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The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective

Cover Page Footnote

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THE PHYSICIAN'S CONSCIENCE, CONSCIENCE CLAUSES, AND RELIGIOUS BELIEF: A CATHOLIC PERSPECTIVE

*Edmund D. Pellegrino**

INTRODUCTION

Conscientious persons strive to preserve moral integrity. 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 do. In our morally diverse world, conscientious persons may come into conflict with each other and with society's moral values. Except for the amoral sociopath, conflicts of conscience are a regular feature of the moral life. Even for extreme relativists, resolving these conflicts is a constant challenge.

Any society purporting to serve the good of its members is therefore obliged to protect the exercise of conscience and conscientious objection. However, this involves a serious dilemma for any pluralist, democratic, liberal, or constitutional state. On the one hand, such a society is committed to tolerance of religious diversity, freedom of individual choice, and "neutrality" with respect to religious belief. On the other hand, optimizing freedom of conscience for some individuals may often limit the legal rights, social entitlements, and moral beliefs of others.

This dilemma is most acute for health professionals who hold strong religious beliefs, some of which cannot be compromised in good conscience. Can conscience clauses protect Catholic and other religious health professionals' moral claims to freedom of the exercise of their conscience? To what extent can these legal measures secure rights of conscience in the face of a liberal, democratic, and secular society's commitments to moral relativism, personal freedom of choice, and an implicit social contract with its professionals? Is there some point at which religious believers are morally compelled not simply to refrain from participation, but to dissent in the public arena using the processes of a democratic soci-

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ety to change public policy? This Essay engages some of these issues in the specific case of Roman Catholic physicians whose religious beliefs are becoming progressively counter-cultural on the so-called "human life" issues.¹ Roman Catholic physicians serve as paradigm cases for all whose religious beliefs compel them to refuse to participate in certain acts, which are legal and even "required" in their societal roles.² Although this Essay focuses on physicians are the focus, the same issues confront nurses, social workers, allied health workers, and all others who serve any function in our health care system. Similarly, although end-of-life issues will be used to illustrate particular conflicts of conscience, similar conflicts arise in other dimensions of modern health care, such as contraception, abortion, various types of assisted reproduction, sterilization, stem cell research, and cloning. This Essay will discuss only the ethical dimensions of the conflicts while others at this conference with the requisite legal expertise will discuss the legal aspects of conscience clauses.

Good law should be based on good ethics; in other words, the rights and claims it protects should carry moral weight and justification. Yet, in resolving conflicts of conscience in secular societies the complexity of the legal issues reflects the complexity of the ethical issues.³ Often they are extremely difficult to dissect. This 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.

For this reason, much more debate is required before conscience and exemption clauses can be applied in ethically defensible ways. The existence of a statutory protection does not assure the exercise of freedom of conscience. This Essay seeks to examine some of the ethical desiderata behind conscience clauses in the case of Roman Catholic physicians' conflicts of conscience. It does so under five headings: first, why conscientious objection is so important in our day; second, the moral grounding for freedom in the exercise of conscience; third, the components of the physician's conscience;

1. U.S. CATHOLIC CONFERENCE, CONGREGATION FOR THE DOCTRINE OF THE FAITH, INSTRUCTION ON RESPECT FOR HUMAN LIFE IN ITS ORIGIN AND ON THE DIGNITY OF PROCREATION, *DONUM VITAE* (1987) [hereinafter *DONUM VITAE*]; John Paul II, *Evangelium Vitae*, *Encyclical Letter*, 24 *ORIGINS* 690, 691-700 (1995) [hereinafter *Evangelium Vitae*].

2. *DONUM VITAE*, *supra* note 1, at 14-20, 35-39.

3. Mark R. Wicclair, *Conscientious Objection in Medicine*, 14 *BIOETHICS* 205, 210 (2000).

fourth, specific conflicts of conscience for Catholics physicians and institutions; and fifth, competing models of conflict resolution.

I. WHY CONSCIENTIOUS OBJECTION IS A PROBLEM

Convictions about the right and wrong conduct, both as a professional and as a person, form the physician's conscience. Conscientious physicians have always had to protect each domain from the demands of tyrants, law, custom, and professional colleagues. Each era has had its own challenges to the physician's conscience. In our own time, profound changes in both the physician-patient relationship and society's construction of the ends of medicine, as well as the secularization of American society, have conspired to the physician's claim to freedom of conscience.

Most powerful perhaps is the shift in the locus of decision-making from the physician to the patient or her surrogate. Beginning in 1914,⁴ extending through both the Karen Ann Quinlan cases⁵ and related cases in the 1970s,⁶ and the accompanying trend to micromanagement, the right to refuse care has rapidly metamorphosized into a right to demand and dictate the details of care. For some, the ends and goals of medicine are no longer defined solely by physicians, but by social convention or the demands of patients or their families.⁷ On this view, the physician practices by virtue of a social contract, which grants her profession the privileges of freedom to practice in return for provision of those services that society requires or demands. What constitutes the practice of medicine is societally determined. In Oregon for example, assisting suicide is defined as a normal part of the physician practice, whereas it is forbidden in other states.⁸

These trends are exacerbated by the de-professionalization of medicine, which views health care as a commodity, and its delivery

4. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93-94 (N.Y. 1914) (stating that a patient has the right to refuse treatment when doctors operate on a patient that explicitly stated that they did not want the operation).

5. See *In re Quinlan*, 355 A.2d 647, 671 (N.J. 1976) (installing father as guardian of comatose daughter "with full power to make decisions with regard to the identity of her treating physicians.").

6. See, e.g., *Rizzo v. United States*, 432 F. Supp. 356, 360 (E.D.N.Y. 1977) (granting patient a preliminary injunction preventing the Food and Drug Administration from prohibiting the importation of a drug not approved for his personal use).

7. Edmund D. Pellegrino, *The Goals of Medicine: How Are They To Be Defined?*, in *THE GOALS OF MEDICINE* 55, 58-60 (Daniel Callahan & Mark J. Hanson eds., 1999) [hereinafter Pellegrino, *The Goals of Medicine*].

8. Compare OR. REV. STAT. § 127.630, 127.635, 127.640 (1996), with ARK. CODE ANN. § 5-10-106 (2001); CAL. PENAL CODE § 401 (1999).

a matter of corporate enterprise, profit, and commercialization.⁹ A managed care organization now monitors and controls physicians' decisions.¹⁰ Corporate policy circumscribes the physician's judgments of conscience about the patients' welfare. Recent professional organizations are trying to recapture professional commitment, but it may not be possible given the fact that most physicians are now employees of corporate entities.¹¹

In such a society, such profoundly religious issues as the morality of abortion, euthanasia, human cloning, and stem cell research are determined on grounds of utility, general consensus, or freedom of choice. In the secular philosophy, there is no other world beyond the immediate utopianism of a man-made heaven on earth. This vision determines secular society's decisions about what is permissible and what is not.

All of this is occurring against the recent historical experience of past and present totalitarian governments subverting the uses of medical knowledge to political and economic purposes. We need not recite again the way the Soviet Union distorted the Hippocratic Oath to make it serve the purposes of Communism,¹² the Nazi physicians' acquiescence in using their knowledge in the service of genocide,¹³ or the participation of physicians as instruments of torture or terrorism by so many petty dictators and war lords.¹⁴ The laws and social conventions of pathological societies justified all these violations of the ethics of medicine.

Today's societal context poses serious conflicts of conscience for all physicians, but especially for the religious physician. The teachings of the Roman Catholic Church on medical morals and human life issues go back half a millennium.¹⁵ Its present positions on

9. Edmund D. Pellegrino, *The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic*, 24 J. MED. & PHIL. 243, 244-51 (1999) [hereinafter Pellegrino, *Commodification*].

10. *Id.* at 253.

11. *Medical Professionalism in the New Millennium: A Physician Charter Project of the ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine*, 136 ANNALS INTERNAL MED. 243, 244-46 (2002), available at <http://www.annals.org/issues/v136n3/toc.html> (last visited Oct. 21, 2002).

12. Edmund D. Pellegrino, *Guarding the Integrity of Medical Ethics: Some Lessons from Soviet Russia*, 273 J. AM. MED. ASS'N. 1622, 1622-23 (1995) [hereinafter Pellegrino, *Guarding the Integrity*].

13. HENRY FRIEDLANDER, *THE ORIGINS OF NAZI GENOCIDE: FROM EUTHANASIA TO THE FINAL SOLUTION* 216-45 (1995).

14. See generally MAXWELL G. BLOCHE, *URUGUAY'S MILITARY PHYSICIANS: COGS IN A SYSTEM OF STATE TERROR* (1987).

15. DAVID F. KELLY, *THE EMERGENCE OF ROMAN CATHOLIC ETHICS IN NORTH AMERICA* 25 (1979).

many crucial issues are distinctly and unapologetically ethically counter-cultural.¹⁶ Many Jewish, Protestant, and Moslem physicians share some of the same beliefs and experience equivalent challenges to their moral integrity. Clearly, for all religiously oriented physicians the question must be addressed—is it possible to maintain moral integrity and remain an active physician in a secular world? Secularists ask the same question, but with different expectations about what would be a morally defensible response.

It was against the background of these changes in the climate of American medicine and its practice that conscience clauses made their appearance. In 1973, when the United States Supreme Court removed the prohibition against abortion, a medical procedure was legalized, which at that time and since, was morally repugnant to many physicians and the public.¹⁷ In recognition of these objections, the United States Congress passed legislation that exempted physicians and others from participation.¹⁸ Most of the states¹⁹ and other countries²⁰ also enacted exemption legislation, which allowed those who objected to abortion and a variety of other procedures to refrain from participation.

Several decades later, individual states recognized patient's legal right to execute advance directives through a living will or a durable power of attorney for health.²¹ The resulting statutes were designed to guarantee a patient's right to direct the manner and extent of end-of-life care when she had lost the capacity to make her own decisions to accept or refuse treatment.

The Americans with Disabilities Act reaffirmed this right and required hospitals to inquire on admission whether patients had executed an advance directive.²² If they had, the hospital was

16. DONUM VITAE, *supra* note 1, at 12-13, 16-20, 23-25, 32-38; *Evangelium Vitae*, *supra* note 1, at 691-700, 709-16; Pope Paul VI, *Encyclical Letter of Pope Paul VI Humanae Vitae: To Our Dearest Sons and Brothers Health and Apostolic Blessing*, in HUMANAE VITAE AND THE BISHOPS: THE ENCYCLICAL AND THE STATEMENTS OF THE NATIONAL HIERARCHIES 33, 37-44 (John Horgan ed., 1972).

17. See generally *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (holding that abortion is a fundamental right guaranteed by the due process clause of the Fourteenth Amendment).

18. 42 U.S.C. § 300a-7(b) (1999).

19. Wicclair, *supra* note 3, at 207 (citing L.D. Wardle, *Protecting the Rights of Health Care Providers*, 14 J. LEGAL MED. 177, 177-230 (1993)).

20. M.L. DiPietro, *Evoluzione Storica dell'istituto, dell'obiezione di coscienza*, 6 ITALIA MEDICINA E MORALE 1093, 1093-1151 (2001).

21. E.g., ARK. COD. ANN. § 5-10-106(d) (Michie 1987); LA. REV. STAT. ANN. § 40:2233 (West 2001); OKLA. STAT. ANN. tit. 63, § 3101.4 (West 1997).

22. 42 U.S.C. § 1395cc(f); 28 C.F.R. § 35.130(e)(2) (2001); see also *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 269-70 (1990) (inferring the necessity of inquiry into a

bound to respect its requirements.²³ Similarly, in the case of abortion, Congress recognized that some physicians would have moral objections to participation, so they were exempt provided they transferred care to another physician.²⁴ In both cases, abortion and advance directives, the moral claim to freedom of conscience was given legal status in “conscience clauses.”

II. MORAL FOUNDATION FOR CONSCIENTIOUS OBJECTION AND CONSCIENCE CLAUSES

Freedom of conscience, however, is a moral right.²⁵ The first axiom of a moral life is to do good and avoid evil. This remains true whatever theory of right and wrong one may hold, whether one is a moral absolutist or relativist, a deontologist or utilitarian, or a communitarian or a social constructionist. Every moral system undertakes to determine what is right and wrong, good and evil, and desires that its worshippers act so that one may be done and the other avoided. This remains true whatever substitute term moralists may use for good and bad, and even if they deny their existence. “Values” is now the term in favor. Values are labeled “good” or “bad,” morally “wrong” or “right.” Values are replacing terms like principles, duties, and virtues; thereby, equating the normative with the subjective.

All humans, ethicists included, possess an inner conviction of what is right and wrong and feel compelled to act in accord with that judgment. That inner conviction is the result of an act of practical reason applied to the moral status of an act performed in the past, or yet to be performed.²⁶ In the Catholic tradition, conscience is called “the law of our intellect” because it is a judgment of reason deduced from natural law.²⁷ In the Catholic tradition,

patient’s desire to refuse treatment as the natural corollary of the duty to obtain consent).

23. 42 U.S.C. § 1395cc(f)(1)(D); see generally *Cruzan*, 497 U.S. at 269-70 (discussing the right of a competent adult to leave express instructions declining consent to life sustaining medical treatment).

24. 42 U.S.C. § 238n.

25. Rev. Donald W. Wuerl, *The Bishop, Conscience and Moral Teaching*, in CATHOLIC CONSCIENCE FOUNDATION AND FORMATION 123, 127-28 (Russell E. Smith ed., 1991).

26. THOMAS AQUINAS, *On Conscience. Disputed Questions on Truth* 17, in THOMAS AQUINAS SELECTED WRITINGS 217, 221-23 (Ralph McInery ed. & trans., 1998) [hereinafter AQUINAS, *On Conscience*].

27. *Id.* at 224-26; THOMAS AQUINAS, I THE SUMMA THEOLOGICA OF ST. THOMAS AQUINAS question 79, at art. 13 (Fathers of the English Dominican Province trans., 1920), available at <http://www.newadvent.org/summa> (last visited Sept. 29, 2002) [hereinafter AQUINAS, SUMMA THEOLOGICA].

and in other moral traditions as well, the judgments of conscience are morally binding, i.e., they must be followed or the moral agent has acted immorally and accountably.²⁸ The act of conscience may be in error about the facts, it may reason erroneously, and it may misunderstand or misapply the moral precept it is using.²⁹ However, when it is convinced that it has seized upon the right thing to do, conscience impels the person to act in a certain way.³⁰ To ignore this “inner voice” is to induce guilt, remorse, and shame. Only the amoral sociopath escapes the grip of conscience.

Errors of conscience occur when an individual misidentifies the good.³¹ The person who follows a wrongful conscience may or may not be morally culpable depending upon whether her ignorance of the good is willful or culpable.³² Roman Catholics are bound to follow the dictates of conscience, but they are also responsible for the formation of a good conscience.³³ This requires serious education and reflection on the content of official church teachings.³⁴ Nominal “Catholics,” who firmly believe that fidelity to conscience dictates opposition to church teachings on the issues of human life and sexuality, are arguably examples of wrongly formed conscience.³⁵ Their “consciences” compel them to oppose official (Magisterial) teaching, which, for Catholics, is a source of authoritative guidance for conscience formation.³⁶

To act against the dictate of conscience is to act against natural law—that portion of divine law accessible to human reason. But, for Catholics, conscience is also “said to be of divine insertion, in the way in which all knowledge of the truth that is in us is said to be from God, by whom the knowledge of first principles has been placed in our nature.”³⁷ Hence, for the Catholic, to then ignore, repress, or act against conscience for any reason is a violation of

28. AQUINAS, *On Conscience*, *supra* note 26, at 228-33 (stating “[t]hat conscience binds means that when one does not follow it he incurs sin.”).

29. *Id.* at 226-28. Aquinas claims that conscience is a science that never errs, but rather, any errors occur from the application of this science to “some special act.” *Id.* at 226.

30. Wuerl, *supra* note 25, at 127-28.

31. AQUINAS, *On Conscience*, *supra* note 26, at 226-27.

32. *See id.* at 234-36 (claiming that not following an erroneous conscience would constitute a sin, but that actively pursuing this erroneous conscience is also a sin).

33. Rev. Benedict Ashley, *Elements of a Catholic Conscience*, in CATHOLIC CONSCIENCE FOUNDATION AND FORMATION, *supra* note 25, at 39, 48-52.

34. *Id.* at 50-52.

35. Frances Kissling, *The Place for Individual Conscience*, 27 J. MED. ETHICS ii24, ii25-27 (2001).

36. Ashley, *supra* note 33, at 50-52.

37. AQUINAS, *On Conscience*, *supra* note 26, at 225.

philosophical as well as theological ethics, an error in moral agency and a sin against God.³⁸ In an analogous way, similar gravity would attach to violations of conscience in all moral systems, religious or secular. Though the idea of a “human nature” is in disfavor today, the conclusion is inescapable, that there exists in all but the most morally obtuse, an operative conscience, a sense of moral compulsion to follow its dictates, and a perception of ethical disquiet in not doing so.

In every belief system, fidelity to conscience is closely identified with the preservation of personal moral integrity. To arrive at a conclusion that something must be done or avoided, and to act accordingly, is to exhibit the kind of person one is, and wants to be. That act provides evidence that the individual is the kind of person she says she is. Not acting in accordance with this conclusion is to incur the justifiable charge of hypocrisy. Often, to act against conscience is to violate personal identity so directly as to lead to severe psychosocial and emotional sequelae.

Therefore, conscience 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. The practical question for positive law in framing legal conscience clauses is how to protect this claim in morally pluralistic societies. How can conscience clauses assure the individual right to conscience while at the same time recognizing how widely the content of conscience can vary between and among individuals in their personal, social, and professional roles? Whose conscience is to prevail in the worlds of individual relations and public policy?

This is a question that confronts all individuals in every walk of life. It is of growing significance in the profession of medicine with respect to doctor’s professional and personal beliefs and practices.³⁹ For Roman Catholics it is so crucial that Pope John Paul II

38. *Id.* at 228-33; see also Wuerl, *supra* note 25, at 127-28.

39. Thomas Faunce, *Peri-Gravid Genetic Screening: The Spectre of Eugenics and Medical Conscientious Non-Compliance*, 6 J.L. & MED. 147, 152-55, 161-66 (1999); Thomas May, *Rights of Conscience in Healthcare*, 27 SOC. THEORY & PRAC. 111, 111-21 (2001); Richard S. Myers, *On Laws: On the Need for a Federal Conscience Clause*, 1 NAT’L CATH. BIOETHICS Q. 23, 23-25 (2001); Carl A. Osborne, *How Can We Practice Veterinary Medicine Conscientiously?*, 215 J. AM. VETERINARY MED. ASS’N. 1238, 1238-39 (1999); Jing-Bao Nie, *Chinese’ Conscientious Acceptance of the Birth Control Policy*, 13 MED. HUMAN. REV. 82, 82-85 (1999) (reviewing CECILIA NATHANSEN MILWERTZ, *ACCEPTING POPULATION CONTROL: URBAN CHINESE WOMEN AND THE ONE-CHILD FAMILY POLICY* (1997)).

has called on physicians to be conscientious objectors with respect to pro-abortion and pro-euthanasia legislation.⁴⁰

III. THE PHYSICIAN'S CONSCIENCE

Physicians, in the course of their work as healers, must form their consciences in two inseparable dimensions of their lives—the professional and the personal. Professional conscience concerns itself with two facets of the physician's daily work. First, the ethical propriety of her conduct qua-physician with references to the moral duties of the physician-patient relationship. Second, is the moral obligation to practice "good" contemporary medicine, i.e., medicine that is scientifically competent and humane. Personal conscience deals with the physician's own moral beliefs of a spiritual, philosophical, cultural, and ethnic nature. Both professional and personal conscience are owed protection.

A. Conscience in Physician-Patients' Relationships

One set of obligations relates to such matters as the construct one puts on the physician-patient relationship, is it a contract, a covenant, a commodity transaction, a service relationship—or a vocation? How much respect for patient autonomy is obligatory? Do the patients' "values" override the physician's beliefs? What is a just allotment of scarce resources in a given case? How absolute is the obligation to preserve confidences? Should physicians have sexual relationships with patients? Is the patient's good primary, or is society's? Is the physician-patient relationship simply whatever is negotiable between them?

In the past, one might have assumed that a more or less general consensus existed among physicians on these issues even though there always were individual lapses in application. The Hippocratic ethic was the moral *lingua franca* of physicians across history and cultures.⁴¹ Today, consensus on the precepts of the Hippocratic ethic has been seriously eroded. Individual physicians and

40. John Paul II, *Doctors Protest Conscience Discrimination, The Holy Father's Address to the International Congress of Catholic Obstetricians and Gynecologists*, 48 DOLENTIUM HOMINUM 65, 65-66 (2001) [hereinafter John Paul II, *Doctors Protest*]; John Paul II, *The Medical Doctor Should Respond as a Conscientious Objector to Legislation in Favor of the Crimes of Abortion and Euthanasia*, 15 DOLENTIUM HOMINUM 133, 133-35 (2000) [hereinafter John Paul II, *The Medical Doctor*].

41. See generally Edmund D. Pellegrino, *Bioethics at Century's Turn: Can Normative Ethics Be Retrieved?*, 25 J. MED. & PHIL. 655, 655 (2000) (discussing the growth of bioethics from traditional medical ethics) [hereinafter Pellegrino, *Bioethics at Century's Turn*].

their professional organizations now hold different positions on the moral status of their relationship with patients.⁴² One cannot assume any longer a common formation of professional conscience, or a shared conception of ethical physician behavior. Physicians in our day may act in accord with their consciences with drastically different and even contradictory presuppositions about what is morally permissible in their relations with patients.

B. Conscience in the Practice of Competent Medicine

A lesser, but nonetheless significant element in the physician's conscience, is her perception of what constitutes "good" medicine. This is a subtle combination of personal and professional morality. Its focus is on medicine as a *tekné*, an art based in skills and knowledge of how to heal well.⁴³ While there are skeptics who would argue that we cannot define what "good" medicine is, there is the fact that we all distinguish between doctors whose judgments and skills we trust, and those we do not. There are also the inescapable differences among physicians in terms of morbidity, mortality, and diagnostic accuracy. Doctors may also differ, as a matter of conscience, in their opinions about the worth of new and old procedures, consultants they do and do not trust, the reliability of clinical data, the use of alternative or complementary medicine, and the role of other health team members. These can be matters of conscience for the physician who wants to be a "good" clinician, surgeon, healer, or counselor; the better to serve the best interests of the patient.

We will consider later whether or not this heuristic dissection of professional and personal ethics is sustainable in actuality or in light of conscience clauses.⁴⁴ First, let us turn to a few illustrations of the way these three sectors of the physician's conscience can conflict in her relationship with patients and then with the demands of our secular democratic societies.

42. See, e.g., *Mich. v. Kevorkian*, 639 N.W.2d 291, 311-12 (Mich. Ct. App. 2001) (demonstrating the spectrum of physicians' interpretations of the Hippocratic Oath's medical ethics according to their conscience).

43. *Tekné* is an ancient greek term that characterizes actions and professions as an art or craft rather than just a normal action. OXFORD CONCISE ENGLISH DICTIONARY 1471 (10th ed. 1999) (origin of the word techno-).

44. See *infra* Part VII.

C. Conscience in Personal Moral Beliefs

In addition to her perception of professional ethics, each physician brings to her relationship with the patient a personal set of moral beliefs. She bases these moral beliefs in religious affiliation, personal preference, or moral reflection. Here we confront such crucial issues as the licitness of abortion, euthanasia, assisted suicide, in vitro fertilization, and stem cell research—the whole Pandora's box of “human life” issues, emerging from our unprecedented control of every phase of human life.

These issues center on how we value human life itself, its purposes, quality, destiny, and utility. Conflicts of belief in this realm are more profound and deeply felt in one's conscience than other issues of professional behavior with patients. For religious individuals of many persuasions, these issues bear directly on their personal spiritual destinies and are, therefore, least subject to compromise.

In the last fifty years, secularism has come to dominate much of medical ethics, despite the fact that most Americans personally hold religious beliefs.⁴⁵ Secularism is a response to the plurality of moral and religious beliefs in our polyglot society in which there is wide disagreement on what a good conscience should dictate. Since no one moral system or religious set of beliefs is universally accepted, society reasons that none can, or should be dominant. All should be free to express themselves, and each should respect the other. So goes the credo of political liberalism. On this view, decisions that must be made as a matter of public policy in areas such as abortion, euthanasia, and stem cell research, should be made democratically, universally, and equally binding. Conscience or exemption clauses presumably are devised to protect the freedom of the dissenter. Without dissecting its merits or demerits, this liberal democratic policy has functioned to avoid civil strife. However, the recent erosion of the number of beliefs held in common, and the increasingly varied demography of our nation, has magnified the complexity and depth of our differences about what is morally right and wrong. The secular solution of moral or value neutrality has generated genuine conflicts of conscience.

Religious exemption laws and conscience clauses have appeared as a device to protect the physician's conscience. Their inade-

45. See Frank Shakespeare, *A View from Administration and Government*, in CATHOLIC CONSCIENCE FOUNDATION AND FORMATION, *supra* note 25, at 259-64 (discussing the evolution of our society into a secular state).

quacy, however, is becoming manifest. Lawmakers have currently drafted some of those clauses so narrowly that they disqualify most religious institutions from exemption, especially if they are involved in providing assistance and social services irrespective of the religious persuasions of those they help.⁴⁶ On these grounds, Catholic institutions are simply not religious enough unless they help the sick and needy for distinctly religious purposes. If they are to be classified as “religious,” Catholic institutions must serve only Catholics.⁴⁷ On the other hand, if they do so, they are disqualified since they would then discriminate against, and take advantage of, the vulnerable, sick, and poor.

Moreover, secular morality, which supposedly tolerates differences, does so only within a narrow range of so-called “values” that are supposedly “free” of moral or religious taint. But secular morality is itself an orthodoxy. Its “values” are based in democratic procedures, personal preference as the basis for moral choice, commitment to a free market economy, the commodification of health care, and an eschewal of religious belief.⁴⁸ To deviate from this notion of moral “neutrality” in public policy is to be “undemocratic,” prejudiced, and intolerably sectarian.

This is not the place to challenge these dicta of secularism as a ruling orthodoxy, but to spell out in more detail their implications for Catholic Christian physicians’ freedom of conscience. Again, the Catholic physician is the focus, but the same conflicts would apply to any other religious or moral system with a clear and unequivocal set of precepts giving substance to the conscience of its followers. The conflicts can be divided into three groups: first, between patients and physicians,⁴⁹ second, between physicians and society,⁵⁰ and third, between Catholic institutions and society.⁵¹

46. Myers, *supra* note 39, at 23-26; Msgr. Dennis Schnurr, *Mandating Employer Coverage of Contraceptives: Protecting Conscientious Objection*, 30 ORIGINS 161, 163-64 (2000).

47. *Cath. Charities of Sacramento, Inc. v. Super. Ct.*, 109 Cal. Rptr. 2d 176, 183 (Cal. Ct. App. 2001), *petition for review granted*, 31 Cal. Rptr. 2d 258 (Cal. 2001); *Religious Refusals and Reproductive Rights*, REPROD. RTS. UPDATE, 2002, at 8, available at http://www.aclu.org/issues/reproduct/refusal_report.pdf (last visited Sept. 24, 2002).

48. Pellegrino, *Bioethics at Century's Turn*, *supra* note 41, at 655, 663-64.

49. *See infra* Part IV.A.

50. *See infra* Part IV.B.

51. *See infra* Part IV.C.

IV. CONFLICTS OF CONSCIENCE FOR CATHOLIC PHYSICIANS

A. Conflicts Between Patients and Physicians

Physicians and patients may differ sharply in what their consciences tell them about the moral licitness of assisted suicide, euthanasia, the dignity and worth of human life, the relative importance of quality of life, age, or economics as criteria for withholding or withdrawing life-sustaining treatments, terminal sedation, or whether death of the whole brain and partial brain death are both equivalent to the death of the patient. The same is true of cloning, stem cell research, and fetal tissues transplantation.

Some would argue that the principle of patient autonomy should prevail in such conflicts, and that the physician, irrespective of her own beliefs, should provide whatever secular social convention legally allows.⁵² On this view, medicine is bound by a social contract to provide the services patients or society deem worthwhile. This obligation is in return for society permitting them to set its own standards of education and practice. In addition, they would claim that it is a failure of the principle of beneficence not to do what the patient believes to be in her best interests. Still, others might reduce the argument to one of commutative justice, holding that the patient is entitled to the same care available to other patients whose doctors do not suffer from the Catholic doctor's scruples against abortion, euthanasia, or other human life issues.

At present, Catholic physicians may withdraw from the care of patients in these circumstances. However, one wonders how long this exemption will survive, as end-of-life and reproductive decisions become so much an individual prerogative that the ethical standard is no longer a determination of what is morally right, but rather, of what can be negotiated to resolve conflicts.⁵³ One can foresee the day when patients may gain legal rights to demand a full range of death "services" from every licensed physician just as many today feel entitled to a full range of reproductive "services."

Already we hear ethicists suggesting that physicians must separate their personal moral beliefs from their professional lives if they wish to practice in a secular society and remain licensed as fully functioning physicians.⁵⁴ If universal health-care were to be

52. Cf. May, *supra* note 39, at 111-12 (suggesting that there are certain situations in which a health care professional could acknowledge her moral concerns with particular treatment choices).

53. Pellegrino, *Bioethics at Century's Turn*, *supra* note 41, at 656-57.

54. See Jeffrey Blustein & Alan R. Fleishman, *The Pro-Life Maternal-Fetal Medicine Physician: A Problem of Integrity*, HASTINGS CENTER REP., Jan.-Feb. 1995,

instituted and "death care," as well as birth and reproductive care, were to be entitlements, would Catholic physicians be given only limited practice licenses?

This same question could logically be raised, for example, with respect to stem cell therapy. Using stem cells derived from the killing of human embryos is morally offensive to Catholic physicians. If the therapeutic potentials of stem cell research, genetic engineering, and cloning are actualized, could a conscience clause protect Catholic physicians in secular hospitals or in managed care organizations? Would they not be legally required to provide a full range of services despite moral objection? In an HMO would the commercial gains of services patients demand trump a conscience clause? Would religious physicians be hired in the first place?

B. Conflicts with Societal Mores

It has already been seriously suggested that Catholic physicians should not become maternal child specialists, since they cannot, in good conscience, provide the whole range of reproductive, pregnancy, and neonatal "services," such as, selective abortion for genetic defects, or late-term abortion.⁵⁵ The logical next step of such proposals is to withhold specialty certification for maternal medicine from Catholic physicians and others who oppose provision of any such services, which are legal. Should anyone who wishes to be a physician be permitted to narrow the range of services to her patients on the basis of moral and religious reservations? A medical education is a socially sanctioned process in which students learn by doing.⁵⁶ Some would argue that the physician's social contract requires her to provide what she has learned in accord with whatever society needs because society granted the privileges of a medical education in the first place.

These are not imaginary scenarios. Catholic and other religiously committed applicants to medical school have been asked about their views on the issues of abortion, euthanasia, ending life support, various reproductive technologies, and stem cell re-

at 22-26 (discussing the dilemma faced by physicians who must perform abortions and maintain their own integrity); Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, HASTINGS CENTER REP., May-June 1995, at 8-17 (analyzing the relationship between professional integrity and physician-assisted suicide).

55. See Blustein & Fleishman, *supra* note 54, at 25.

56. Edmund D. Pellegrino, *Philosophy and Ethics of Medical Education*, in 2 THE ENCYCLOPEDIA OF BIOETHICS, 860, 863-69 (Warren T. Reich ed., 2d ed. 1978).

search.⁵⁷ Evidence that responses consistent with Catholic teaching have militated against admission is hard to come by for obvious legal reasons. Therefore, we do not know how heavily medical schools weigh the “Catholic” responses against a candidate. The fact that they asked the questions in the first place, is sufficient cause for worry given the dominance of the secular viewpoint in academic circles today.

Based on personal experience on admissions committees, there is more than a mere suspicion that “conservative” Catholics, Orthodox Jews, and fundamentalist Christians may be looked upon with disfavor. Much depends on the lottery of interviewers one encounters by chance. Those who hold certain religious beliefs, it is argued, cannot provide all the services patients have a right to expect. Whether we shall ever come to the point at which religious believers who insist on following their consciences will be barred from certain specialties or from medicine itself is, therefore, a source of more than imaginary concern.

C. Conflicts Between Catholic Institutions and Society

Organizational ethics is the newest addition to the broadening spectrum of ethical issues being subsumed under the term “bioethics.”⁵⁸ While it may include business ethics, it covers much more, and already embraces such varied aspects of institutional behavior as relationships with employees, advertising, community commitments, quality of care for the poor and uninsured, and mergers with other institutions.

Organizational ethics is a systematic examination of the morality of collective actions in human institutions dedicated to some specific purposes in society.⁵⁹ 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.⁶⁰ All who work in that institution are in some way accountable for adherence to the organizational mission, which is in effect a promise by the institution to behave in a particular way. Catholic institutions in America have for a long time had specific ethical

57. *Id.*

58. Susan Dorr Goold, *Trust and the Ethics of Health Care Institutions*, HASTINGS CENTER REP., Nov.-Dec. 2001, at 26, 27-28.

59. *Id.* at 32.

60. *Id.* at 28.

directives that define them as Catholic hospitals.⁶¹ They are also committed to a charitable, even preferential treatment for the sick and the poor.⁶² Catholic hospitals can properly be considered to have a definable institutional “conscience,” one, which given the content of the Catholic moral tradition, could and does come into conflict with secular society and its “values.”⁶³

The ethical content of the institutional conscience of particular hospitals is well known with respect to sterilization, abortion, euthanasia, assisted suicide, contraception, and cooperation through mergers with other institutions that accept these practices.⁶⁴ Fidelity to these prohibitions is not negotiable.⁶⁵ It applies to all who practice in these hospitals regardless of their personal beliefs. Catholic hospitals, like Catholic physicians, do not have the option of being “value-neutral” or of separating religious from professional ethical precepts.

There is growing evidence that public funding for Catholic health care and social service institutions may be in jeopardy if these institutions do not provide the “full range” of reproductive services. For example, the District of Columbia City Council recently passed a bill mandating that all employers in the city had to provide coverage for contraceptives in their prescription coverage plans.⁶⁶ The move to include a conscience clause to exempt Catholic institutions was rejected vitriolically by one member of the Council.⁶⁷ Fortunately, the mayor, a Catholic himself, gave the bill a pocket veto.⁶⁸

This sort of challenge to institutional conscience is certain to return in one way or another. Some who oppose Catholic moral teaching vehemently and frankly admit to wanting to eliminate the Catholic health care system and at the least deny access to public funds.⁶⁹ The more moderate alternative is to interpret exemption clauses so narrowly that Catholic institutions cannot be classified as “religious” institutions since they treat all regardless of belief and provide much more than religious services.⁷⁰

61. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL DIRECTIVES FOR CATHOLIC HEALTH CARE INSTITUTIONS 9-11, 13-16, 18-22, 25-28, 30-33, 36-37 (4th ed. 2001), available at <http://www.nccbuscc.org/bishops/directives.htm> (last visited Oct. 2, 2002).

62. *Id.* at 8-11.

63. *Id.* at 12-16, 23-33.

64. *Id.* at 8-16, 23-37.

65. *Id.*

66. Schnurr, *supra* note 46, at 161-63.

67. Myers, *supra* note 39, at 23-26; Schnurr, *supra* note 46, at 164.

68. Schnurr, *supra* note 46, at 161-63.

69. Myers, *supra* note 39, at 23-26.

70. *Id.*

The challenge to institutional conscience promises to grow in severity as new, morally questionable therapeutic procedures emerge from the laboratories and research centers. There is a genuine probability that stem cell research of the kind that depends on the death of embryos, human cloning for therapeutic purposes, or cross species genetic manipulation will eventually be allowed.⁷¹ Should these measures become clinically effective, the public demand for their availability will increase the pressure for conformity by all hospitals regardless of religious affiliation.

Even if Catholic hospitals are allowed the protection of exemption clauses there is still the more subtle threat to the conscience, stemming from cooperation with secular institutions through mergers. These mergers may be dictated by the need for economic survival, but such survival cannot be bought at the cost of even material cooperation of a direct kind with institutions that violate the established ethical directives for Catholic health care institutions. Already there is concern that mergers already in existence may involve Catholic hospitals too closely with activities that are morally objectionable.⁷² Can these Faustian bargains survive closer moral scrutiny?

Catholic moral tradition contains a carefully nuanced set of conditions under which cooperation with those individuals or institutions that do not share Catholic moral beliefs may be licit.⁷³ Considerable controversy has already arisen as to whether the interpretation of these conditions in some mergers has been too lax. This is the case even where the non-Catholic partner promises to abide by the ethical directives of the Catholic bishops.⁷⁴ Commingling of funds, administrative entanglements, and other interminglings characteristic of today's complex institutional relationships raise serious questions of illicit cooperation in seemingly "safe" mergers.⁷⁵ Exemption and conscience clauses in these mergers or in the relationships with public policy may not be sufficient to permit financial viability for Catholic health care systems. Much depends on how well Catholic institutions can maintain their moral integrity and institutional conscience. Catholic health care institutions constitute a very significant sector of service for Americans,

71. *Id.*

72. U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 61, at 34-37.

73. See generally ORVILLE N. GRIESE, CATHOLIC IDENTITY IN HEALTH CARE: PRINCIPLES AND PRACTICE 373-416 (1987).

74. U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 61, at 34-37.

75. *Id.*

Catholic and non-Catholic.⁷⁶ If these institutions do not survive financially, the loss to the general public will be great. If they survive only by a loss of their institutional Catholic conscience, something even more fundamental will be lost, not just for Catholics, but for that sector of the American public who, for their own moral integrity, cannot accept the dictates of a secular order.

VII. CONFLICTING MODELS OF CONFLICT RESOLUTION

How, in a morally pluralist society, can the moral claim to freedom of conscience owed to every person as a human being be sustained? Specifically, how can the Catholic physician or institution sustain freedom of conscience in a secular world whose culture is a-religious, if not anti-religious? What role might conscience clauses play? Several ways out of the dilemma have been suggested, none of them entirely satisfactory. They include: dissociation of the moral and professional life, abandonment of medicine as a profession, or maintaining moral integrity with judicious dissent.

It would be in keeping with secular orthodoxy to allow Catholic physicians and hospitals freedom of conscience, but to limit its overt exercise. Catholic physicians could have the right not to participate in medicine as a profession as long as they would do what is allowable by law (for example euthanasia in Oregon, abortion everywhere, sterilization, etc.). The only thing Catholics would need to do is to provide whatever services are defined by social convention as legal medical practice. On this view, all physicians, Catholic and others, whose moral beliefs are at odds with a secular society simply need to take a “value free” stance. In this way, the autonomy of the patient is preserved and the doctor does not “impose” her beliefs.⁷⁷ This is the strong version of value neutrality as the litmus test for medical licensure or certification.

In a weaker version, Catholic physicians could be granted the right to participate in medicine as a profession as long as they would agree to what is allowable by law or defined as part of medical practice by the rest of the profession. Catholics, for example, could object to euthanasia in Oregon, sterilization, abortion, reproductive technologies, and stem cell research. They could refuse

76. See *id.* at 34-36 (discussing how Catholic Healthcare institutions are forging partnerships and ventures with many other healthcare providers).

77. Blustein & Fleishman, *supra* note 54, at 22-26; Miller & Brody, *supra* note 54, at 8-17; Edmund D. Pellegrino, *Commentary: Value Neutrality, Moral Integrity, and the Physician*, 28 J.L. MED. & ETHICS 78, 78-80 (2000) [hereinafter Pellegrino, *Commentary*].

personally to participate. But in practice they would have to be “value neutral” if they entered specialties that required acts to which they had moral objection.

At the very least, they would have to commit themselves to arrange for referral to a physician they know would do what the patient wished and assist the patient in every way to achieve her purposes. On a stronger version of this form of accommodation, Catholic physicians would be compelled to make a clear choice, either fulfill the conditions of the social contract and provide what is legal or socially acceptable or drop out of any specialty, which required services of which they took moral exception.

In its strongest form this model would logically exclude from medical practice, and eventually the study of medicine, all who did not see their social roles as conforming to all the services society felt necessary and required of physicians. Needless to say, such a compromise as accommodation requires even in its mildest form would be morally objectionable for several reasons.

It assumes that the Catholic physician and others who hold firm moral beliefs can separate their professional and personal lives when this means cooperation with what is morally objectionable. For a physician with deep religious commitments, a “value free” stance on certain issues is simply unthinkable.⁷⁸ Certain matters are so clearly prohibited as inherently wrong that there is no possibility of compromise without compromise of moral integrity and danger to one’s spiritual well-being.

For Catholics, Orthodox Jews, and Moslems, the teachings of the Gospel, Torah, or Koran take precedence in their lives and indeed inspire their healing vocations. For these major religions, healing the sick is ultimately a religious act and it comes ultimately from God.⁷⁹ To practice medicine that contravenes religious teaching would be to subvert conscience to secular society and its “values,” to act hypocritically, and to violate moral integrity intolerably.

For Catholics this would also apply to the secular demand that those who must refrain from certain practice must refer physicians who will provide the disputed treatment or procedure would also be intolerable. To cooperate in an act which is regarded as inherently morally wrong, such as arranging for an abortion or assisted suicide, is to be a moral accomplice.⁸⁰ Respectfully, courteously, but definitively the religious physician must inform the patient of

78. Pellegrino, *Commentary*, *supra* note 77, at 78-80.

79. 38 *Ecclesiasticus (Sirach)* (Jerusalem Bible).

80. GRIESE, *supra* note 73, at 386-90.

her objection while promising to care for the patient until transfer or referral can be arranged by the patient, family, or social services.

Obviously the patient cannot be abandoned, legally or morally, and must be cared for until a transfer has been effected. The doctrine of cooperation does not forbid transferring information, findings, or records to another physician or hospital.⁸¹ Indeed, this is required in the interests of patient care. What is illicit is active cooperation in finding a physician who will provide the morally objectionable service.

The requirement of a secular society that physicians practice "value neutrality," is impossible to achieve. First, it is a psychological schism that violates the integrity of the person as a unity of body, soul, and psyche. What it amounts to is the elevation of secularism to the level of a social orthodoxy; thereby, violating one of the major tenets of secularism itself—that no ideology would have preference over any other.⁸² It also violates a prized precept of the secular, democratic, constitutional social order by discriminating against a significant segment of the population, and the physicians who share certain religious beliefs.

The difficulty of a meaningful compromise between the secular orthodoxy and religious belief is illustrated in those pragmatic attempts to find a way to respect moral integrity and the right of conscientious objection. For example, Wicclair would allow for conscientious objection as long as it corresponded to "one or more core values of medicine."⁸³ He would use congruence with these core values as the moral test for an acceptable claim to conscientious objection.⁸⁴

Wicclair offers a guide for assigning moral weight within recognized medical norms. For example, he gives more weight to preventing death than protecting confidentiality.⁸⁵ He takes his cue here from the integrity of the profession, rather than the integrity of the physician as a moral person.⁸⁶ In one of his examples, he clearly states that more moral weight should be given to a physician's request to preserve moral integrity as a physician than to her

81. *Id.*

82. *See also* May, *supra* note 39, at 111 (discussing the conflict that arises when a physician's values and conscience conflict with a patient's values and autonomy rights, and noting that society increasingly and unfairly pressures physicians to disregard their personal consciences in their professional roles).

83. Wicclair, *supra* note 3, at 217.

84. *Id.*

85. *Id.* at 223.

86. *Id.* at 224.

“moral integrity as an Orthodox Jew who happens to be a physician.”⁸⁷

In his guidelines, Wicclair clearly makes religious belief subservient to professional medical belief about what is right and wrong.⁸⁸ Its effect is to require the kind of value and belief dichotomy, which is incompatible with moral integrity for a true religious person. The moral values of religious persons transcend the “values” of the profession—especially now that those values have changed so drastically. Where there might have been concurrence in the past between medically-held and religiously-held beliefs, that congruence has been seriously eroded today.

Indeed, consensus on the moral values of medicine is being progressively reduced to competence, refraining from harm, and the protection of confidentiality. The recent set of commitments advanced by the American Board of Internal Medicine, the American Society for Internal Medicine, and the European Federation attempts to recover the idea of professionalization.⁸⁹ However, it omits the prohibitions against abortion and euthanasia, the precepts that are most significant for many religious physicians and especially for Roman Catholics. The “moral integrity” of the profession is thus judged to be morally insufficient to justify overriding the physician’s conscience.

The moral authority of professional codes does not derive from their acceptance by the profession or social convention.⁹⁰ Rather, the ethics of medicine is grounded in something more fundamental, namely the ethical obligation peculiar to what it means to be ill, to be healed, and to offer oneself as a healer.⁹¹

Respecting a physician’s conscience claims, however, does not mean that the physician is empowered to override the patient’s morally valid claim to self-determination. Both the physician and the patient as human beings are entitled to respect for their personal autonomy. Neither one is empowered to override the other. The protection of freedom of conscience is owed to both.

Therefore, patients have an uncontested moral right to informed consent and informed refusal.⁹² Wicclair and May spend consider-

87. *Id.* at 225.

88. *Id.*

89. *Medical Professionalism in the New Millenium: A Physician Charter*, 136 *ANNALS INTERNAL MED.* 243, 243-44 (2002).

90. Edmund D. Pellegrino, *Professional Codes*, in *METHODS IN MEDICAL ETHICS* 70, 74-76 (Jeremy Sugarman & Daniel Sulmasy eds., 2001).

91. *Id.* at 78-79.

92. Wicclair, *supra* note 3, at 208.

able time defending the patient's moral right to refuse treatment, prolong their life, request palliative care, or "reproductive freedom." This is not the issue here. Conscientious objection implies the physician's right not to participate in what she thinks morally wrong, even if the patient demands it. It does not presume the right to impose her will or conception of the good on the patient.

Therefore, May is correct in stating that, "[r]ights of conscience in health care must be exercised in the context of patients' rights to informed consent."⁹³ This does not at all imply that we should or must acknowledge limits on the physician's rights of conscience.⁹⁴ May agrees that patients do not have a right to demand "anything" they take to be beneficial.⁹⁵ Clearly the patient's moral and legal right to self-determination has limits, even in May's view.⁹⁶

Both May and Wicclair, but especially May, spend much time on examples of conflict in choice of treatment and somewhat miss the point of religious objections, which is not whether a religious believer may impose her beliefs on a patient, but rather whether she has the moral right to refuse to be an accomplice in an act her religion teaches is wrong.⁹⁷

The only ethically viable course for the religious physician is to maintain fidelity to moral integrity and the dictates of conscience while practicing in a secular world. Catholic physicians and institutions have the same moral claim to exercise of conscience, as all other humans, even when the fruit of conscience is refusal and even resistance to accommodation of secular beliefs or the changing beliefs of their professional colleagues. This moral claim entails the right and obligation to use the methods available in a democratic society to protest morally objectionable practices by persuasion, judicious political action, and public debate, particularly in the most egregious situations.

For such a position to be tenable, Catholic physicians must make their positions publicly known, as in the case with the Directives for Catholic Health Care Institutions. Individual physicians should prepare a leaflet outlining what they can, and cannot, in good con-

93. May, *supra* note 39, at 127.

94. Edmund D. Pellegrino, *Bioethics as an Interdisciplinary Enterprise: Where Does Ethics Fit in the Mosaic of Disciplines?*, in *PHILOSOPHY OF MEDICINE AND BIOETHICS: A TWENTY YEAR RETROSPECTIVE & CRITICAL APPRAISAL 1-23* (Ronald A. Carson & Chester R. Burns eds., 1997).

95. May, *supra* note 39, at 127.

96. *Id.*

97. *Id.*; Wicclair, *supra* note 3, at 205-11.

science do.⁹⁸ Patients should know in advance of a crisis that what they desire and believe to be morally acceptable may not be acceptable to the physicians they may be engaging.

Such advance knowledge will not be possible in emergencies or remote areas where the choice of physicians is limited. Even under these circumstances, the Catholic physician cannot violate her conscience to provide a morally objectionable procedure or treatment. Physicians must know their own belief system well enough to recognize where compromise is possible without loss of moral integrity and where it is not. Parenthetically, the Catholic physician is under serious obligation to know the content of her own faith, so that she does not impose hardship on the patient when alternative routes are morally permissible. Sadly, this is not always the case.

The dissenting physician must always treat her patient with respect, avoid moralizing condemnations, and explain the reasons for her moral objections. She must also be aware that every matter of conscience is not of equal gravity. Choosing when to take a morally dissenting stand is crucial if one's exercise of conscience is to be valid and respected.

The same prescriptions and proscriptions are applicable to the institutional conscience of Catholic health care institutions. They cannot compromise on fundamental Catholic moral teachings even if resistance might lead to their extinction. Total extinction is not likely, however, the withdrawal of public funds will probably restrict the number of persons in the community, Catholic or non-Catholic, that can be served by institutions faithful to their religious commitments. Although morally illicit, Catholic hospitals may also "cooperate" more fully with the secular mores.

Conscience clauses for physicians probably have a limited value, although they ought to be sought whenever possible. The likelihood, given the current societal mores, is that conscience clauses will be denied or progressively applied so narrowly as to be self-defeating. At the least they provide legal limits that in a democratic society should protect dissenting physicians and institutions from the grosser forms of ostracism.

Catholic institutions will probably find greater difficulty obtaining exemption clauses, especially if they accept public funds or purport to serve community needs. Survival may require formation of a Catholic health care system nationally. Mergers with non-Catholic institutions, except those that share Catholic perspectives

98. See *supra* notes 61-65 and accompanying text.

on the human life issues, will raise an increasing number of questions about cooperation. Given the size, geographic extent, and resources a Catholic health care system faithful to magisterial teachings is not an impossibility. Much would be lost were a secular society's dissonances to require the dissolution or "ghettoization" of Catholic health care.

All the societal and political forces of our day are converging on an actualization of the secular state. As medical technology endows humans with ever greater power over the reproduction, genetic endowment, and dying of our species, crises of conscience will surely increase for those who hold religious beliefs about human life, its creation, and ending. In democratic societies, there is a commitment to protection of the right to hold and exercise individual and institutional conscience.

Conscience clauses are straws in the wind telling all of us that public policy and individual conscience on some of the most important matters of human life may be on a collision course. How individual physicians and institutions preserve their moral integrity in such a socio-political milieu is a matter of significance for both secularists and believers.

Conscience clauses will help at least to establish a right to dissent. However, the conditions under which they will be applicable and their effectiveness are very much at issue. It will be a stringent test both of democracy and religious beliefs to see how these conflicts will be resolved.