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The Case against Institutional Conscience

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NOTES

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INTRODUCTION

In the United States today, federal laws immunize healthcare providers who refuse, on moral or religious grounds, to perform or assist in performing certain procedures. These "conscience clauses" cover not just individual providers, but institutions as well. Catholic hospitals[1] are chief among those institutions receiving conscience protection. Catholic hospitals operate in accordance with the *Ethical and Religious Directives for Catholic Health Care Services* ("*Directives*"), promulgated by the U.S. Conference of Catholic Bishops (USCCB).[2] The *Directives* define Catholic healthcare's mission of caring for the underserved and also limit or prohibit particular medical treatments, including abortion, tubal ligation, vasectomy, advance directives, and other end-of-life procedures.[3] Catholic hospitals assert the right, as an entity, to act in accord with the *Directives*, which are deemed to be a hospital's conscience. Further, all employees must comply with the

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1 This Note's argument applies equally well to any religious healthcare institution, but for reasons discussed below, Catholic healthcare institutions are particularly important and relevant.

2 U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 1 (5th ed. 2009) [hereinafter DIRECTIVES], *available at* http://www.nccbuscc.org/meetings/2009Fall/docs/ERDs_5th_ed_091118_FINAL.pdf.

3 *See infra* Part I.B.

Directives.[4] Therefore, the recognition of institutional conscience restricts the full protection of individual conscience for those employees whose moral or religious persuasions diverge from the *Directives*.

That restriction is possible because a Catholic hospital's conscience overrides individual conscience when the two conflict, sometimes causing practitioners serious dilemmas. In December of 2000, a Catholic hospital asked its Chief of Obstetrics and Gynecology, Dr. Yogendra Shah, to step down from that position because he performed abortions at a private clinic.[5] In March of 1998, a Roman Catholic hospital in New York forced Dr. David Mesches out of his position as Chairman of the Department of Family Medicine.[6] In an attempt to ensure the completion of a merger between one Catholic and two secular hospitals, Dr. Mesches had offered to lease space in his offices as a clinic to provide the reproductive services that the surviving hospital would no longer offer.[7] Dr. Mesches commented to a local newspaper that the right to an abortion is "the law of the land" and added "it's the right thing to do."[8] He was afterwards dismissed.[9]

A recent article, which published the results of thirty interviews with obstetrician-gynecologists who described their experiences treating miscarriages in Catholic hospitals, documented the challenge faced by those who work in Catholic hospitals and struggle to abide by the *Directives*.[10] Dr. S, who used to work in an urban Catholic hospital in the Northeast, described the following situation:

> I'll never forget this; it was awful—I had one of my partners accept this patient at 19 weeks. The pregnancy was in the vagina. It was over . . . . And so he takes this patient and transferred her to [our]

4 *See* DIRECTIVES, *supra* note 2, pmbl. at 4 (stating that the *Directives* provide "authoritative guidance on certain moral issues" to "sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients"); *id.* Directive 5, at 12 ("Catholic health care services must adopt these Directives as policy [and] require adherence to them within the institution as a condition for medical privileges and employment . . . .").

5 *See* Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 136 (2003); Heather Ratcliffe, *Doctor Who Does Abortions at Clinic Is Demoted by Catholic Hospital: But He Will Stay on Staff at St. Elizabeth's in Granite City*, ST. LOUIS POST-DISPATCH, Dec. 21, 2000, at B2.

6 *See* Eisenstadt, *supra* note 5, at 136.

7 *See id.*

8 *Id.* at 136–37.

9 *See id.* at 137.

10 *See generally* Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774 (2008) (recounting the experiences of obstetrician-gynecologists in Catholic hospitals).

> tertiary medical center, which I was just livid about, and, you know, "we're going to save the pregnancy." So of course, I'm on call when she gets septic, and she's septic to the point that I'm pushing pressors on labor and delivery trying to keep her blood pressure up, and I have her on a cooling blanket because she's 106 degrees. 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 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 just snapped the umbilical cord and so that I could put the ultrasound—"Oh look. No heartbeat. Let's go." She was so sick she was in the [intensive care unit] for about 10 days and very nearly died. . . . She was in DIC [disseminated intravascular coagulpathy]. . . . Her bleeding was so bad that the sclera, the white of her eyes, were red, filled with blood. . . . And I said, "I just can't do this. I can't put myself behind this. This is not worth it to me." That's why I left.[11]

Dr. G, a physician at a southern Catholic hospital, described this situation:

> She was 14 weeks and the membranes were literally out of the cervix and hanging in the vagina. And so with her I could just take care of it in the [emergency room] but her cervix wasn't open enough . . . so we went to the operating room and the nurse kept asking me, "Was there heart tones, was there heart tones?" I said "I don't know. I don't know." Which I kind of knew there would be. But she said, "Well, did you check?" . . . . I said, "I don't need an ultrasound to tell me that it's inevitable . . . you can just put, 'The heart tones weren't documented,' and then they can interpret that however they want to interpret that." . . . I said, "Throw it back at me . . . I'm not going to order an ultrasound. It's silly."[12]

Dr. H, at a midwest Catholic hospital, discussed sending a patient ninety miles away by ambulance to get treatment after the hospital's ethics committee denied her case[13]:

> She was very early, 14 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 that often, but from what I understand it,

11 *Id.* at 1777 (alterations in original).

12 *Id.* (alterations in original).

13 *See id.* at 1776.

> it's pretty clear. Even if mom is very sick, you know, potentially life threatening, can't do anything.[14]

Cases like these, which present difficult moral or ethical questions, are likely infrequent and do not, in themselves, justify the adoption or rejection of any public policy. Rather, they are valuable because they better illustrate the fundamental issue driving the more routine instances of conflict between individual and institutional conscience,[15] which, although less serious, have no less moral validity.

Conscience clauses permit a section of the populace to opt out from the application of a law that would ordinarily have universal application. This is too serious an enterprise to rest on an unsteady theoretical foundation. As Dr. Edmund D. Pellegrino writes, the complexity of the ethical issues presented "is significant because once the ethical issues are expressed in law, the debate may be reduced to instrumental and procedural details that cannot resolve underlying moral sources of controversy."[16] Yet the justification for institutional conscience has not been rigorously tested and scrutiny reveals significant flaws. If individual conscience is to be protected, then it must be a complete recognition of individual conscience—a recognition which includes not just the right of refusal, but also a physician's right to make medical decisions consistent with her ethical code and prevailing medical standards, unhindered by an institution's assertion of conscience.

The right of conscience is rooted in autonomy, an interest that patients and doctors share. As a necessary precursor to autonomous decision making, patients have an informational right as well. The goal is to lessen (or, ideally, eliminate) the gap between the patient's and doctor's understanding of the medical condition and available treatment options, empowering the patient to make an informed decision. At the same time, a physician has a moral right to refuse to recommend or perform medical interventions that conflict with her moral or religious principles. Conscience clauses explicitly protect this interest. But this is only part of the physician's right of conscience. A physician also has a powerful interest in affirmatively providing medically indicated care as dictated by her clinical morality[17]

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14 *Id.* (alterations in original).

15 A recent study found that nineteen percent of physicians who had worked in a religiously affiliated hospital experienced conflict with the institution's patient care policies. *See* Jennifer Harper, *Doctors Report Religious Conflicts at Some Hospitals: Obligation to Patients at Issue*, WASH. TIMES, Apr. 14, 2010, at A6.

16 Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 222 (2002).

17 I use this term to refer to a physician's ethics as applied in a clinical context.

and prevailing medical standards.[18] Conscience clauses fail to adequately protect this interest. In fact, the expansion of conscience clauses to include institutions—commonly Catholic hospitals[19]—undercuts the affirmative aspect of individual conscience by requiring physicians to refrain from acting in accord with their clinical morality or prevailing best practices if doing so would violate the institution's conscience.

Institutional conscience is fundamentally different from individual conscience but is mistakenly treated in legislation[20] and academic discussion[21] as equivalent. Legal fiction aside, a hospital is not a person; it is a physical structure within which providers give medical care. It does not perform procedures or counsel patients. It does not take lunch hours or vacations. And it does not have a conscience. In practice, institutional conscience serves as a trump card whenever (and to the extent that) the institution's religious principles diverge from the physician's own religious or ethical principles. Such an arrangement is illogical and unwise, and must be remedied by limiting conscience clause protection to individuals.

In Part I of this Note, I discuss the pattern of hospital mergers in the 1980s and 1990s and the part played by Catholic healthcare institutions. Catholicism's substantial presence in modern healthcare is of particular importance because of the sectarian framework (the *Directives*) which guides the operation of Catholic hospitals. The *Directives* embody both Catholic healthcare's uncontroversial mission to minister to the underserved and their more divisive policies, which limit or completely ban particular procedures inconsistent with Catholic teaching. Catholic healthcare's growth creates new possibilities for conflict between the *Directives*' edicts and individual conscience.

Part II recounts the shift from a strong recognition of physician autonomy toward today's strong protection of patient autonomy. To provide the groundwork for a discussion of conscience, I posit four characteristics of conscience: (1) conscience is inherently human; (2) conscience reflects a private, internal judgment; (3) conscience is

18 *C.f.* Michael P. Moreland, *Institutional Conscience and Moral Dilemmas: Why "Freedom of Conscience" Is Bad for "Church Autonomy,"* 7 GEO. J.L. & PUB. POL'Y 217, 227 (2009) ("[A] physician might be legally obligated in some cases—but is at least required by the standards of her profession—to respect her patient's autonomy and to offer . . . all legally available and professionally accepted services.").

19 *See* Susan Berke Fogel & Lourdes A. Rivera, *Religious Beliefs and Healthcare Necessities: Can They Coexist?*, 30 HUM. RTS. 8, 8 (2003) ("Catholic institutions control . . . the largest single group of nonprofit hospitals.").

20 *See infra* Part II.B.

21 *See infra* Part III.

predicated on recognition of the autonomous moral agent; and (4) conscience compels a person to act or refrain from acting. The protection of these same characteristics in other aspects of American law helps explain the existence of conscience legislation. Part II then details the birth and growth of conscience clauses that check, somewhat, the rising tide of patient autonomy. Part II concludes with a discussion of the degree to which conscience clauses protect clinical morality.

In Part III, I test the strength of arguments for institutional conscience against those opposing it. I conclude first that institutional conscience is dubious in the abstract, as it does not serve the justifications for recognizing rights of conscience in the first place and is different in kind from individual conscience. Furthermore, institutional conscience is indefensible as a trump over individual conscience, played by those who would otherwise have no place in medical decision making. It is this latter characteristic of institutional conscience that is most objectionable.

I conclude in Part IV that the best way to remedy this problem is to redefine "healthcare provider" in conscience legislation to exclude institutions. Although the text of the Church Amendment,[22] the first federal conscience clause, appears to provide the protection needed, courts have foreclosed this option by holding that the Church Amendment provides no private right of action.[23] The charitable trust doctrine is likewise a flawed solution because only public officials or those with a special interest have standing to bring suit.[24] Beyond the individual difficulties posed by each of these solutions, neither addresses the problem at its core. In this case, the simplest solution is the best. The notion of institutional conscience must simply be dropped from conscience legislation.[25]

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22 42 U.S.C. § 300a-7 (2006).

23 *See infra* note 163.

24 *See infra* notes 174–77 and accompanying text.

25 In writing this Note, I hope to avoid adding to the mass of politically entrenched pseudo-scholarship whose purpose is to proclaim, rather than discuss. I do not write from a pro-Catholic or anti-Catholic perspective. Other major religions have rules regarding the provision of medical care, but the prevalence of healthcare institutions under Catholic control, and the detailed rules which guide them, bring my discussion out of the theoretical sphere into grounded relevance. My purpose is to question the law as it stands, specifically the recognition of institutional conscience, which I believe is unfaithful to the underlying justification for recognizing healthcare providers' right of conscience.

I. THE STATE OF CATHOLIC HEALTHCARE

A. Merger Mania

These issues are no mere academic exercise. In every Catholic hospital lurks the possibility of conflict between institutional and individual conscience. Catholicism has a long history of involvement with American healthcare[26] and retains a substantial presence, despite the turmoil of the past three decades. The 1980s saw a rash of hospital mergers[27] spurred by a shift from a fee-for-service structure to managed care,[28] along with reduced Medicare payouts and heated competition.[29] During this decade, Catholic hospitals generally merged with each other.[30] In the 1990s, when the Clinton Administration's push for healthcare reform further galvanized mergers and affiliations to protect against "anticipated economic shifts,"[31] Catholic hospitals recognized that, to stay competitive, they would need to merge with non-religious hospitals.[32] Between 1990 and 1998, there were 127 mergers between Catholic and non-Catholic hospitals.[33] As one hospital board

26 *See* Jason M. Kellhofer, Note, *The Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers Between Catholic and Non-Catholic Healthcare Systems*, 16 J.L. & HEALTH 103, 114–15 (2001–2002) (describing the Catholic Church's early medical work in the United States).

27 *See id.* at 105.

28 *See id.* (describing "managed care" as "coordinat[ing] all heath care services an individual receives in order to maximize benefits and minimize cost").

29 *See* Kimberly A. Parr, Note, *Beyond Politics: A Social and Cultural History of Federal Healthcare Conscience Protections*, 35 AM. J.L. & MED. 620, 635 (2009) ("[E]ntities struggled in the face of a changing economic climate triggered by decreased Medicare provider payouts and increased competition.").

30 *See id.* at 635 (noting that during the merger trend of the 1980s, "Catholic hospitals typically merged with other Catholic hospitals"); *see also* Eisenstadt, *supra* note 5, at 138 ("As a further solution to the financial difficulties experienced by many health care institutions, Catholic hospitals have begun to merge with one another . . . .").

31 *See* Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1093 (1996). Even after President Clinton's national health-care reform effort failed, health organizations continued to consolidate. *See id.*

32 *See* Parr, *supra* note 29, at 635–36; *see also* Eisenstadt, *supra* note 5, at 138 ("In the past ten years, 'almost 170 non-Catholic hospitals have merged or otherwise affiliated with Catholic health care entities.'" (quoting NAT'L WOMEN'S LAW CTR., HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES 6 (2001))); Kellhofer, *supra* note 26, at 107 ("To remain a competitive force, Catholic hospitals have merged with non-Catholic hospitals."). In order to give guidance to hospitals in this new endeavor, the National Conference of Catholic Bishops amended the *Directives* and formed the Ad Hoc Committee on Health Care Issues and the Church. *See* Ikemoto, *supra* note 31, at 1094.

33 *See* Parr, *supra* note 29, at 636.

member put it, "'[w]e woke up and realized the big issue was survival."[34]

Catholic hospitals have done more than simply survive. As the pace of mergers slowed,[35] the dust settled to reveal an expansive Catholic presence. By 2004, Catholic institutions controlled twenty percent of the nation's hospital beds.[36] In 2009, there were 624 Catholic hospitals nationwide[37] and Catholic health systems accounted for eleven of the forty largest systems in the United States.[38] Most strikingly, Catholic hospitals are often sole community providers—hospitals without a like provider nearby.[39] That fact is of particular concern to advocates for increased access to reproductive services,[40] because in those situations, community access is defined by the scope of services the hospital is willing to offer.

B. The Directives

The *Directives* are binding upon Catholic hospitals and all of their employees.[41] Their purpose is to "reaffirm the ethical standards in health care that flow from the Church's teaching about the dignity of

34 Kellhofer, *supra* note 26, at 108 (quoting HARRY NELSON & ANN F. MONROE, MILBANK MEM'L FUND, CONVERTING AND MERGING HOSPITALS (1999), *available at* http://www.milbank.org/reports/mrtrustees.html).

35 *Id.* at 111.

36 *See* Kristin M. Roshelli, Note, *Religiously Based Discrimination: Striking a Balance Between a Health Care Provider's Right to Religious Freedom and a Woman's Ability to Access Fertility Treatment Without Facing Discrimination*, 83 ST. JOHN'S L. REV. 977, 985 (2009).

37 *See Health Care Reform Facts and Statistics*, U.S. CONF. CATH. BISHOPS, http://www.nccbuscc.org/healthcare/facts.shtml (last visited June 20, 2011).

38 *See id.*

39 *See* Eisenstadt, *supra* note 5, at 137–38. By 1996, the Health Care Financing Administration had identified forty-six Catholic hospitals as "sole community providers." *See* Ikemoto, *supra* note 31, at 1092 (quoting 42 C.F.R. §§ 412.90, 412.92 (2010)).

40 *See* William W. Bassett, *Private Religious Hospitals: Limitations upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455, 485 (2001) ("The consolidation of rural and small community hospitals poses . . . problems of restricted choice . . . ."); Susan Berke Fogel & Lourdes A. Rivera, *Saving* Roe *Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 734 (2004) ("These restrictions are felt especially strongly in rural areas."); *see also* Jane Hochberg, Note, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 OR. L. REV. 945, 954 (1996) (describing the creation of a Catholic sole provider as a *de facto* elimination of services).

41 *See* DIRECTIVES, *supra* note 2, Directive 5, at 12 ("Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.").

the human person" and to "provide authoritative guidance on certain moral issues that face Catholic health care today."[42] The overarching mission of Catholic institutions is to care for society's marginalized populations.[43] The controversy lies not in that goal, but in the type of care that the *Directives* prescribe. A Catholic hospital will not honor an advance directive that conflicts with Catholic teaching.[44] A rape victim is not permitted to receive emergency contraception without evidence that conception has not occurred.[45] Certain types of fertilization are limited.[46] Abortion, as defined by the *Directives*,[47] is prohibited,[48] as is surrogacy,[49] contraception,[50] and sterilization.[51] It is these restrictions and prohibitions that concern some community members when secular and Catholic hospitals seek to merge.[52]

Catholic hospitals generally insist on retaining the *Directives* when merging with secular hospitals,[53] though sometimes creative com-

42 *Id.* pmbl., at 4.

43 *See id.* Directive 3, at 11 (calling on Catholic institutions to give particular care to "the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees"). For example, during the beginning of the AIDS crisis in the 1980s, Catholic hospitals filled a void left by other institutions and providers. *See* John J. Coughlin, *Catholic Health Care and the Diocesan Bishop*, 40 CATH. LAW. 85, 88 (2000) (describing Catholic healthcare institutions' role in combating the spread of AIDS).

44 *See* DIRECTIVES, *supra* note 2, Directive 24, at 19.

45 *See id.* Directive 36, at 21–22.

46 *See id.* Directives 40–41, at 25.

47 *See id.* Directive 45, at 26.

48 *See id.*

49 *See id.* Directive 42, at 26.

50 *See id.* Directive 52, at 27.

51 *See id.* Directive 53, at 27.

52 *See, e.g.*, Steve Chambers, *Merger Pits Care and Doctrine*, STAR-LEDGER (Newark, N.J.), May 16, 1999, at 1 (reporting on a hospital merger, after which the city's only hospital "will stop performing abortions, tubal ligations, vasectomies and all contraceptive counseling"); Anne Constable, *Merger Questions Linger, Despite Promises*, SANTE FE NEW MEXICAN, Dec. 22, 2007, at A1 (noting wariness over a Medical Center's partnership with a Catholic health system); Cliff Peale, *St. Luke to Cut Services for Merger*, CINCINNATI ENQUIRER, June 14, 2008, at B3 (describing efforts to pass on to a community foundation those services that will no longer be offered when a Catholic and non-Catholic hospital merge).

53 *See* Parr, *supra* note 29, at 636. A survey found that, in seventeen percent of cases in which Catholic and secular hospitals merged, there was no overall loss of services; thirty-one percent of such mergers resulted in a complete loss of reproductive choice. *See* Joyce Gelb & Colleen J. Shogan, *Community Activism in the USA: Catholic Hospital Mergers and Reproductive Access*, 4 SOC. MOVEMENT STUD. 209, 211 (2005).

promises are reached.[54] The Church hierarchy has significant control over mergers, as the Vatican must authorize any agreement involving more than one million dollars in Church assets.[55] For example, in 1998 the Vatican stopped a proposed merger "in part because the Robert Wood Johnson University Hospital would have continued to perform abortions and other reproductive surgeries."[56] After getting the Vatican's blessing, merger agreements must also be approved by the diocesan bishop.[57] The diocesan bishop is also empowered to interpret the *Directives* promulgated by the USCCB.[58] As a result, application of the *Directives* varies between dioceses.[59] For example, Brackenridge Hospital in Austin, Texas, despite being under Catholic management, provided sterilizations and birth control through unaffiliated employees as per an agreement with city officials.[60] At the other end of the spectrum, in Phoenix, Arizona, Bishop Thomas J. Olmstead decided that a nun who, in her capacity as head of the hospital's ethics committee approved an emergency abortion necessary to save a mother's life, was automatically excommunicated.[61] Thus, in a Catholic hospital the Vatican, the USCCB, and the diocesan bishop all

54 *See* Cathleen F. Crowley, *Merger Creates Health Giant*, ALBANY TIMES UNION, Feb. 26, 2009, at A1 ("To continue offering reproductive services not allowed under Catholic rules, Samaritan Hospital will create a separately owned 'hospital within a hospital' that will provide tubal ligations, vasectomies and other services."); *see also infra* note 60 and accompanying text (discussing a compromise between Brackenridge Hospital and the city of Austin, Texas).

55 *See* Ikemoto, *supra* note 31, at 1097.

56 Chambers, *supra* note 52, at 1.

57 *See* DIRECTIVES, *supra* note 2, Directive 68, at 36.

58 *See* Leonard J. Nelson, III, *God and Woman in the Catholic Hospital*, 31 J. LEGIS. 69, 124 (2004) (noting the "increased emphasis on the role of the local bishop in supervising health care institutions and on compliance with the [*Directives*]").

59 *See* Donald H.J. Hermann, *Religious Identity and the Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers*, 34 CREIGHTON L. REV. 927, 958 (2001) ("Although each bishop is encouraged to follow [the] directives, guidelines have had different interpretations and applications depending on the particular bishop or hospital board involved."); Hochberg, *supra* note 40, at 954.

60 Rob Boston, *Emergency! How a City-Owned Hospital in Florida Wound up Operating Under the Catholic Bishops' Control—and What Americans United and Its Allies Are Doing About It*, CHURCH & ST., Oct. 2000, at 4. In response, conservative Catholic leaders petitioned the Vatican, who named a more conservative replacement for the Austin Archbishop who would soon retire. *See id.*

61 Jerry Filteau, *Gray Areas of Excommunication: Canon Lawyers Assess 'Automatic' Penalty for Nun Who Approved an Abortion*, NAT'L CATH. REP., June 25, 2010, at 8, *available at* http://ncronline.org/news/faith-parish/gray-areas-excommunication. Not all canon lawyers and theologians agreed with the Bishop's interpretation of the *Directives*. *See id.*

figure prominently in determining the range of care available to patients.

When negotiating a merger, a Catholic institution is unlikely to compromise in any dispute regarding the provision of services that the Vatican forbids. Reverend F. Patrick Hanser stated the position as follows: "If we would have had to compromise any of our ethical or religious values or our Catholic identity, it would have been better for us to close."[62] In light of this stance, something-is-better-than-nothing logic makes it improbable that a secular hospital would be willing to go under rather than agree to a limitation on the services it provides.

The contested services are also infrequently provided, giving secular hospitals another reason not to insist on retaining them. As one hospital executive put it, "you have to remember that this is a very small portion of our business right now. And in terms of proportionality, there are so many more benefits to the community [from a] merger despite the unfortunate loss to some."[63] In other words, for cash-strapped hospitals, the contested services do not generate enough revenue to justify turning down a merger in order to protect them. Thus, when Catholic and secular hospitals merge, Catholic entrenchment and multidimensional economic considerations push secular institutions to assent to retaining the *Directives*.

So where does this leave doctors? Catholic hospital employees are caught at the confluence of their own consciences, the patient's right to be informed, the dictates of prevailing best practices, and the *Directives*' demands. Of course, Catholic hospitals require their employees to abide by the *Directives*.[64] Some merged hospitals even require doctors to sign an agreement promising to comply with Catholic moral teachings.[65] But, as noted above, compliance can exact a heavy cost.[66]

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62 Charles Ornstein, *Hospital Mergers Tread Fine Line Between Religion, Economics*, DALLAS MORNING NEWS, June 14, 1998, at 1H.

63 Esther B. Fein, *Hospital Deals Raise Concern on Abortion*, N.Y. TIMES, Oct. 14, 1997, at B1.

64 DIRECTIVES, *supra* note 2, Directive 5, at 12 ("Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.").

65 *See* Monica Sloboda, Note, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140, 143 (2001).

66 *See supra* note 9 and accompanying text.

II. AUTONOMY IN MEDICINE

A. *Autonomy Ascendant*

On one conception, autonomy[67] is a right to be recognized as an independent moral agent whose judgments, freely made, are worthy of respect.[68] Choice making is an intrinsically human act, so that infringements on autonomous choice are infringements on an aspect of one's humanity and thus inspire suspicion.[69] However, constraints on patient autonomy were not always mistrusted. For centuries, a paternalistic approach to medicine reigned in the United States.[70] It was "considered the duty of physicians to decide what was best because the patient lacked medical knowledge and might lose hope if he knew the whole truth about his options or prognosis."[71] It was not until the mid-1960s that paternalistic medicine came under fire as an infringement on patients' self-determination[72] and patient autonomy gained increasing respect.[73] Because freedom of choice is a hollow right without access to relevant information, the doctrine of informed consent emerged as the primary vehicle for mitigating the power disparity between doctors and their patients.[74] As the Maryland Supreme Court stated, informed consent was adopted as a requirement

> primarily to enable the patient to make an informed choice about a particular therapy or procedure so that healthcare providers did not substitute their own judgment for that of the patient's . . . . Thus, we recognized that personal autonomy and personal choice were the primary foundations of the informed consent doctrine.[75]

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67 The term "autonomy" itself is not without controversy. I adopt here Dr. Edmund Pellegrino's description of "an autonomous person [as] one who, in his thoughts, words, and actions, is able to follow those norms he chooses as his own without external constraints or coercion by others." Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 48 (1994).

68 *See id.*

69 *See id.* at 48–49.

70 *See id.* at 50.

71 *Id.*

72 *See* Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593, 598–99 (2007).

73 *See* Pellegrino, *supra* note 67, at 49. Pellegrino identifies the confluence of improved public education, the civil rights movement, and generalized suspicion of authority claims as the catalysts for the change. *See id.*

74 *See* Steven I. Addlestone, Note, *Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy*, 46 VAND. L. REV. 1255, 1257–58 (1993).

75 McQuitty v. Spangler, 976 A.2d 1020, 1031 (Md. 2009); *see also* Cruzan *ex rel.* Cruzan v. Harmon, 760 S.W.2d 408, 417 (Mo. 1988) (en banc) ("The doctrine of

Today, patient autonomy is ascendant,[76] and though widely applauded as a general matter, some criticize the deference to patient autonomy for transforming physicians from moral agents into vendors of medical services.[77] The situation creates a conflict for individual providers who may find themselves obliged by their clinical morality and prevailing best practices to inform a patient of her full range of options while obliged by sectarian command not to materially cooperate with a sinful course of treatment. Conscience clauses attempt to address this friction.

B. Conscience Codified

1. The Nature of Conscience and Why We Recognize Conscientious Objection

Conscience clauses are now commonplace fixtures in American legislation. The federal government was the first to recognize the rights of medical providers to refuse to participate in medical treatment, even if medically indicated, when doing so would conflict with a moral or religious belief.[78] Many states followed its lead.[79] Federal conscience laws originally referred to "religious beliefs or moral conviction,"[80] but some later conscience clauses dropped such limiting

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informed consent arose in recognition of the value society places on a person's autonomy and as the primary vehicle by which a person can protect the integrity of his body."); *In re* Jobes, 529 A.2d 434, 454 (N.J. 1987) ("In medical treatment decisions, the law developed the doctrine of informed consent as the primary means for protecting the right of self-determination.").

76 *See* Judith F. Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J.L. & MED. 221, 223 (1995) ("Over the past two decades the bioethics movement has done much to advance the realities of patient autonomy, at least as revealed by the written laws of our country."). Some argue that the pendulum has tipped too far toward patient autonomy. *See, e.g.*, Pellegrino, *supra* note 67, at 59–61 (enumerating the problems that arise when physicians become mere dispensaries of medicine and medical services).

77 *See* Curlin et al., *supra* note 72, at 599; *see also* Pellegrino, *supra* note 16, at 223–25 (discussing the "shift in the locus of decision-making from the physician to the patient or her surrogate").

78 *See* Health Programs Extension Act of 1973 (Church Amendment), Pub. L. No. 93-45, § 401, 87 Stat. 91, 95–96 (codified as amended at 42 U.S.C. § 300a-7(b) (2006)).

79 For example, Arkansas, California, Colorado, Florida, Georgia, Idaho, Maine, Mississippi, South Dakota, Tennessee, and Washington all protect, to varying degrees, pharmacists' refusal to fill certain prescriptions. *See Pharmacist Conscience Clauses: Laws and Legislation*, NAT'L CONF. ST. LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=14380 (last updated Feb. 2011).

80 *See* Health Programs Extension Act § 401.

language.[81] The scope of state protections varies—some states protect only those refusals founded in religious belief but many do not.[82]

In general, a society cannot have two equally valid codes of law.[83] If anyone may simply disregard legal obligations based on a claimed religious or moral belief, sincerely held or not, then law is a suggestion, not a command, and anarchy is our reward.[84] All members of a community must forego some of their freedom in order to enjoy the benefits of ordered society.[85] It is a serious thing to grant exemptions from the supremacy of secular law and they must be carefully limited.

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81 *See* Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, §§ 507–508, 121 Stat. 1844, 2208–09 (2007); 42 U.S.C. § 238n (2006).

82 *See* Leslie C. Griffin, *Conscience and Emergency Contraception*, 6 HOUS. J. HEALTH L. & POL'Y 299, 302 (2006) (discussing state legislation following, and modeled on, the Church Amendment).

83 *See* Emp't Div. v. Smith, 494 U.S. 872, 885, 888 (1990) ("To make an individual's obligation to obey . . . a [generally applicable] law contingent upon the law's coincidence with his religious beliefs, except where the State's interest is 'compelling' . . . contradicts both constitutional tradition and common sense. . . . Any society adopting such a system would be courting anarchy . . . ."); Reynolds v. United States, 98 U.S. 145, 166–67 (1878) ("Can a man excuse his practices to the contrary because of his religious belief? To permit this would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself. Government would exist only in name under such circumstances."). The care taken to divide power in the Constitution between state and federal governments, and to prescribe when one overrules the other, illustrates this point. *See* U.S. CONST. art. VI, cl. 2.

84 Indeed, Piero Tozzi, who vehemently criticized "Catholics being affirmatively excluded from full participation in civic life," admits this point when he writes: "To state things bluntly, the question is not whether values or morality exist and whether they are to be imposed . . . but rather, whose values or whose morality (or amorality) is to be imposed." Piero A. Tozzi, *The Blessing or the Curse: Whose Values Will Guide Us? Where Will They Lead Us?*, 47 J. CATH. LEGAL. STUD. 167, 172, 174 (2008). To recognize that one set of values or the other must triumph is to admit their mutual exclusivity.

85 Thomas Hobbes described the state of humanity without such a compromise as "a time of Warre, where every man is Enemy to every man," where there are "no Arts; no Letters; no Society; and which is worst of all, continuall feare, and danger of violent death; And the life of man, solitary, poore, nasty, brutish, and short." THOMAS HOBBES, LEVIATHAN 186 (C.B. Macpherson ed., Penguin Books 1968) (1651). In order "to erect . . . a Common Power, as may be able to defend them from the invasion of Forraigners, and the injuries of one another . . . [that] they may nourish themselves and live contentedly," human beings must "conferre all their power and strength upon one Man, or upon one Assembly of men, that may reduce all their Wills, by plurality of voices, unto one Will . . . ." *Id.* at 227; *see also* THOMAS PAINE, COMMON SENSE 1–2 (Wiley Book Co. 1942) (1792) (asserting that "were the impulses of conscience clear, uniform, and irresistibly obeyed, man would need no other lawgiver," but because that is not so, man "finds it necessary to surrender up a part of his property to furnish means for the protection of the rest"—this security is "the true design and end of government").

Conscience clauses are just such exemptions and therefore ought to be warily endorsed, and then only after a thorough vetting. Conscience clauses should be evaluated with an eye toward the purposes that justify their existence. Conscience rights must be rejected the instant they fail to serve these purposes.

Any attempt to define or characterize conscience risks descending into a morass of philosophy, ethics, and morals from which one might never return. However, without some working description, further discussion lacks foundation. Conscience is predicated on the recognition of the autonomous moral agent.[86] Choice precedes action. In order to choose to act rightly or wrongly, a person must have first defined for herself what is right or wrong. For that reason, there is something deeply human about conscience.[87] As Kevin Seamus Hasson writes, "[c]onscience is the interior, quintessentially human voice that speaks to us of goodness and duty, the voice we must obey if we are to keep our integrity. It counsels doing good and avoiding evil, and serves as a referee to rule on which is which."[88] Professor Steven D. Smith states that "when we describe an act as being done from 'conscience' we usually mean at least to say that the person in question acted on the basis of a sincere conviction about what is morally required or forbidden."[89]

Dr. Pellegrino describes the conscientious person as "striv[ing] to preserve moral integrity."[90] He continues: "This requires that their external behavior be congruent with their conscience's internal dictates about what they take to be morally right and feel compelled to

86 *See* Moreland, *supra* note 18, at 225.

87 *See* John Locke, *A Letter Concerning Toleration*, *in* JOHN LOCKE, TREATISE OF CIVIL GOVERNMENT AND A LETTER CONCERNING TOLERATION 173 (Sterling P. Lamprecht ed. 1937) (1690) ("And such is the nature of the understanding, that it cannot be compelled into belief of anything by outward force."); Pellegrino, *supra* note 16, at 228 ("[C]onscience clauses are firmly rooted in what it is to be a human person morally, intellectually, and psychologically. Every individual, by virtue of being human, has a moral claim to the free exercise of conscience.").

88 KEVIN SEAMUS HASSON, THE RIGHT TO BE WRONG 14 (2005); *see also* LOCKE, *supra* note 87 ("No way whatsoever that I shall walk in, against the Dictates of my Conscience, will ever bring me to the Mansions of the Blessed.") Locke's letter contemplated conscience based in religion, but the logic of his argument extends into the secular realm. *See* Ronald Beiner, *Three Versions of the Politics of Conscience: Hobbes, Spinoza, Locke*, 47 SAN DIEGO L. REV. 1107, 1121 (2010).

89 Steven D. Smith, *The Tenuous Case for Conscience*, 10 ROGER WILLIAMS U. L. REV. 325, 328 (2005).

90 Pellegrino, *supra* note 16, at 221.

do."[91] Mr. Hasson agrees, writing "conscience requires action, not just conviction. It demands that we live according to the truth as we know it."[92] For John Locke, the "law of conscience" was a judgment that "lays a bond on the mind."[93] Synthesizing these varied (and by no means exhaustive) descriptions renders four touchstones of conscience: (1) conscience is inherently human; (2) conscience reflects a private, internal judgment; (3) conscience is predicated on recognition of the autonomous moral agent; and (4) conscience compels a person to act or refrain from acting.

These characteristics help explain the law's willingness to protect conscience, as they are the basis for other familiar legal principles. Independence—respect for the autonomous moral agent—is a principle long treasured by the American legal system.[94] For example, the retributive justification for punishment of crime is rooted in the idea of the independent actor.[95] Consent's prominent place in tort law is a further instance of the value placed upon individual autonomy.[96]

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91 *Id.* As Sophocles put it: "There is no witness so terrible—no accuser so powerful as conscience which dwells within us." THE FORBES BOOK OF BUSINESS QUOTATIONS 138 (Ted Goodman ed., 90th Anniversary ed. 2006).

92 HASSON, *supra* note 88, at 14.

93 JOHN LOCKE, ESSAYS ON THE LAW OF NATURE 185 (W. Von Leyden ed., Oxford Univ. Press 1965) (1663).

94 *See, e.g.*, Martinez v. Court of Appeals, 528 U.S. 152, 161 (2000) ("[A]ny individual right to self-representation on appeal based on autonomy principles must be grounded in the Due Process Clause."); Hurley v. Irish-Am. Gay, Lesbian, and Bisexual Grp. of Bos., 515 U.S. 557, 573 (1995) ("[T]his use of the State's power violates the fundamental rule of protection under the First Amendment, that a speaker has the autonomy to choose the content of his own message."); Robert E. Toone, *The Incoherence of Defendant Autonomy*, 83 N.C. L. REV. 621, 650–51 (2005) ("The idea of autonomy has acquired considerable popularity in the United States and other western societies . . . . [It has] become central to the Supreme Court's constitutional jurisprudence.").

95 *See, e.g.*, Dan Markel & Chad Flanders, *Bentham on Stilts: The Bare Relevance of Subjectivity to Retributive Justice*, 98 CALIF. L. REV. 907, 931 (2010) ("Retributive punishment for legal wrongdoing is justified in part because, in treating the offender as a responsible moral agent, it communicates to him a respect for his dignity as an autonomous moral agent."); John A. Powell & Stephen M. Menendian, *Remaking Law: Moving Beyond Enlightenment Jurisprudence*, 54 ST. LOUIS U. L.J. 1035, 1061 (2010) ("[T]he theory of blame and punishment continues to rest on notions of free choice by autonomous, rational actors. The heat of passion 'defense' is another application of this theory of culpability . . . ." (footnote omitted)).

96 *See* Mark A. Geistfeld, *The Value of Consumer Choice in Products Liability*, 74 BROOKLYN L. REV. 781, 781 ("The role of consent within tort law derives from the value of individual autonomy or self-determination."). This is particularly true in the medical context. *See* Margo Kaplan, *"A Special Class of Persons": Pregnant Women's Right to Refuse Medical Treatment After* Gonzales v. Cahart, 13 U. PA. J. CONST. L. 145, 163 n.72

Also, the law often seeks to protect those aspects of life that are private or internal, or reflect our inherent dignity as humans.[97] Compulsions to act or not act sometimes excuse liability in defenses such as duress[98] or defense of habitation.[99] Since conscience has characteristics that the law protects in other contexts, it is not surprising that lawmakers developed protections for provider conscience when they believed it to be under attack.

2. Conscience Clauses: Legal Protection for Provider Conscience

The first federal conscience clause emerged in response to a Montana district court's ruling in *Taylor v. St. Vincent's Hospital*,[100] enjoining a Catholic hospital from interfering with a planned tubal ligation[101] because, by receiving federal funding, it had become a

(2010) ("Tort law recognizes [the value in meaningful choice] by holding a health care provider who does not obtain informed consent before treating a patient liable because the provider has intruded on the bodily autonomy of the individual."); Lars Noah, *Informed Consent and the Elusive Dichotomy Between Standard and Experimental Therapy*, 28 AM. J.L. & MED. 361, 364 (2002) (noting that "informed consent doctrine emerged from the intentional tort of battery" and "reflects a commitment to patient autonomy and self-determination").

97 *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 567 (2003) ("[A]dults may choose to enter upon [a] relationship in the confines of their homes and their own private lives and still retain their dignity as free persons . . . . The liberty protected by the Constitution allows homosexual persons the right to make this choice."); McKaskle v. Wiggins, 465 U.S. 168, 176–77 (1984) ("The right to appear *pro se* exists to affirm the dignity and autonomy of the accused and to allow the presentation of what may . . . be the accused's best possible defense." (emphasis in original)). Fourth Amendment cases often invoke a conglomerate of human dignity, privacy, and security interests. *See* Hudson v. Michigan, 547 U.S. 586, 594 (2006) ("[T]he knock-and-announce rule protects those elements of privacy and dignity that can be destroyed by a sudden entrance."); United States v. Flores-Montano, 541 U.S. 149, 152 (2004) ("[T]he reasons that might support a requirement of some level of suspicion in the case of highly intrusive searches of the person—dignity and privacy interests of the person being searched—simply do not carry over to vehicles."); Schmerber v. California, 384 U.S. 757, 769–70 (1966) ("The interests in human dignity and privacy which the Fourth Amendment protects forbid any such intrusions on the mere chance that the desired evidence might be obtained.").

98 RICHARD J. BONNIE ET AL., CRIMINAL LAW 479 (2d ed. 2004) ("Traditionally, the duress defense has been the main device by which the law takes into account external constraints on a person's capacity to choose to comply with the law.").

99 *Id.* at 428 ("Under [a] traditional common-law doctrine, a person was permitted to use deadly force to prevent an entry into his or her home based on the reasonable belief that such force was necessary to prevent robbery, burglary, arson, or felonious assault.").

100 369 F. Supp. 948, 950–51 (D. Mont. 1973), *aff'd*, 523 F.2d 75 (9th Cir. 1975).

101 *See* H.R. REP. NO. 93-227, at 11 (1973) ("The background for subsection (b) of Section 401 of the [Health Programs Extension Act of 1973] is an injunction issued

state actor.[102] This holding came down in "an environment electrified by the *Roe* [*v. Wade*] decision, one steeped in uncertainty as to the effects of the Court's recognition of a woman's right to terminate her pregnancy before viability."[103] Congress expressed its disagreement with the *Taylor* court by passing the Church Amendment,[104] which states that an entity's or individual's receipt of federal funding does not authorize a court or public authority to require that the entity or individual perform sterilizations or abortions if doing so would violate the individual's or entity's religious convictions.[105] The Church Amendment also states that no entity that receives federal funding may discriminate against physicians or other healthcare personnel because they refuse to perform an abortion or sterilization due to moral or religious convictions, or because they choose to perform an abortion or sterilization.[106] The Church Amendment counterbalanced *Roe*'s newly minted privacy right with a recognition that, for providers, forced performance of sterilization and abortion can intrude upon the personal arenas of conscience, morality, or religion.

But the Church Amendment's internal inconsistency sows the seeds of further conflict. It permits a hospital to forbid its employees from performing certain procedures based on conscientious objection, while simultaneously forbidding that same hospital from discriminating against a physician who provides that treatment. Therefore, although the discrimination prohibition strives to protect the full range of individual conscience (i.e., the conscience of objectors and non-objectors alike), the inclusion of protection for entities undermines this goal.

. . . in *Taylor v. St. Vincent's Hospital* . . . . The court enjoined St. Vincent's Hospital . . . from prohibiting Mrs. Taylor's physician from performing in that hospital a sterilization procedure on her during the delivery of her baby by Caesarian section. . . . In ruling on a motion to dismiss [a 42 U.S.C. § 1983 suit] for lack of jurisdiction, the court stated [that the hospital's receipt of Hill-Burton Act funds supports the finding of jurisdiction]."); *see also Taylor*, 369 F. Supp. at 950–51 (recounting issuance of a preliminary injunction and its dissolution after new legislation prohibited the court from deeming a hospital to be a state actor because it received Hill-Burton funds).

102 *See Taylor*, 369 F. Supp. at 950 n.1; *see also* Tom C.W. Lin, *Treating an Unhealthy Conscience: A Prescription for Medical Conscience Clauses*, 31 VT. L. REV. 105, 107 (2006).

103 Parr, *supra* note 29, at 632.

104 *See* 42 U.S.C. § 300a-7 (2006).

105 *See* Health Programs Extension Act of 1973 (Church Amendment), Pub. L. No. 93-45, § 401, 87 Stat. 91, 95–96 (codified as amended at 42 U.S.C. § 300a-7(b)).

106 *See* 42 U.S.C. § 300a-7(c).

The 1990s saw a proliferation of conscience legislation,[107] which built upon the Church Amendment's inconsistency. In 1996, Congress passed the Coats Amendment,[108] "which prohibits the government from 'discriminating' against medical residency programs or other entities that lose accreditation because they fail to provide or require training in abortion services."[109] In 1997, Congress sanctioned Medicare and Medicaid managed care plans' refusal "to provide, reimburse for, or provide coverage of a counseling or referral service if the . . . organization offering the plan . . . objects to the provision of such service on moral or religious grounds."[110] In 1999, Congress exempted religiously affiliated health plans from a requirement that federal employees' health plans cover prescription contraception.[111] The Weldon Amendment,[112] a rider attached to the Consolidated Appropriations Act of 2008, states that the funds it distributes are not meant to fund abortions,[113] though an exception is made for abortions necessary to save a woman's life.[114] The Act further prohibits the appropriation of funds to any federal agency or program, or state or local government, that discriminates against a healthcare entity on the ground that the entity refused to "provide, pay for, provide coverage of, or refer for abortions."[115] The Weldon Amendment protects "health care entit[ies]," an expansive term which includes hospitals, insurance plans, and HMOs.[116] Recently, the Department of Health and Human Services (HHS) has proposed an interpretive rule following this definitional trend.[117] The prolifera-

107 *See* Martha S. Swartz, *"Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL'Y L. & ETHICS 269, 283 (2006).

108 Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104-134, § 515, 110 Stat. 1321, 1321–245 (codified as amended at 42 U.S.C. § 238n).

109 Swartz, *supra* note 107, at 283.

110 Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 295 (codified as amended at 42 U.S.C. § 1395w-22(j)(3)(B)).

111 *See* Swartz, *supra* note 107, at 283 (citing Consolidated Appropriations Resolution, 2003, Pub. L. No. 108-7, div. E, tit. II, 117 Stat. 11, 163).

112 Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, §§ 507–508, 121 Stat. 1844, 2208–09 (2007). Sources alternatively refer to this legislation as the "Hyde Amendment" and the "Hyde-Weldon Amendment."

113 *Id.* § 507, 121 Stat. at 2208.

114 *Id.* § 508(a), 121 Stat. at 2208.

115 *Id.* § 508(d)(1), 121 Stat. at 2209.

116 *Id.* § 508(d)(2), 121 Stat. at 2209.

117 *See* Rohit Talwar, Note, *The Dangers of Broad Federal Conscience Law*, 21 HEALTH LAW., Aug. 2009, at 23, 25–30 (arguing against the breadth of HHS' proposed rule, located at Ensuring that Department of Health and Human Services Funds Do Not

tion of broadly defined conscience clauses brings more individuals into a decision that would otherwise lie solely between a patient and her doctor.

3. Clinical Morality

Physicians have their own claim to autonomy; in fact, autonomy has been described as "the cornerstone of physician professionalism."[118] However, as noted above, the flourishing of patient autonomy has diminished provider independence, inspiring complaints that modern physicians have become mere vendors of requested medical services.[119] A physician's autonomy is broader than merely a right to refuse to perform certain procedures, which conscience clauses firmly protect. Providers also have an interest in acting consistent with best practices and prevailing medical ethics. In fact, widely respected medical associations command healthcare providers to observe certain principles in the practice of medicine, not dissimilar from the requirements found within the *Directives*. The American Medical Association's (AMA) eighth principle of medical ethics states that "[a] physician shall, while caring for a patient, regard responsibility to the patient as paramount."[120] The AMA's Policy on the Provision of Life-Sustaining Medical Treatment reads:

> As stated by our Code of Medical Ethics, the American Medical Association believes that:
>
> . . . .
>
> Life-sustaining treatments should provide medical benefits and should respect a patient's preferences, as communicated by the patient or a legally recognized surrogate. . . . Once initiated, life sustaining treatments may be ethically withdrawn upon request of the patient, or a surrogate or court acting on the patient's behalf.[121]

Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50,274-01, (Aug. 26, 2008) (codified at 45 C.F.R. § 88.2 (2009)). The trend persists is new legislation working its way through committee. A proposed addition to the Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 124 Stat. 119 (2010), expansively defines the healthcare entities to which its proposed funding, training, and nondiscrimination provisions would apply. *See* H.R. 358, 112th Cong. (2011).

118 Simon C. Mathews & Peter J. Pronovost, *Physician Autonomy and Informed Decision Making: Finding the Balance for Patient Safety and Quality*, 300 J. AM. MED. ASS'N 2913, 2913 (2008).

119 *See supra* notes 76–77 and accompanying text.

120 COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCATION, at iii (2004).

121 *AMA Policy on the Provision of Life-Sustaining Medical Treatment*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-eth-

A report from the American College of Obstetricians and Gynecologists (ACOG) ethics committee states that "[i]n an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care."[122] It is easy to see the conflict between these guidelines and the *Directives*.

The AMA's statements on medical ethics go beyond mere commentary. They define what constitutes acceptable practice when potential conflicts arise. When lethal injection emerged as a method of execution preferable to electrocution, the AMA balked at any participation by physicians. It swiftly adopted a resolution now embodied in Article 2.06 of the AMA's 1992 Code of Medical Ethics, which states that "[a] physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution."[123] The AMA permitted physicians only to provide sedatives to ease the prisoner's anxiety and to certify death after another person had pronounced it.[124] The American Nurses Association adopted a similar position.[125] Very few physicians will participate in executions at all and those that do limit their involvement. For example, some participating physicians declined to assist a hapless warden struggling to perform the injections.[126] Others refused to personally pronounce death.[127] They were even reluctant to discuss their involvement, despite a guarantee of anonymity.[128] Physicians manifest their clinical morality, a species of individual conscience, when they refuse to participate in executions or strictly limit their participation. Clinical morality also guides affirmative action, exemplified by ACOG's command to perform all medically indicated care in an emergency and by a physician's choice to participate in

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ics-group/ethics-resource-center/end-of-life-care/ama-policy-provision-life-sustaining-medical.shtml (last visited June 20, 2011).

122 Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, Comm. Op. 385 (2007), *available at* http://www.acog.org/from_home/publications/ethics/co385.pdf (discussing the limits of conscientious refusal in reproductive medicine).

123 Atul Gawande, *When Law and Ethics Collide—Why Physicians Participate in Executions*, 354 NEW ENG. J. MED. 1221, 1222–23 (2006) (quoting AM. MED. ASS'N, CODE OF MEDICAL ETHICS art 2.06 (1992)).

124 *See id.* at 1223.

125 *See id.*

126 *See id.*

127 *See id.*

128 *See id.*

executions on a limited basis or to respect a patient's end-of-life requests.[129]

But conscience clauses do a poor job of protecting both facets of clinical morality. In addition to protection for individuals, the Church Amendment extended protection to institutions whose conscience may very well conflict with that of its employees, creating an internal inconsistency which subsequent conscience clauses have exacerbated by conferring conscience protection upon a more varied group of entities,[130] all of which may assert conscience rights antagonistic to a physician's clinical morality. Institutional conscience is fundamentally different from individual conscience and has no place among the pantheon of jealously guarded individual rights.

III. THE INCONSISTENCY OF INSTITUTIONAL CONSCIENCE

It is a weighty thing to recognize an individual's right to declare that she is exempt from the operation of a law that is intended to bind all of society.[131] Chaos follows closely behind a failure to carefully limit such exceptions. State law and church law do not exist side by side as equally valid systems of governance. No citizen is free to submit to secular law only to the extent that it does not conflict with religious edict,[132] and conscience clauses provide only a limited exception to this rule. Recognition of the right of healthcare providers to act

129 This is not to say that the AMA or ACOG should have their own right of conscience. This would be just as problematic as imputing conscience to hospitals and HMOs. Rather, the AMA and ACOG promulgate rules of ethical conduct, similar to the *Directives*, which a physician may feel morally obliged to follow in her *individual* capacity.

130 *See supra* notes 109–16 and accompanying text.

131 Assertions of conscientious objection in the cases discussed in this Note must be distinguished from the civil disobedience espoused and practiced most notably by Dr. Martin Luther King, Jr., Henry David Thoreau, and Mahatma Gandhi. A critical component of civil disobedience is the willingness to accept the penalty for that disobedience. As King argued, "an individual who breaks a law that conscience tells him is unjust, and *who willingly accepts the penalty of imprisonment in order to arouse the conscience of the community over its injustice*, is in reality expressing the highest respect for law." MARTIN LUTHER KING, JR., *Letter from Birmingham Jail*, *in* WHY WE CAN'T WAIT 76, 83–84 (1964) (emphasis added). In the cases discussed here, those demanding conscience protection seek what Ellen Goodman has called "conscience without consequence." Ellen Goodman, *Dispensing Morality: Pharmacists and Others Are Asking for Conscience Without Consequence*, KAN. CITY STAR, Apr. 13, 2005, at B7.

132 All who request the shelter of conscience clauses implicitly recognize this fact by virtue of their appeal to secular law for protection.

according to their consciences[133] must not be extended to institutions without rigorously testing the justifications for doing so.

A. Theoretical Defects: Institutional Conscience in the Abstract

Even as a stand-alone concept, institutional conscience is problematic. How does an institution have a conscience?[134] Entities are imbued with personality and extended significant benefits by way of legal fiction.[135] And yet a legal fiction is just that—a fiction. Institutional conscience is inherently derivative, taking form only through the action of individuals.[136] To the extent that it can be identified at all,[137] institutional conscience is no more than the amalgamated conscience of the institution's directors. It is difficult to see how the conscience of like-minded individuals is transformed into the cohesive conscience of a fictitious entity.

Some respond that an institution is something more than simply the sum of its parts.[138] Ostensibly, such an argument concludes that the synergistic effect of collective action creates a "something more" which is equivalent to individual conscience. In short, an institution's charter or ethical precepts, as the products of collective action, are its

133 Other professions do not receive such charitable treatment. Attorneys, for example, are held to the same standard of practice regardless of the nature of their clients. *See* Daniel Markovits, *Legal Ethics from the Lawyer's Point of View*, 15 YALE J.L. & HUMAN. 209, 216 (2003) ("Any account of legal ethics that is connected to a recognizably adversary conception of legal process will acknowledge that lawyers must prefer their clients over others in a manner that would ordinarily be immoral . . . .").

134 *See* Kent Greenawalt, *Objections in Conscience to Medical Procedures: Does Religion Make a Difference?*, 2006 U. ILL. L. REV. 799, 824 ("[I]t is somewhat difficult to say what gives a collective entity an objection in conscience . . . .").

135 *See* Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, 186 (1993).

136 *See* Moreland, *supra* note 18, at 226 ("[I]nstitutional conscience . . . will always be derivative—and problematically so—of the language of individual conscience."). Here, Moreland suggests that the problem is linguistic—that "the language of 'conscience' undermines a robust understanding of church autonomy." *Id.* However, as the discussion below makes clear, the problems posed by institutional conscience run far deeper than a simplistic terminological difficulty.

137 This is not at all problematic in the case of Catholic hospitals as the *Directives* constitute an explicit iteration of Catholic teaching with respect to healthcare institutions.

138 *See* Robert K. Vischer, *When Is a Catholic Doing Legal Theory Doing "Catholic Legal Theory?,"* 40 SETON HALL L. REV. 845, 857 (2010) ("The corporation's moral identity is not simply the sum of its parts; the corporation needs discretion to shape its own identity.").

conscience.[139] Not only does this argument depend on some ill-defined alchemy to transform collective action into conscience, but it also relies on the unwarranted supposition that, because a corporate charter and an individual's conscience share some general characteristics, the analogy is perfect. The analogy is decidedly imperfect. Institutional charters or ethical precepts lack some of the fundamental characteristics of conscience enumerated above.[140] Taking Catholic hospitals as an example, there are serious difficulties with the argument that the *Directives* are distinctively human. They are certainly the product of human creation, but they do not reflect individual, private judgment. Instead, they reflect layered judgment: Centuries of Catholic teaching combine with the Pope's authoritative leadership to provide a framework within which a group of bishops (the USCCB) determines rules. A diocesan bishop interprets those rules and a hospital ethics committee applies them to individual cases. Furthermore, the compulsion to act or not act arising from institutional conscience differs from the compulsion arising from individual conscience because the interaction between the conscience and the act is not self-contained—institutional conscience instead imposes obligations on others.[141] This is not to say that collective action creates nothing that transcends the individual. Christopher Kutz aptly describes the social dynamics.[142] But to equate any transcendence to conscience is an unjustified leap, with serious implications.

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139 *See* Pellegrino, *supra* note 16, at 235 ("The ethical 'code' or commitment of a specific institution is now customarily expressed in its mission statement. This is in a way the 'conscience' of the institution.").

140 *See supra* Part II.B.1.

141 Although superficially applicable, the question of institutional conscience does not fit into the corporate personality debate because that debate considers the extent to which a corporation shares in the rights granted to a natural person. *See* Jess M. Krannich, *The Corporate "Person": A New Analytical Approach to a Flawed Method of Constitutional Interpretation*, 37 LOY. U. CHI. L.J. 61, 61–62 (2005) ("[A] corporation is simply not a 'person' as most understand the term. To overcome this dichotomy, corporate theorists have devised various metaphors to help supply a legal definition for the corporate entity. . . . The use of metaphorical descriptions of the corporate entity is especially prevalent in the Supreme Court's corporate constitutional jurisprudence. The Court's decisions in this area seem to assume that a corporation is a 'person' under the Constitution and is thus entitled to many of the same rights as a natural person." (footnote omitted)). But in the circumstances under discussion, investing a hospital with conscience does more than place it on an equal plane with natural persons—it *elevates* the hospital by permitting it to impose its conscience on others.

142 *See* CHRISTOPHER KUTZ, COMPLICITY 72 (2000) ("[G]roup identity is explained in terms of individual participatory intentions . . . [which] include not just inchoate, romantic feelings of group solidarity, but a willingness to assume obligations taken on

In his oft-cited article, Professor Lynn D. Wardle makes two more objections to differentiating between individual and institutional conscience. First, he argues that denying institutional conscience is an indirect method of denying individual conscience protection to the institution's creators, which "contradicts the central purpose of conscience clauses."[143] In fact, a complete recognition of individual conscience can only be achieved by denying institutional conscience,[144] because institutional conscience, by imposing its commands on third parties, actually encroaches on individual conscience. The loss of conscience protection for the institution's creators, which would result from eliminating institutional conscience, is not a defect; it simply reveals the creators' tenuous relation to the actual provision of medical care. Moreover, Wardle's concern that removing institutional conscience protection injures the institution's creators, and not the institution itself, is a tacit admission that an entity's conscience is not truly distinct from the aggregated conscience of its directors or creators.

Second, Wardle argues that permitting individual but not institutional conscience cannot be reconciled with other legal doctrines like First Amendment protection for individual and collective speech.[145] This argument misrepresents the two interests at stake. Free speech doctrine defines the law in its primary form, whereas conscience clauses are secondary exemptions from the law's operation. The primary rights to which citizens are entitled are not inherently suspect. On the contrary, the right of free speech and its ilk express cherished and generally applicable principles.[146] For this reason, extending free

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by other group members, to speak, decide, and act on others' behalf, and to deliberate about how best to act so as to further collective plans and intentions.").

143 Wardle, *supra* note 135 at 186.

144 The burden that denying institutional conscience places on, for example, a Catholic hospital's directors is no different from the burden that the directors of a secular hospital bear when a physician at the hospital acts, on the basis of religious or moral belief, in a manner which the director finds unconscionable.

145 Wardle, *supra* note 135, at 187.

146 *See* Citizens United v. Fed. Election Comm'n, 130 S. Ct. 876, 898 (2010) ("The right of citizens to inquire, to hear, to speak, and to use information to reach consensus is a precondition to enlightened self-government and a necessary means to protect it. . . . Premised on a mistrust of governmental power, the First Amendment stands against attempts to disfavor certain subjects or viewpoints."). Wardle also chides as ironic a state's assertion that a hospital either does not have a conscience or is not entitled to express or implement it because it is not a natural person. *See* Wardle, *supra* note 135, at 186. "After all," he continues, "a state is not a human being either, but merely an entity created to express and enforce collective will." *Id.* at 186–87. But of course, the state is not acting on the basis of conscience, but rather utilizing the governmental authority that the citizenry has conferred upon it.

speech to institutions is less worrisome than expanding exceptions to a general rule. These exceptions are disquieting by their very nature and are thus only grudgingly broadened. Wardle's use of a primary right like free speech to set the standard for expanding conscience protection is misleading because it measures the scope of a narrowly tailored exception by a yardstick reserved for first principles. For these reasons, the very idea of institutional conscience as a freestanding structure sags atop buckling theoretical pillars.

B. Conflict with Individual Conscience

Institutional conscience protection is also dubious in its practical application because it impinges on and *overrides* individual conscience. Even if one rejected the fundamental characteristics of conscience proposed above, created a different set of criteria to describe conscience, and on this basis decided that the *Directives* do represent a Catholic hospital's institutional conscience, this would only support the conclusion that institutions and individuals have an *equal* right to conscience protection. And yet, in the current legal landscape, institutional conscience wins out when the two conflict. It is this superseding characteristic of institutional conscience as currently recognized that is least defensible.[147]

By permitting a Catholic hospital to dictate the treatments a physician may prescribe, a Catholic healthcare institution's "conscience" takes primacy over the physician's clinical morality. A non-Catholic healthcare provider practicing in a Catholic hospital does not have the same freedom of individual conscience that is enjoyed by others who do not work in Catholic hospitals. A Catholic who works in a Catholic hospital may still experience this conflict if she fundamentally disagrees with, but is obliged to follow, a bishop's or ethics committee's interpretation of the *Directives*. In this respect, the derivative nature of institutional conscience takes on greater significance. The *Directives* were written by the USCCB and are interpreted by local bishops, neither of which is a "healthcare provider" under federal conscience legislation.[148] But a grant of institutional conscience gives this group not simply a right of conscience equal to direct providers (despite their very unequal participation), but a *superior* claim to conscience protection, since employees at Catholic hospitals must abide

147 Even more troubling is that the superseding nature of institutional conscience is only selectively given. Religious physicians' right of refusal would exist in theory only if a secular institution was permitted to declare a moral objection to denying patients any treatment that is medically indicated and consistent with best practices.

148 *See supra* Part II.B.2.

by the *Directives*, regardless of their religious persuasion or clinical morality. Therefore, institutional conscience provides individuals only tangentially related to the actual provision of medical services a right to dictate treatment options to providers and patients. And yet this imposition of values is precisely what conscience clause advocates deplore when they support an individual Catholic physician's broad right of refusal, even when contrary to hospital policy.[149]

That inconsistent message is symptomatic of a deeper problem: the practical application of institutional conscience is asymmetrical. An entity cannot assert a right of conscience without first identifying that conscience. A Catholic hospital has, in the *Directives*, a comprehensive set of moral rules it can claim as its conscience. This means that a Catholic hospital can demand that its employees abide by the *Directives*, notwithstanding those employees' countervailing clinical morality. But secular hospitals generally have no analog to the *Directives*. Without comprehensive *moral* rules of its own to assert, a secular hospital must accommodate the conscience-based refusals of its staff. Thus, institutional conscience operates as a one-way ratchet protecting the rights of religious providers and institutions at the expense of their secular counterparts.

Advocates of conscience protection for Catholic hospitals and providers must, by definition, refuse to accept that the justifications for either protection cut both ways. All of the arguments in favor of protecting an individual provider's right to object over her employer's policy cut against recognizing the hospital's right to impose its policy against the moral objection of an employee. But this is precisely the imposition to which such advocates object when imposed on Catholic employees. This is the fundamental hypocrisy on which federal conscience legislation rests.

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149 *See* Edward T. Mechmann, *Illusion or Protection? Free Exercise Rights and Laws Mandating Insurance Coverage of Contraception*, 41 CATH. LAW. 145, 166 (2001) ("A conscience clause amendment to ERISA would thus bar state governments from imposing morally-offensive mandates on employee benefit plans."); Melissa Duvall, Comment, *Pharmacy Conscience Clause Statutes: Constitutional Religious "Accommodations" or Unconstitutional "Substantial Burdens" on Women?*, 55 AM. U. L. REV. 1485, 1507 (2006) ("[S]ome pharmacy conscience clause provisions . . . clearly remove the burden that pharmacy laws impose on Catholic and other religious pharmacists who believe that life begins at conception."); Jessica J. Nelson, Comment, *Freedom of Choice for Everyone: The Need for Conscience Clause Legislation for Pharmacists*, 3 U. ST. THOMAS L.J. 139, 162 (2005) ("Forcing a pharmacist to provide a medication that the pharmacist believes will lead to the death of a person is imposing the patient's views onto the pharmacist, not the other way around."). This inconsistency is particularly troubling, as it creates the appearance of advocates seeking merely to protect the primacy of their religious values, whatever the argument needed to reach that result.

Some resolve the inconsistency by treating a religious justification for a refusal as having special weight, rendering it superior to objections cast purely in moral or ethical terms.[150] On this understanding, the religion-based conscience of the institution has priority over the morality-based objection of an individual physician. But the justifications for protecting faith-based conscience do not vanish when the conscience is instead based in morality. Moreover, the moral weight of an objection is not necessarily greater because it is based in religious teaching. Kent Greenawalt writes: "Because the great majority of existing refusal laws do not single out religious conscience . . . and because some nonreligious persons will have strong moral reasons not to participate in certain medical procedures, general privileges to refuse should not be limited to religious claimants."[151] Practical difficulties also counsel against giving more weight to religious objection. An exemption applicable only to faith-based objections could, by giving preference to religious ideas, run afoul of the First Amendment's Establishment Clause.[152] Then there is the added problem of determining what constitutes a religion. Although this is less persuasive, as courts must confront this question in any freedom of religion claim, it is a practical problem that should not be needlessly confronted.

Finally, there is the argument that those who do not want to be subject to the *Directives* should not work at Catholic hospitals.[153] Ironically, advocates for faith-based conscience protection quite rightly rejected the nearly identical argument[154] that Catholic physicians should find a specialty that does not implicate the conflicts between their faith and the prevailing best practices.[155] It is hard to see a prin-

150 *See* Pellegrino, *supra* note 16, at 224–25.

151 Greenawalt, *supra* note 134, at 824; *see also* Vischer, *supra* note 138, at 857 ("[W]e should hesitate to legitimize religiously derived claims of conscience over other types . . . .").

152 *See* Greenawalt, *supra* note 134, at 823 (noting that conscience clauses that create "[e]xcessive imposition might . . . violate the Establishment Clause. An exemption cast directly in religious terms is most clearly vulnerable in this respect,"). The Establishment Clause ensures religious liberty by requiring government action to have a true secular purpose; laws that lack such a purpose are invalid. *See* Andrew D. Cohen, Note, *How the Establishment Clause Can Influence Substantive Due Process: Adultery Bans After* Lawrence, 79 FORDHAM L. REV. 101, 121–22 (2010).

153 This argument was suggested to me by Professor O.C. Snead, Associate Professor of Law at the University of Notre Dame Law School.

154 *See* Julie D. Cantor, *Conscientious Objection Gone Awry—Restoring Selfless Professionalism in Medicine*, 360 NEW ENG. J. MED. 1484, 1485 (2009) ("Qualms about abortion, sterilization, and birth control? Do not practice women's health. Believe that the human body should be buried intact? Do not become a transplant surgeon. Morally opposed to pain medication . . . ? Do not train to be an intensivist.").

155 *See* Greenawalt, *supra* note 131, at 820.

cipled distinction between applying the if-you-don't-like-it-leave argument to a physical area (i.e., a particular hospital), but rejecting its application to a practice area. Measuring the relative burden of moving between specialties against moving to a different employer or area of the country is an individual calculus that will vary with the circumstances. No matter how it comes out in a particular instance, it provides little defense for any general rule. Furthermore, it is undesirable to require that a person forego a major vocational option in order to abide by her conscience. As Greenawalt noted, "the government should not create conditions that force individuals and organizations long committed to [ministering to the sick] to give it up."[156] Society at large has an interest in preventing the Balkanization of the medical profession, where institutions or geographic areas tolerate only like-minded individuals.

IV. SOLUTION

The problem posed by institutional conscience's impingement on individual conscience has been recognized before. Professor Robert Vischer dismisses the problem entirely "as the price of the corporation's mediating role."[157] This response does nothing to resolve the problem and is at odds with Vischer's endorsement of individual conscience protection.[158] The logical extension of Vischer's argument would conclude that the "price of the corporation's mediating role" also requires a Catholic physician to abide by a secular hospital's policies even when they contravene her religious values, a result Vischer opposes.[159] Evading the issue is not a viable option.

Others suggest the Church Amendment as a vehicle for denying institutions the right to infringe on physicians' clinical morality.[160] The language of the Church Amendment does purport to protect from discrimination a physician who performs a procedure to which a hospital objects.[161] However, this protection would be limited to sterilizations and abortions, the only procedures covered by the Church Amendment.[162] More importantly, the Church Amendment does not create a private right of action, as numerous courts have held.[163]

156 *Id.*

157 Vischer, *supra* note 138, at 857.

158 *See id.* at 850.

159 *See id.*

160 *See* Eisenstadt, *supra* note 5, at 155–72.

161 *See supra* notes 104–06 and accompanying text.

162 *See supra* notes 104–06 and accompanying text.

163 *See* Cenzon-DeCarlo v. Mount Sinai Hosp., No. 09 CV 3120 (RJD), 2010 WL 169485, at *4 (E.D.N.Y. Jan. 15, 2010) ("The Court finds no basis for implying a pri-

Without a private right of action physicians would have to rely on the federal government to protect their clinical morality. But the government's consistent expansion of institutional conscience indicates a definite lack of concern for institutional infringement on physicians' clinical morality. Therefore, the Church Amendment is not a promising avenue for relief.

Still others suggest the charitable trust doctrine as a source of protection, but here, too, standing presents a challenge. A charitable trust "is a fiduciary relationship with respect to property arising as a result of a manifestation of an intention to create it, and subjecting the person by whom the property is held to equitable duties to deal with the property for a charitable purpose."[164] A charitable trust is believed to create a "social contract between the charity and the public beneficiaries."[165] In Elizabeth, New Jersey, the town's only two hospitals, one secular and one Catholic, merged to form a new entity, which agreed to abide by the *Directives*.[166] The Attorney General of New Jersey required the hospitals to get leave of the court before continuing with the merger.[167] When the hospitals filed their complaint with the court, the American Civil Liberties Union of New Jersey (ACLU-NJ) intervened as a party in interest.[168] The court agreed with the ACLU-NJ that the merger might constitute a change in the hospital's charitable mission.[169] This favorable preliminary ruling gave the ACLU-NJ sufficient bargaining power to negotiate a settlement, which ensured that those services no longer offered at the hospital would remain available to the community.[170]

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vate right of action under the Church Amendment."); Nead v. Bd. of Trs. of E. Ill. Univ., No. 05-2137, 2006 WL 1582454, at *5 (C.D. Ill. June 6, 2006) ("The defendants argue that the Church Amendment does not confer a private right of action. The defendants are correct; it does not."); Moncivaiz v. Dekalb Cnty., No. 03 C 50226, 2004 WL 539994, at *3 (N.D. Ill. Mar. 12, 2004) ("The [Church Amendment] does not create an express private right of action . . . .").

164 RESTATEMENT (SECOND) OF TRUSTS § 348 (1959).

165 Alison Manolovici Cody, Note, *Success in New Jersey: Using the Charitable Trust Doctrine to Preserve Women's Reproductive Services When Hospitals Become Catholic*, 57 N.Y.U. ANN. SURV. AM. L. 323, 341 (2000) (quoting OFFICE OF THE ATTORNEY GEN. OF N.H., REPORT ON OPTIMA HEALTH 9 (1998)).

166 *See id.* at 334–35.

167 *See id.* at 336.

168 *See id.* at 336–37.

169 *See id.* at 338.

170 *See id.*

Although successful in New Jersey,[171] New Hampshire,[172] and New York,[173] the charitable trust doctrine has serious limitations. First, only a public officer—usually the attorney general—has standing to sue.[174] Attorneys general might not be motivated to intervene or may lack the resources to do so.[175] An attorney general may also be wary of tackling such a politically charged issue.[176] Beneficiaries often find it very difficult to meet the "special interest" standing exception utilized by the ACLU-NJ.[177] Therefore, the charitable trust doctrine is also an unsuitable shield.

In this case, the most obvious solution is the best one. Legislative conscience clauses must remove protection for institutions, which is illogical, damaging, and theoretically unsound. This is the simplest and best means to protect the full spectrum of individual conscience.

CONCLUSION

Catholic healthcare institutions have emerged from the rash of hospital mergers in the 1980s and 1990s with an expansive presence in the United States. This is a blessing in some contexts and deeply divisive in others. Catholic hospitals and their employees are required to follow the *Directives*, a set of rules promulgated by the USCCB, for the moral operation of a Catholic healthcare institution. Inevitably, friction results when a physician's clinical morality conflicts with the *Directives*' commands.

A physician's right to make autonomous decisions has long been under siege with respect to patients, who currently enjoy broad rights of autonomy. Forced adherence to the *Directives* represents pressure from the opposite direction. In order to protect some vestige of physician autonomy American legislatures passed conscience clauses, which recognize a right of conscience for physicians. These same statutes also extend protection to institutions, imputing to the institution the same conscience recognized in natural persons.

Even as an isolated concept, institutional conscience is problematic. Unlike its individual counterpart, institutional conscience does not have the qualities that make conscience protection vital. To use Catholic hospitals as an example, while the *Directives* are certainly the

171 *See generally id.* at 323–59 (describing an instance in which the charitable trust doctrine prevented a merger between Catholic and non-Catholic hospitals).

172 *See id.* at 344–45.

173 *See id.* at 346–47.

174 *See id.* at 347.

175 *See id.* at 348–49.

176 *See id.* at 349.

177 *See id.* at 349–50.

product of human creation, they reflect the layered judgment of Catholic teaching, the Pope's leadership, and the interpretations of local bishops and ethics committees, as opposed to the private, personal judgment characteristic of individual conscience. Furthermore, the *Directives* command to act or not act differs from the compulsion arising from individual conscience because the interaction between the conscience and the act is not self-contained; institutional conscience is instead imposed on third parties.

Even more problematic is the trump card which institutional conscience gives to individuals, like local bishops or hospital administrators, whose indirect relation to the actual provision of medical services would otherwise render their opinion irrelevant to a medical decision made by a patient and her doctor. Even assuming that institutions were properly imbued with the conscience of individuals, this utterly fails to explain why the religious institution's derivative conscience supersedes a physician's individual conscience when the two conflict. In fact, those who support a Catholic physician's right to refuse to offer medically indicated treatment must admit the supremacy of the individual physician's conscience protection. And yet these same supporters advocate the reverse, an institutional trump of individual conscience, when a Catholic hospital obliges a non-Catholic physician to adhere to the *Directives*, contrary to the physician's clinical morality. This is the intrinsic hypocrisy of modern conscience legislation.

Neither the Church Amendment nor the charitable trust doctrine is likely to rectify this inconsistency. The Church Amendment does not create a private right of action and, given its expanding recognition of institutional conscience, the federal government cannot be relied upon to protect physician's clinical morality. Suit under the charitable trust doctrine can be maintained only by a public officer or those with a "special interest." Public officers are unlikely to wade into such a controversial issue and therefore cannot be counted on to rigorously protect clinical morality. Beneficiaries have difficulty qualifying as a "special interest." In order to truly recognize and protect the full range of individual conscience, institutional conscience must be excised from conscience legislation.