condition that increased her risk of mortality to nearly 100 percent if she were to continue the pregnancy. Following an ethics committee review of the case, the decision was made by the patient, in consultation with her physicians, to terminate the pregnancy; the termination was then performed at the hospital. Subsequently, the bishop of the Diocese of Phoenix, Thomas Olmsted, learned of

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the case and insisted that terminating the pregnancy violated the ERD. Following months of dialogue among the diocese, St. Joseph's, and CHW, Bishop Olmstead determined that St. Joseph's could no longer be deemed a Catholic institution. He also declared that Sister Margaret McBride, a senior hospital administrator who served on the institution's ethics committee, was automatically excommunicated because she had assented to an abortion.[30]

Absent from the extensive media coverage of this case was any discussion of the potential legal ramifications if the pregnancy had not been terminated in time to prevent the death of the patient. If the consensus view of the physicians involved in this case—that it was virtually inevitable that, without prompt termination of the pregnancy, neither the woman nor the fetus would have survived—was correct, and if the hospital had refused to allow the procedure to be performed, and if the patient was too unstable to be safely transferred to another hospital that would permit the procedure, would the ERD constitute an effective legal defense for both the institution and the responsible physicians against a wrongful death claim on behalf of the patient? It is important to note that the Catholic doctrinal issue is further complicated by the fact that, in retrospective reviews, the decision by St. Joseph's and Sister McBride was strongly defended by the CHA, by an independent moral analysis by a professor of Roman Catholic theology, and by other religious commentators, thereby undermining the efficacy of the ERD as a conscience-based defense. If the plaintiff were able to present competent, credible expert testimony that the standard of care called for immediate termination of the pregnancy, and if the gestational age of the fetus was incompatible with survival, then only the most extensive conscience provisions under state law, such as the one in Mississippi noted in the following section, would preclude malpractice liability in this case.

Legislating Conscience without Consequences

A comprehensive review of conscience legislation, including the Church, Coats, and Weldon amendments at the federal level, is beyond the scope of this article.[31] Over the decades since the Supreme Court decision in *Roe v. Wade* prompted early federal and state provisions making it clear that neither courts nor governmental agencies could require physicians or facilities to perform abortions or sterilizations, there has been a distinct trend toward expanding the scope of such provisions beyond abortion and contraception to a wide range of medical therapies, as well as making such protections available to individuals who work in health facilities but are not directly involved in patient care.

A prime example of this conscience creep is the Mississippi Health Care Rights of Conscience Act, which provides that no healthcare provider may be held civilly, criminally, or administratively liable for declining to participate in a healthcare service that violates his or her conscience and that no institution, provider, public official, or regulatory board may discriminate in any manner against anyone who declines to participate in a healthcare service on the grounds of conscience.[32]

None of these broadly worded conscience provisions mention protection for the rights of conscience of professionals who provide controversial healthcare services consistent with patient need or preference and the prevailing standard of care. Neither is there any exception in the law or alternative means of compensating patients when adverse consequences to patients follow from a conscientious refusal

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that constitutes a departure from the standard of care. This glaring absence has been aptly criticized by one commentator as a blind spot in the law as well as in the academic and professional literature.[33] Indeed, the wholesale fashion in which such statutes enable healthcare providers to violate the standard of care and to privilege their personal morality or religious beliefs over the needs of their patients has moved another commentator to characterize such provisions as "unconscionable clauses."[34] It is difficult, if not impossible, to discern by what strange moral calculus the ethical sensitivities or religious beliefs of a healthcare professional can be deemed, as a matter of sound law and public policy, to be of greater significance than meeting the medical needs of a patient whose health and safety has been entrusted to them. When such conflicts of commitment lead to litigation, as we shall see in the next section, it is not unusual for courts to rule that professional responsibilities to patients must take precedence over individual moral or religious convictions.

Judicial Responses to Assertions of Professional and Institutional Conscience

The cases discussed in this section provide some perspective on how the courts look at assertions of conscience by healthcare institutions and professionals. The first, from California, specifically (albeit somewhat indirectly) addresses the issue of whether a conscientious refusal that departed from the standard of care and resulted in harm to the patient might be grounds for medical malpractice liability.[35] The second, a New Jersey case, balances institutional concerns with patient needs but, even more importantly, explores the legitimacy of institutional conscience claims that are made in isolation from the professional staff.

In the first case, it is interesting to note that the defendant hospital was Catholic, although nothing in its name would suggest this to a casual observer. There are very likely even more examples of this in the 25 years of expansion of Catholic healthcare since this case took place. It is also of note that the plaintiff, a rape victim, was taken to this hospital for emergency care pursuant to what the court referred to as "written contractual arrangements."[36] One can legitimately question why law enforcement would take a rape victim to a Catholic hospital where there was at least a distinct possibility that certain information and preventive measures might be medically indicated yet the institution would decline to provide. The pertinent part of directive 36 states, with regard to victims of sexual assault:

> A female who has been raped should be able to defend herself against a potential conception from sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with implantation of a fertilized ovum.[37]

The hospital staff did treat Ms. Brownfield for her injuries, advised her to see her personal physician in the next two days, and acknowledged that it would not offer postcoital contraceptive measures.

Rather than filing a standard malpractice claim, the patient brought an action ostensibly designed to protect future rape victims in the community by seeking an

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injunction mandating that the hospital provide such patients with information and access to appropriate pregnancy prophylaxis or discontinue treatment of rape victims altogether. The court declined to issue the injunction because it found that the petitioner had an adequate remedy at law, stating: "Implicit in the allegations of her complaint is the contention that appellant's right to control her treatment must prevail over respondent's moral and religious convictions. We agree."[38] In California, under the law of this case, when a rape victim can show that the prevailing standard of care required providing access to pregnancy prophylaxis and that the failure to do so resulted in injury or harm to her, then a cause of action for medical malpractice has been stated. The clear implication is that neither institutional nor individual conscience would constitute a defense to a breach of the standard of care.

The second case, *Matter of Requena*, presents a situation involving end-of-life care in the context of the consolidation of two facilities and the subsequent subjection of all patients to care consistent with Catholic doctrine.[39] Beverly Requena suffered from ALS when she became a patient at the Respiratory Rehabilitation Center of Riverside Hospital. Eight months later, Riverside and St. Clare's Hospital merged, and the new entity was placed firmly under the control of a Catholic religious order. As Mrs. Requena's physical condition continued to deteriorate in the months that followed the merger, she declined the tube feeding that had become necessary to sustain her life. Her family (her husband and three adult children) and the physicians who had been caring for her supported her in this difficult decision. However, the matter was reviewed by the hospital's board of trustees, which issued a formal resolution providing, in part, that "food and water are basic human needs and such fundamental care cannot be withheld from patients . . . and neither the Medical Center nor personnel will participate in the withholding or withdrawal of artificial feeding and/or fluids."[40] Although there was a comparable facility less than 20 miles away that was prepared to admit Mrs. Requena and respect her decision not to receive artificial nutrition and hydration, she declined the transfer because she had become acclimated to the unit where she had been receiving attentive care during the past 17 months. In order to resolve the stalemate, the hospital filed an action seeking a court order requiring Ms. Requena to submit to the transfer.

Although on its face the compromise proposed by the hospital appeared reasonable, ultimately the court concluded that to compel Mrs. Requena to be uprooted from familiar surroundings and caring relationships in order to receive treatment consistent with her wishes and with her rights under the law of New Jersey was coercive. The court disagreed with the hospital's efforts to characterize the dispute as one of "pro-life versus anti-life" as well as with its description of the situation as one in which the hospital would be forced to "deny" food and water to a patient, because she was refusing it.[41] Still more importantly, on the question of institutional conscience and conflicts between the tenets of Roman Catholic theology and prevailing clinical and professional standards of patient care, the court was particularly critical of the hospital's approach of dictating the policy of the merged institution without meaningful input from the medical staff:

> In reaching its policy decisions about Mrs. Requena, the Hospital has not even consulted, much less seriously considered, the views of the treating physicians. Furthermore, it apparently has not in any organized,

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> comprehensive way involved its medical staff in developing its general ethical rules. . . . A process for making ethical policy decisions for a hospital that does not meaningfully include the medical staff is seriously flawed. A process for making ethical decisions which does not even take into account the views of the treating physicians directly involved with the individual patient whose care is under consideration is even more seriously flawed.[42]

The perspective of the court is most certainly applicable to more recent mergers between public or private secular hospitals and Catholic institutions in which the new organization is required to adopt and the medical and nursing staffs are required to submit to the ERD. In theory, dissenting healthcare professionals can stay true to their convictions and provide care consistent with prevailing standards unencumbered by theological constraints by going elsewhere to practice their profession. As a practical matter, however, when the merged entity is the only provider in the area, doing so may well impose a significant burden on those professionals and their families. A more foundational question raised by the court in the *Requena* case is the following: in what legitimate way can the ERD be characterized as the values of the institution when those values have been imposed without discussion, debate, or strong consensus on the very people who must provide the care that those values profoundly affect, sometimes in ways that are detrimental to the health and well-being of the patient or in conflict with the patient's constitutional liberty interests? Moreover, if matters of conscience were truly taken seriously by all stakeholders, not merely those who own and operate the hospital, then the professional obligation of physicians and nurses of beneficence, nonmaleficence, and respect for patient autonomy would be afforded reasonable accommodation, and the ERD would evidence sensitivity to these competing considerations. The fact that they do not do so suggests that they constitute yet another manifestation of what Wicclair characterizes as conscience absolutism.[43]

The Case for Conscience with Consequences

Conscientious refusal to provide a patient with treatment that is medically necessary in order to avoid significant harm, or that is medically indicated such that failure or refusal to provide it constitutes a departure from the minimal standard of acceptable care, should have consequences for the refusing clinician or institution. This proposition presupposes that the provider in question (the individual or institution) is capable of providing the intervention.

A surprising number of legal commentators who are sympathetic to the role and mission of Catholic (and other religiously affiliated) healthcare organizations have nevertheless supported the proposition that there are instances in which individual and institutional conscience must yield to the immediate and compelling needs of patients. Kathleen Boozang, for instance, grounds limitations on conscientious refusal by religiously affiliated institutions on four factors: (1) states need to expand access to care, (2) federal and state funds pay substantial sums for care provided at such facilities; (3) a significant portion of patients receiving care at religious hospitals are not members of that faith and do not have nonsectarian options in their area; and (4) because of the respect for patient autonomy that infuses American jurisprudence from statutory, common law, and constitutional sources, states can

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and should prioritize patient access to treatment over accommodation of religious doctrine.[44] As we have noted, however, some states have taken the opposite approach, exponentially expanding the rights of conscientious refusal, even when patients may be harmed as a result. She is highly critical of these as "simplistic solutions that are detrimental to patient access to care."[45]

The current trend toward ever-expanding religiously based healthcare systems, which in their operations and nomenclature have become significantly less religious and charitable and more commercial and monopolistic, places the legitimacy of their moral autonomy at risk. As a practical matter, according to another otherwise sympathetic commentator:

> Hospitals' ethical independence must be measured by the informed right and feasibility of choice of those contracting for their services. . . . To remain free to curtail otherwise legally-permissible medical procedures the hospitals must accentuate their religious identity in unmistakable terms so that patients know what their choices are, avoid monopolization of general health services in particular communities, and refrain from the semblance of competitive commercialization. Patients must know in advance what services are or are not available from contract health care providers and practically and feasibly be able to act on those choices.[46]

Thus we now turn to this contention—that there is both a professional and moral obligation to provide adequate notice to prospective patients as to what clinical services that they might desire or require will not be provided. For such notice to be adequate, it should include a disclosure that the unavailability of such services is based solely on religious or moral principles espoused by that provider and not because they are in any sense categorically medically inappropriate or illegal.

The Virtue of Transparency and the Duty to Disclose Doctrinally Based Limitations on Healthcare Services

We previously discussed the case and resulting controversy that took place at St. Joseph's Medical Center in Phoenix. Only those in the hierarchy of CHW know the extent to which that case influenced the decision announced two years later to change the name of the umbrella corporate entity from CHW to Dignity Health. The announcement of this transformation stated:

> Under the new governance structure, Dignity Health is a not-for-profit organization, rooted in the Catholic tradition, but is not an official ministry of the Catholic Church. The new structure and name enable the organization to grow nationally while preserving the identity and integrity of both its Catholic and non-Catholic hospitals. The organization's Catholic hospitals will continue to be Catholic, directly sponsored by their founding congregations, and adhering to the *Ethical and Religious Directives for Catholic Health Care Services*. Dignity Health's non-Catholic hospitals will continue to be non-Catholic, adhering to the *Statement of Common Values*.[47]

Assuming for the purposes of discussion that the names of individual hospitals within the new Dignity Health system actually enable prospective patients to easily distinguish between Catholic and non-Catholic institutions, the diligent and

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discerning patient must then, in advance of seeking care, locate and review the Statement of Common Values in order to ascertain what, if any, limits it might impose on the provision of care that would otherwise be available in a public, nonsectarian healthcare facility that is not "rooted in the Catholic tradition."

Previously noted efforts on the part of the CHA to discount the prevalence and clinical significance of the limitations on otherwise available therapies that the ERD imposes raise another important ethical consideration, that is, whether or not there is an ethical (and perhaps legal) obligation on the part of institutions adhering to the ERD—or, in the case of Dignity Health, to the Statement of Common Values—to provide potential patients adequate notice of the range of limitations they may impose on care that would otherwise be provided because it falls within the range of medically acceptable care. The late Edmund Pellegrino assiduously defended the role of conscience in the provision of healthcare by Catholic physicians in particular. However, in recognition of the very real potential in a pluralistic society for a conflict of values between physician and patient, he suggested the following approach to properly put patients on notice: "We are likely to see the emergence, in the not-too-distant future, of the expectation that physicians will announce in advance their positions on the more crucial human life decisions. These decisions may involve such things as abortion, artificial insemination, withholding of treatment prolonging life, or using socioeconomic determinants in allocating scarce medical resources."[48] An approach that is reasonable to expect of physicians is, at least, equally (if not more) incumbent on healthcare institutions that assert the same right of conscience to refuse to provide medical care that is legal, within the parameters of ethically acceptable care in the community, and medically indicated given the patient's current condition. For prospective patients to be able to act on such notice and to make provisions to receive care at another institution that does not limit care in this way, there must be such alternative facilities reasonably available. If there are not, because the institution in question is the sole provider of inpatient care in the community, should that be a sufficient justification to limit the imposition of institutional conscience-based constraints on clinical practice? The argument that it should emphasizes that, when a hospital or physician secures the licensure of the state to become a provider of patient care, the implicit pledge is that such care will be provided consistent with prevailing standards of quality, professionalism, and respect for the legal rights of patients to pertinent clinical information and to accept or refuse recommended therapeutic measures. The duty to prioritize the patient's need is virtually unqualified, and those institutions or individuals who fail or refuse to do so, even when such failure or refusal is based on matters of conscience, should be held accountable for the adverse consequences that follow.

Concluding Thoughts on the Role of Conscience in the Morality of Patient Care

The late Edmund Pellegrino, in his proposed reconstruction of medical morality, argued that at the center of medical morality is the healing relationship. A healing decision, he goes on to say, is one that is good for the patient "in the fullest sense," and not simply one that is "scientifically correct."[49] What is good for the patient is consistent with the patient's values. Yet in our increasingly morally pluralistic society, the values and priorities of patients may conflict with those of healthcare

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providers. Thus Pellegrino insists that it is absolutely imperative that patients and providers recognize when their value systems diverge so that the compromise of either is avoided whenever possible.

Rosamond Rhodes, in an otherwise supportive commentary on Pellegrino's article, invokes the standard of care in pointing out a glaring inconsistency in Pellegrino's presentation. Whereas, in all other respects, he recognized the responsibility of the physician to provide care that is consistent with the patient's values and priorities, he nevertheless insisted that the physician's personal morality trumps professional responsibility to adhere to the standard of care.[50] Yet, as I have maintained throughout this article, those who insist on the primacy of the right of personal-conscience-based refusals over adherence to the standard of care fail to acknowledge or to take seriously the disproportionality of the consequences, that is, the moral distress of the provider versus the morbidity or mortality of the vulnerable patient.

Law, ethics, and public policy should require healthcare institutions and professionals to adhere to recognized standards of clinical competence and professional responsibility. Therefore, regardless of whether a departure from the prevailing standard of acceptable care resulting in harm to a patient is the product of negligence or conscientious objection, the individual and/or institution involved should be liable in civil damages to the injured party and vulnerable to regulatory sanction or disciplinary action by administrative agencies.[51] Similarly, the core professional obligations of medicine should act as constraints on the exercise of personal conscience. As enumerated by Wicclair, for physicians these are as follows: respecting patient autonomy, promoting the well-being of the patient as one's paramount duty, and providing clinically competent patient care.[52] In those instances in which acting consistently with these societal expectations necessitates that institutional policy or individual conscience be compromised, the moral distress of the provider is justified by the much greater harm that the patient is spared. If such situations arise with any degree of frequency, then, as Rhodes suggests in her commentary, either the institution or individual involved may need to pursue another enterprise or occupation.

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