

IN GOOD CONSCIENCE

RESPECTING THE BELIEFS OF
HEALTHCARE PROVIDERS
AND THE
NEEDS OF PATIENTS



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FOR
CHOICE

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Over the last few years those opposed to reproductive freedom have become more creative in placing hurdles in front of women seeking safe and legal reproductive health services. One of the more recent tactics involves significantly expanding the concept of refusal clauses (also known as exemption clauses or conscience clauses) beyond protecting the religious and moral beliefs of healthcare providers and, in effect, acting as a means to refuse some treatments and medications to all comers. Under the guise of protecting religious freedom, antichoice activists—with the backing of some members of the Catholic hierarchy—have aggressively used the political process to allow healthcare professionals, including doctors, nurses and pharmacists, to opt out of providing essential reproductive healthcare services and medications. The Catholic hierarchy—through the United States Conference of Catholic Bishops and the Catholic Health Association of the United States—has collaborated with antichoice organizations across the country both to suggest that the consciences of medical professionals are routinely violated and to expand the number of services that are considered to be subject to such an exemption. Today, many institutions struggle to formulate policies that balance the needs of patients with the beliefs of providers.

Most often, these refusal clauses (as we will refer to all such clauses that go beyond a true conscience clause) are promoted as a means of protecting the consciences of those healthcare providers who have a religious or moral objection to providing some or all reproductive health services. The Catholic teaching on conscience—one that

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stretches back to the earliest days of Christianity—is however, much more nuanced than the one that is usually presented in legal and policy debates.

This pamphlet has been written to give a brief overview of some of the key themes in the debate—how conscience clauses evolved, Catholic teachings on conscience and how the concept of conscience has been manipulated, especially within the context of reproductive health and rights. We hope that it will be useful for those who have an interest in healthcare ethics, those who may be negotiating conscience clauses in their own institutions and states as well as for those who may be considering their own positions on conscience clauses.

A Brief History of Conscience Clauses

Conscience clauses have gone through many permutations since they first appeared after the 1973 *Roe v. Wade* decision that permitted abortion in the US. Traditionally, these clauses sought to protect healthcare workers who refused to participate in certain healthcare practices such as the provision of contraception, sterilization or abortion, claiming that participation in these services violated their consciences.

The first refusal clause (passed in 1973) is known as the **Church Amendment** after Senator Frank Church (R-Idaho). It said that the receipt of federal funds does not require an individual or entity to provide abortion and/or sterilization if it “would be contrary to [the individual’s or entity’s] religious beliefs or moral convictions.” (42 USC § 300a-7(b)) It took a “neutral stance” towards abortion and sterilization with regard to employment. In other words, an institution receiving federal funding may not discriminate

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in hiring, firing, promoting or the granting of privileges to physicians or staff members based on their performance or on any refusal to perform sterilization or abortion.

We can see from the Church Amendment how, from the outset, refusal clauses claimed to balance freedom of conscience for the provider and the patient. Ostensibly, the amendment's "neutral stance" respects the consciences of providers who both agree to and refuse to perform some services. However, there is no stipulation that ultimately guarantees the provision of an abortion or sterilization to a patient.

More recently, the **Omnibus Consolidated Rescissions and Appropriations Act of 1996** banned state and local governments from discriminating against healthcare entities that refuse to provide abortion training, perform abortions or even provide referrals for abortions or abortion training. By refusing to even provide a referral, the Act becomes an infringement on the conscience of the patient by denying her the means to obtain an abortion in a safe, convenient and timely manner. Additionally, this law goes beyond being simply a conscience clause, and instead becomes a refusal clause since providers can deny service for any reason, not just on moral or religious grounds. (Jody Feder, "The History and Effect of Abortion Conscience Clause Laws," *Congressional Research Reports*, January 14, 2005, p2)

In addition, starting in 2005, the **Hyde-Weldon Amendment** was attached to appropriations bills for the Departments of Labor, Health and Human Services, and Education so that state and local governments could not deny federal funding to any "health-care entity"—defined

broadly to include health-insurance companies and HMOs as well as hospitals, clinics, etc.—that refuses to perform, pay for or refer for abortions. (Feder, op cit, p5)

Since 1973, 46 states have passed some form of refusal clause for certain professionals and medical institutions. Of those, 17 protect doctors who refuse to perform sterilizations and 14 allow providers to refuse to provide contraception-related services. Currently there are laws in **Arkansas, Georgia, Idaho, Mississippi** and **South Dakota** that specifically protect pharmacists who choose not to dispense emergency contraception. Colorado, Florida, Maine and Tennessee have more general refusal clause policies that don't mention pharmacists but would likely protect them. Illinois has a similar policy but also requires all pharmacies that stock contraceptives to dispense all contraceptive measures. In California, refusal is allowed if the pharmacist's employer approves and the woman can still get the contraceptive in a timely manner. (Guttmacher Institute, "State Policies in Brief," July 10, 2010) In addition, reports abound of doctors in general practice refusing to dispense regular contraceptives, a move that especially impacts women in rural communities who may not have any other medical providers nearby.

These refusal clauses have been heavily supported by both the **US Conference of Catholic Bishops** and the **Catholic Health Association** (CHA), the trade association of the Catholic health industry, representing the interests of Catholic healthcare providers on Capitol Hill and in state legislatures. (Roger J. Limoges, "Prescriptions Denied," *Conscience*, Autumn 2005, p36)

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Professional organizations such as the **American Public Health Association** deem refusal clauses as being appropriate only if they provide an adequate plan for referral and do not disrupt or obstruct a patient's access to care. In order to accommodate the rights of the patient, it is usually argued that professionals who refuse to provide a certain service do so consistently and inform their employers so that the proper arrangements can be made in a timely manner for patients who seek that service. This includes setting up a timely and convenient referral procedure to another convenient doctor, medical institution or pharmacy. For pharmacists, they must direct the patient to another pharmacist or a nearby facility that will provide the medication in a timely manner. If a medication cannot be provided by alternative means (e.g. through a referral) in a timely manner, the refusing pharmacist should then be required to dispense the medication. (American Public Health Association, "Preservation of Reproductive Health Care in Medicaid Managed Care," 2003, as cited in: Planned Parenthood Fact Sheet, "Refusal Clauses: A Threat to Reproductive Rights," p3)

The result of the expansion of refusal clauses is that women and men seeking legal reproductive healthcare services are routinely denied access to or have great difficulty in accessing these services.

Catholic Teachings on Conscience and Medical Ethics

While there are many definitions of conscience, nearly everybody recognizes it as an internal moral compass, a place where truth and guidance are revealed through the lens of personal values and an understanding of right and wrong. It is a central element of Catholic moral teaching and is derived from our free will which allows us to make truly voluntary choices. **Professor of Moral Theology Richard Gula from the Franciscan School of Theology in Berkeley, Calif.**, writing in Charles Curran's collection *Conscience* (Readings in Moral Theology, No.14, Paulist Press, 2004, p62), describes conscience as "our

fundamental capacity for moral discernment, the process of discerning and the judgment we make in light of the truth that we discover.”

Yet, while conscience has a vital internal aspect, in order for it to be fully exercised we must also be fully aware of how our decisions affect and are affected by external reality. In the long history of the Catholic moral tradition, this is referred to as the conflict between the subjective and the objective aspects of conscience. Subjectively, one’s conscience can possess an intention that is either sincere or insincere. Objectively, one’s conscience can possess information that is either true or erroneous. (Curran, p172)

Drawing from this framework, one’s conscience can take four forms. The ideal form is the true and sincere conscience; the worst form is the insincere and erroneous conscience. The other two forms are more ambiguous. However, the Catholic moral tradition grants primacy to the subjective aspect of conscience and therefore questions the moral value of acts resulting from a true but insincere conscience—e.g. donating money to help the poor just to impress others. When one’s conscience is sincere in intention but based on erroneous information, one’s error can further be subdivided into two forms: vincible ignorance—where you were negligent or should have known better—and invincible ignorance—where ignorance is justifiable and you need not act with a guilty conscience. (Curran, p172)

St. Thomas Aquinas argued simply that one must follow an erroneous conscience. In fact, he said that ignoring an erroneous conscience is a mortal sin—even if it means going against the teachings of a professional or religious superior. (Curran, p174)

In his letters, St. Paul grants primacy to one’s own conscience, yet he does not consider it to trump the conscience of others. He notes that “anything which does not arise from conviction is a sin,” (Romans 14:23), and also believes that sometimes it would be more loving to

refrain from exercising one's own conscience in order to demonstrate respect for the conscience of another, even if that other's conscience is erroneous. (John Maguire, *Conscience—A Cautionary Tale?*, Church Archivists Press, 1999, p34)

In post-Reformation Catholicism, theologians taught that conscience could be guided, but not forced in any direction. As Catholicism entered the age of the scientific revolution, it became more apparent that human beings needed to trust their own experience. Yet, as in the case of Galileo, the hierarchy often could not accept that evidence might require it to re-examine its own teachings. (Curran, p41) However, as the **1965 Declaration on Religious Freedom** noted,

“It is through his conscience that man sees and recognizes the demands of divine law. He is bound to follow this conscience faithfully in all his activity so that he may come to God, who is his last end. Therefore he must not be forced to act contrary to his conscience.”
(*Dignitatis Humanae*, Vatican II, 1965)

These teachings apply today in discussions about refusal clauses that are enacted to give, for example, pharmacists the right to deny emergency contraceptives to a patient on moral or religious grounds. A Catholic pharmacist does not have to deny emergency contraceptives to a customer in order to be considered a good and faithful Catholic. In fact, as explained further below, Catholic teaching requires due deference to the conscience of others in making decisions—meaning that the pharmacist must not dismiss the conscience of the person seeking emergency contraception.

As Gula argues, “If a person spends his or her life doing what he or she is told to do by someone in authority simply because the authority says so, or because that is

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the kind of behavior expected by the group, then that person never really makes moral decisions which are his or her own. For moral maturity, one must be one's own person. It is not enough to follow what one has been told." (Curran, p58) Others agree. A Catholic should never feel as though she or he must accept without question the teachings of the church to prove loyalty to the institution. To do so, as **Professor of Moral Theology Timothy E. O'Connell at Loyola University in Chicago** rightly asserts, "is ultimately to violate the nature of the church, the nature of humanity, and surely the nature of conscience." (Curran, p36)

We are regularly reminded about the primacy for freedom of conscience when it differs from or conflicts with official church teaching. Pope Pius XII noted that "out of respect for those who are in good conscience ... and are of a different opinion, the church has felt herself prompted to act, and has acted, along the lines of tolerance." (Curran, p48)

Fr. Richard P. McBrien, Professor of Theology at the University of Notre Dame in Indiana, concurs in his widely respected book *Catholicism* (HarperSanFrancisco, 1994, p973): "If ... after appropriate study, reflection, and prayer, a person is convinced that his or her conscience is correct, in spite of a conflict with the moral teachings of the church, the person not only may but must follow the dictates of conscience rather than the teachings of the church."

Today, most Catholics exercise their conscience against some of the pope's more well-known public policy pronouncements. For example, with respect to contraception, 75 percent of US Catholics believe that the church should allow contraception and fully 97 percent of sexually active Catholic women say they have

used a contraceptive method banned by the hierarchy. (Limoges, p36)

In light of Catholic teachings on the primacy of conscience, the public policy efforts of the hierarchy should take into account the experiences of individual Catholics as well as the beliefs of patients and healthcare providers of other faiths and no faith so that patients would not be refused any legal and medically appropriate treatment. Moreover, good practice should also compel the employer to make sure that the consciences of both the employee and the patient are accommodated by, for example, having policies in place that enable patients to receive whatever medications they are prescribed.

Unfortunately, that has not been the case.

To take a specific example, the *Ethical and Religious Directives for Catholic Health Care Services* of the US Conference of Catholic Bishops, although strict and traditional when it comes to the denial of emergency contraceptives, still allows material evidence to come into play in one telling circumstance. When a woman who has suffered a sexual assault comes to a Catholic hospital, she is allowed to be given emergency contraception if it can be determined that fertilization has not taken place. (Directive 36) However, within the timeframe that EC requires (72 hours), there is no test that would show whether fertilization had occurred. As a result, practices among Catholic hospitals are inconsistent. The most frustrating fact about all of this is the willful ignorance of the USCCB of the documented evidence that progestin-only emergency contraceptive pills—such as Plan B, which is available over the counter—work only by preventing ovulation or fertilization and do not act as

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abortifacients nor do they affect an already-fertilized embryo. (Planned Parenthood Fact Sheet, "Obstructing Access to Emergency Contraception in Hospital Emergency Rooms," 2005, p1) Given this evidence, there is no excuse not to provide a woman who has been the victim of sexual assault with progestin-only emergency contraceptive pills.

If conscience truly is one's "most secret core and his sanctuary [where] he is alone with God, whose voice echoes in his depths," as the *Catechism* states, how can anyone, or any institution for that matter, justify coercing someone into acting contrary to her or his conscience? Could it be that the Catholic hierarchy only wants people to follow their consciences if those consciences are in agreement with the bishops' interpretation of Catholic teaching?

For either the Catholic hierarchy or antichoice organizations to lay claim to be the arbiters of any person's good conscience is clearly disingenuous. When pharmacists refuse to fill prescriptions for contraception, they are negating the right to conscience of the woman, or man, standing in front of them. This does not fall under anybody's definition of what a good conscience is.

A Catholic Approach to Conscience

Given the ever-broadening character of refusal clauses, there is evidence that conscience is in danger of being killed by ideology, a point argued by **JF Keenan SJ and Thomas R Kopfensteiner**, when they say, "When conscience is reduced simply to serving norms or an ideology, conscience is dead." (Cited in Maguire, p52) The goal of any reasonable conscience clause must be to strike the right balance between the right of healthcare professionals to provide care that is in line with their moral and religious beliefs and the right of patients to

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have access to the medical care they need. For that reason, we believe that institution-encompassing refusal clauses are far too broad to be equitable clamping down, as they do, on the rights of both the professional and the patient.

Within the field of medical ethics, the accepted resolution to a conflict of values is to allow the individual to act on their own conscience and for the institution (the hospital, clinic or pharmacy) to serve as the facilitator of all consciences.

When an institution rejects this role and instead asserts its own “conscience-based” refusal to provide services, it violates the rights of both patients and healthcare providers—who may well consider the services the institution is denying to be profoundly moral and medically necessary—to make conscience-based decisions.

There has always been an ethical preference for ensuring that patients have the primary opportunity to act on their conscience. Thus, it is the obligation of the institution to provide doctors and nurses who will provide services that patients deem moral and that are legal, while allowing those medical professionals who choose to opt out to do so.

There is no doubt that there are times when the conscience of an individual doctor, nurse or pharmacist may conflict with the wishes or needs of a patient. This will likely most often happen in cases related to abortion. In these situations, women seeking an abortion should not have to worry about the religious and moral beliefs of their providers interfering with the provision of the best possible care—so it is in their best interests that only medical professionals committed to providing such services do so.

When this is not possible, a reasonable ethical fallback is for the institution to provide the patient with a meaningful referral that will ensure that the patients receive continuity of care without facing an undue burden, such as traveling long distances or encountering additional barriers to obtaining the desired services.

Therefore, while we recognize the right of individual medical professionals to decline to provide services they consider immoral, we believe that it goes too far to grant such a right to an entire institution—such as a hospital or managed-care provider. (Private institutions may provide whatever services they deem fit, but we are aware of no reasonably sized medical institution that receives absolutely no public funding.)

Regardless of what allowances are made for the **individual conscience** of the provider, **institutions** should not seek to impose an ideology and should instead defer to the **individual conscience** of the patient by respecting her or his right to comprehensive healthcare.

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Catholics for Choice shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women's well-being and respect and affirm the moral capacity of women and men to make decisions about their lives.

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