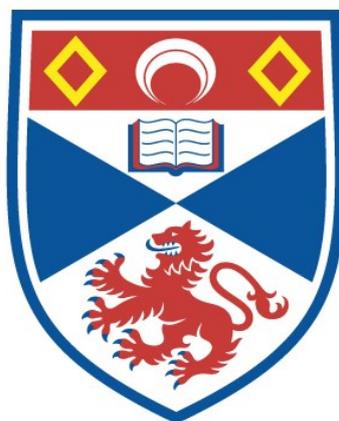


WOMEN'S HEALTH CARE IN AMERICAN CATHOLIC
HOSPITALS: A PROPOSAL FOR NAVIGATING ETHICAL
CONFLICTS IN ACCESSING REPRODUCTIVE HEALTH CARE

Taylor Jacob O'Grady

A Thesis Submitted for the Degree of PhD
at the
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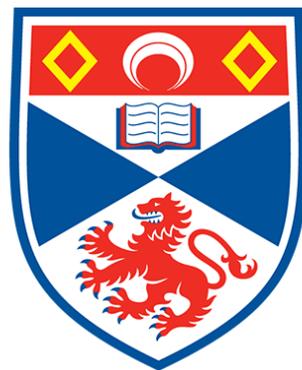
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Women's Health Care in American Catholic Hospitals: a
Proposal for Navigating Ethical Conflicts in Accessing
Reproductive Health Care

Taylor Jacob O'Grady



University of
St Andrews

This thesis is submitted in partial fulfilment for the degree of

Doctor of Philosophy (PhD)

at the University of St Andrews

September 2017

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I, Taylor Jacob O'Grady, do hereby certify that this thesis, submitted for the degree of PhD, which is approximately 72,000 words in length, has been written by me, and that it is the record of work carried out by me, or principally by myself in collaboration with others as acknowledged, and that it has not been submitted in any previous application for any degree.

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ABSTRACT

The Catholic Church is one of the largest providers of medical care in the US, with 1 in 6 acute-care beds residing in a Catholic hospital. One third of these hospitals are in rural or underserved areas in the US, and advocacy for the vulnerable is a central platform of the Catholic Healthcare Association. Despite this, the Church has been under attack for allegedly putting women at risk of injury or death due to the care restrictions concerning reproductive health stipulated in the Ethical and Religious Directives (ERDs). Additionally, scholars are questioning the distinctiveness of the Catholic healthcare mission in practice, pointing to the increased homogenization of Catholic and non-Catholic hospitals. For these reasons, it is necessary to assess if and how women are being harmed in Catholic hospitals and, if there is harm being done, if there is a way to prevent these harms while preserving the Catholic Social Tradition in medicine.

In carrying out this assessment, I read the current literature closely to explore both the origins and the practical consequences of these ethical conflicts. Subsequently, I use Chris Durante's "pragmatic perspectivism" to formulate a proposal that considers both Catholic medical ethics and secular medical ethics on the same plane. The proposal suggests the adoption of an alternative and complementary lens for Catholic health care. Using this framework would allow the Church to pursue its health care mission in a fuller sense, unencumbered by the inertia of the medical industry towards homogenization due to legal and economic pressures. It also provides the potential for Catholics to more easily receive Catholic care in all hospitals, not just those under Catholic sponsorship. Importantly, it would also prevent any American woman from being practically forced to receive Catholic care, circumventing many of the ethical conflicts present in the current system.

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to pursue my dreams, suffering through the challenges of a three-year long-distance relationship leading up to our wedding. I love you more than you could ever imagine, and I dedicate this work to you.

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CHAPTER 1: INTRODUCTION

Background

The American Catholic healthcare system is gargantuan. There are 649 Catholic hospitals in the US, representing 12 percent of all hospitals. 1 in 6 patients on any given day receive care at a Catholic hospital.¹ Based on latest available estimates, the Church pumps approximately \$100 billion dollars annually into Catholic healthcare systems.² This level of entrenchment in the American healthcare system is no accident; many regions of the US saw their first hospital due to the diligent work of Catholic orders.³ The same mission that inspired those religious orders in the 1700's endures today, which is to carry on "Jesus' mission of love and healing."⁴ Their mission encourages work in many facets of healthcare that are largely uncontroversial, including advocacy, health disparities, community benefits, and environmental care.⁵ In addition, there are an estimated 46 Catholic hospitals that serve as "sole community providers" and are the only reliable place to access healthcare services in those regions, demonstrating a commitment to the underserved.⁶

¹ Catholic Health Association of the United States, "U.S. Catholic Health Care," https://www.chausa.org/docs/default-source/default-document-library/cha_2017_miniprofile.pdf?sfvrsn=0.

² The Economist, "The Catholic Church in America; Earthly Concerns," <http://www.economist.com/node/21560536>.

³ Barbra Mann Wall, *American Catholic Hospitals : A Century of Changing Markets and Missions*, Critical Issues in Health and Medicine (New Brunswick, NJ: Rutgers University Press, 2011), 1-22.

⁴ Catholic Health Association of the United States, "A Shared Statement of Identity," <https://www.chausa.org/Mission/a-shared-statement-of-identity>.

⁵ "Focus Areas," <https://www.chausa.org/focus-areas>.

⁶ Catholics for Choice, "Is Your Health Care Compromised?; How the Catholic Directives Make for Unhealthy Choices," http://www.catholicsforchoice.org/wp-content/uploads/2017/01/2017_Catholic-Healthcare-Report.pdf.

Ironically, the organization responsible for providing health care to many vulnerable and underserved Americans is being accused of creating a disparity in access to necessary care. According to Catholic theology, some aspects of legally available reproductive health care is immoral, despite its legality. Broadly, this includes contraception, sterilization, and abortions, although these categories of care become blurred on closer examination.⁷ These forms of care are prohibited in all Catholic Healthcare Institutions (CHIs). This prohibition is stipulated in the Ethical and Religious Directives (ERDs), which are guidelines for CHIs published by the United States Conference of Catholic Bishops (USCCB). In the context of Catholic social teaching, these prohibited services are immoral and do not serve the ends of medicine. In the context of secular medicine, these services are considered greatly beneficial and sometimes necessary depending on a given patient's situation.⁸ This conflict in beliefs gives rise to the accusation previously mentioned, that American women are being harmed by restrictions in care caused by Catholic institutions.

The configuration of the current American health care system appears to be unsatisfactory for both women and the Catholic Church. The Church faces increasing economic and political pressure to become homogenized and to offer services that contradict its mission. Women face more prescient consequences when they are forced to receive care at a Catholic institution through necessity; the unavailability of treatment

⁷ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

⁸ The American Congress of Obstetricians and Gynecologists The American College of Obstetricians and Gynecologists, "Restrictions to Comprehensive Reproductive Health Care; Position Statement," <https://www.acog.org/Resources-And-Publications/Position-Statements/Restrictions-to-Comprehensive-Reproductive-Health-Care?IsMobileSet=false>.

options that have become expected in reproductive healthcare can have drastic and permanent effects on a woman's health and life. Public discourse on this clash between Catholic and secular medical ethics is polarized, often being reduced to the prioritization of one group at the expense of the other. Academia has failed to present a satisfactory solution, proposing resolutions that are instable or that fail to consider the positions of both parties equally. If no resolution comes to fruition, women might continue to be harmed and the Church will continue to be pressured to offer services it considers unjustifiably evil. For the sake of both American women and the Catholic Church, a solution is needed.

Research Question and Aims

In my thesis, I answer the following question: is it possible to reduce harm experienced by American women while simultaneously preserving the Catholic Social Tradition in medicine? I posit that it is indeed possible to preserve this moral tradition in medicine while reducing harm experienced by American women, although reform is required to do so. I use the last portion of the thesis to propose a plan for reform that would allow this to be accomplished, confirming my hypothesis. In order to answer the main research question, I fulfill the following objectives:

1. Establish the peculiarities of the current health care system that led to the current ethical conflicts experienced by women, physicians, and the Church
2. Outline the theoretical and practical consequences of the ERDs for women
3. Survey evidence of harm experienced and reported by women and physicians due to the ERDs
4. Outline current political and economic pressures on Catholic hospitals that make it increasingly difficult to pursue a Catholic health care ministry

These objectives are completed over the course of the 7 chapters of this thesis. In Chapter 1, in addition to introducing the research question and the format of the thesis, I provide context for my research in the form of a survey of the current literature.

Chapter 2 is dedicated to completing objective 1, which is to situate the context of Catholic hospitals in the broader American healthcare system. In this chapter, I describe the origins of Catholic healthcare in the US and the evolution of CHIs through time. CHIs originated as recognizable ministries of the Church, run by religious orders motivated to bring healthcare to largely underserved and undeveloped parts of the early US.⁹ A combination of a decline in religious orders, standardization of the medical field, and economic pressures have led to the homogenization of Catholic and non-Catholic hospitals. This homogenization has led experts to question the distinctiveness of the Catholic healthcare mission. In addition, I discuss the legal battles that CHIs and the Church face because of the restrictions laid out in the ERDs. Considering this information, I posit that CHIs in the US straddle a very thin line between private religious practice and public service. Occupying this peculiar space in American healthcare has led to the perfect breeding ground for the ethical conflicts in question.

Chapter 3 accomplishes objective 2 by analyzing the Ethical and Religious Directives, discussing consequences for both women and physicians in conjunction with the relevant medical information and with clinical information from primary sources. I start with a discussion of the relationship between Catholic Social Tradition and the formulation of the ERDs. I also discuss how ERDs are practically or theoretically enforced and what this means for consistency across CHIs, as this also has implications for women that seek care at a CHI out of necessity.

⁹ Wall, *American Catholic Hospitals : A Century of Changing Markets and Missions*, 2.

I complete objective 3 in Chapter 4, as I discuss in depth how women are being potentially harmed at CHIs. I organize the chapter thematically, presenting case studies in the following categories: treating women with previable pregnancies, treating female victims of rape, complications with contraceptive access, and barriers to sterilization. Each of the case studies presented is sourced either from physicians that perceive harm has been done to their patients or from patients that perceived that they have been harmed. I also discuss the utilization of the word harm, since the word might apply differently when considered within secular or Catholic medical ethics. Despite the differences in what can be considered “harm,” the women mentioned in this chapter experience tremendous, heroic suffering that would have been avoided had they been taken to a non-Catholic hospital. Even if this is not considered “harm” by all parties, these women’s suffering requires consideration.

In Chapter 5, objective 4 is fulfilled. I discuss the factors that impede the Church’s healthcare ministry. These factors are divided into three categories: the use of Church resources to accomplish what the Church considers to be unjustifiable, evil acts, the loss of integrity of the Church’s position as a countercultural option in healthcare, and the imperfect relationship between Catholic Social Tradition and the ERDs. The first category of obstacles to the ministry are those associated with non-compliance or covert action by employees, which usually are made by employees that have a moral disagreement with the ERDs in certain cases. The second category consists of internal obstacles like inconsistency or danger of scandal and external obstacles like economic or legal pressure to conform to a standard of care that contradicts the ERDs. Lastly, I explore how the ERDs sometimes do not perfectly reflect the Catholic Social Tradition and how this might be impeding the ministry.

Finally, in Chapter 6, I use Durante's pragmatic perspectivist methodology to identify a key moral bridge between the American Medical Association's code of ethics and the Catholic ERDs. I use this bridge, which is the respect for the patient's right to information and autonomous decision making, as the foundation for a proposal that would honor the belief systems of both parties. I demonstrate that the proposal would address the ethical challenges presented throughout the thesis. I use the complementary and alternative medical system as a framework for the proposal. I then draw on lessons from Osteopathic medicine and the American Catholic school system to demonstrate how my proposed system could address the previously mentioned ethical challenges in practice.

Audience and Stance

This research is geared towards bringing authority figures in both Catholic and secular medicine together, encouraging productive conversation aimed at reform. As will be demonstrated later, the basis of the reform I propose will be contingent on authentic cooperation between the USCCB, the AMA, and other governing bodies. In order to accomplish this, mistrust and skepticism between both parties will need to be overcome. Throughout this thesis, both moral traditions will be explored and accepted at face value. If a conversation is possible at all, it is one where both parties come prepared to work collaboratively to identify common ground without surrendering their own core beliefs.

In this spirit, the work done in this thesis will assume that both parties will adhere to their respective moral traditions and the proposed reform will only work within these confines. I will purposely refrain from making personal ethical judgments on the morality of Catholic or secular medical ethical traditions. Within Catholic

medicine, adherence to the Catholic Social Tradition will be assumed. For the purposes of this thesis, secular medicine is defined the collection of health care institutions in the United States that follow the ethical guidelines put forth by the American Medical Association and other governing professional groups where applicable. This classification might even include institutions under religious sponsorship that do not impose a particular religious tradition or ethical code on the institution's operations. Although secular medicine is somewhat more ambiguous as a tradition, which will be discussed later, adherence to a secular, universalist, and principlist tradition will be assumed. My role will be to act as a navigator between these two traditions, identifying certain places where cooperation is possible and other places where sufficient separation between the two traditions is necessary. I aim to consider both traditions equally and not to prioritize one over the other based on my own personal beliefs. In this way, with mutual respect and equal regard for both traditions, progress might be achieved in these difficult ethical disagreements.

Methodology

Bioethics, as a relatively new field, is plagued by a lack of standardization in methodology. One study that calls for standardization in the field found almost as many methodologies as they did bioethical studies.¹⁰ The numerous methodologies each have unique strengths and weaknesses. For my thesis, I am using a bioethics methodology developed by Chris Durante called "pragmatic perspectivism," which is best suited to provide the framework for equal prioritization of both a secular and a religious

¹⁰ Rachel Davies, Jonathan Ives, and Michael Dunn, "A Systematic Review of Empirical Bioethics Methodologies," *BMC Medical Ethics* 16, no. 15 (2015), <https://bmcmethics.biomedcentral.com/articles/10.1186/s12910-015-0010-3>.

universalist principle based ethics.¹¹ In a field dominated by secular philosophical thought, religious bioethics is often given secondary status.¹² The prevailing code of ethics used by clinical bioethicists and secular physicians is the set of four principles developed by Beauchamp and Childress in *Principles of Biomedical Ethics*, which are autonomy, beneficence, justice, and non-maleficence.¹³ This system has received criticism from both universalist groups of other traditions like Christian Ethicists and some “particularist” groups.¹⁴ Despite this, Beauchamp and Childress’ system has gone largely unchallenged, either because a “universal” and secular solution is believed to be better for a pluralistic society rather than one that stems from a particular religious tradition, or because of the potential dangers of “creating a slippery slope towards relativism” from the particularist camp.¹⁵

Building on the selectively pragmatist work done by Jeffrey Stout in *Ethics After Babel*, Durante develops a methodology that allows various secular and religious forms of universalist ethics to come into conversation with each other.¹⁶ Combining Stout’s theory that allows one to consider the justification in a belief to be relative, while considering the belief itself to be universally true or false with components of comparative ethics developed by Thomas Lewis and Aaron Stalnaker, Durante outlines

¹¹ Chris Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity," *Med Health Care and Philos* 12 (2009).

¹² Ibid.

¹³ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Fifth Edition ed. (New York: Oxford University Press, 2001).

¹⁴ Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity".

¹⁵ Ibid.

¹⁶ The methodology can be used to bring other types of ethical codes into conversation, but for the purposes of this thesis, I am interested in conflicting sets universalist ethics. Jeffrey Stout, *Ethics after Babel; the Languages of Morals and Their Discontents* (Boston: Beacon Press, 1988).

a novel methodology for bioethics.¹⁷ Recognizing the distinction between the relativity of justification and the universality of truth, Durante argues, opens a “panoply of new options when analyzing moral disagreements, for we can come to recognize that an individual is justified in asserting a claim without having to resort to either an acceptance of the truth of her claim or the verity of beliefs constitutive of her epistemic context.”¹⁸ This way, one can engage and respect the claims of others while remaining consistent in their own beliefs. Durante takes the idea of “bridge concepts,” or mutual propositions that might be derived from contrasting principles or epistemic contexts, from Stalnaker’s work.¹⁹ Durante then introduces the concept of using a question as an “ad hoc and revisable frame” for the purpose of comparison derived from Lewis’ work.²⁰ Durante’s methodology prescribes the following steps:

1. Posit a specific question, providing a “frame of comparison”
2. Search for “bridge concepts” in responses to the question
3. Attempt to achieve consensus based on “bridge concepts”²¹

Durante’s framework is explicitly meant for fostering dialogue, indicating the importance of the participation of all parties involved in order to find as many conceptual bridges as possible.²² I will be employing this methodology perhaps more circuitously, while preserving the ultimate goal of fostering discussion. I will use this system to analyze the written positions of both parties to identify conceptual bridges, so as to demonstrate how this might work between the USCCB and the AMA. I will also

¹⁷ Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity".

¹⁸ *Ibid.*, 41.

¹⁹ *Ibid.*, 44.

²⁰ *Ibid.*

²¹ *Ibid.*

²² *Ibid.*

use the conceptual bridges identified to build a basis for my healthcare reform proposal. Using the prescribed methodology, I arrive at the conclusion that there indeed is a way to protect both women and the Church and reform of the current health care system is necessary. I present a proposal that will allow women to avoid harm associated with being required to receive Catholic health care while simultaneously allowing the Church to pursue its healthcare ministry in a more focused manner to a larger segment of the American Catholic population.

Scope

For the purposes of this thesis, I will be looking at women's reproductive health in Catholic and non-Catholic hospitals only. Although there are other areas of care where similar ethical clashes exist, I have chosen to focus on this particular area for a few reasons. First, there is a paradox of sorts specifically in reproductive health care that is worth investigation. The Catholic Church is committed to caring for the vulnerable and this underpins many of the restrictions stipulated in the ERDs. Others, most notably the American Civil Liberties Union (ACLU), claim that these restrictions are a danger to vulnerable segments of the American population.²³ This concern about social justice alone makes this area worthy of focused inquiry. Second, it is necessary to limit the investigation to one area of health care to make the thesis feasible in the allotted space. That being said, the resulting proposal would work to resolve similar ethical conflicts in other areas like end-of-life care.

In terms of the ethical analyses presented in this thesis, I will not make any judgments about the validity of the principles used in Catholic or non-Catholic health

²³ Other major groups advocating against Catholic reproductive restrictions in healthcare are Catholics for Choice, and the American Congress of Obstetricians and Gynecologists.

care. Rather, I will discuss the impacts of Catholic principles in reproductive health care on American women, especially those that do not subscribe to a Catholic ethos on life. After the discussion, I will attempt to put both the secular and Catholic medical ethical tradition on equal footing, identifying conceptual bridges between the two that could serve as the basis of an agreement for reform. The purpose of this reform is to ameliorate any negative impacts on women that are found without either party having to concede their principled beliefs.

I will not be assessing the validity of various theories on the accommodation of conscientious objections in medicine. While issues surrounding institutional conscientious objection certainly are relevant and will be discussed, it is a separate issue entirely to consider whether an institution should be allowed to conscientiously object in a broader sense.

The nature of the proposal made in this thesis is theoretical, serving as a vision for change and progress. The proposal, however, is not a finished piece of policy and I do not posit that it is ready for implementation. This proposal could serve as the foundation of a potential policy along with economic stipulations discussed by economists, policy experts, medical experts, and the USCCB. Ultimately, the proposal is meant to foster constructive discussions between the USCCB and the medical community in order to disrupt the status quo that is unsatisfactory for both the Church and American women.

Review of the Literature

There are two themes that sustain the ongoing conflicts about reproductive health and Catholic hospitals in the US. The first theme is the presence of contrasting definitions of what constitutes appropriate health care for women, drawing on debates

about autonomy, personhood, and the limits of exercising one's conscience. The second theme is the challenges of pluralism; how does society deal with conflicts in fundamental beliefs, especially within medicine? It is worth providing a brief overview of the literature on these themes in order to understand what is at stake in the aforementioned conflicts.

When discussing restricted access to women's health care, it is necessary to consider the impact of conscientious objection. Conscientious objection is when a health care provider refuses to provide a service or information that conflicts with a deeply-held and sincere belief. Defining the actual concept of conscience, although an interesting topic of philosophy, is not an important consideration here. The word conscience can be invoked in a colloquial sense, giving a sense of justified protection to a set of beliefs about what is right and wrong, especially when they are religious beliefs.²⁴ Using the word "conscience" is sometimes meant to indicate a level of protection from the standards of logic and reason; our personal conceptions of right and wrong are influenced by many aspects of our being and the context in which we live, and these aspects are sometimes outside the realms of rationality. For example, although one can explain a particular belief about personhood before birth logically, the underpinnings of those beliefs may simply be a matter of faith.

When a provider objects to a specific treatment, access to that treatment can be affected in multiple ways. If that provider is the only person legally able to provide the treatment at any given place in time or space, then access to that treatment is restricted. This might happen because of shift scheduling, locations of healthcare institutions, or

²⁴ Mark R. Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis*, (Cambridge: Cambridge University Press, 2011). Electronic. 4.

the level of overall availability of healthcare in the immediate area. In the case of CHIs, the USCCB is effectively enacting institutional objections to the treatments that are deemed unethical in the ERDs. This influences access to procedures on a broad scale, as was already mentioned. Institutional conscientious objection is a widely debated concept in its own right, but the point relevant to the discussion is that enacting a set of beliefs institutionally can lead to restriction in care for patients.

The impact of conscientious objection on access to care, both institutional and personal, is hotly debated in academia. Mark Wicclair provides an extensive overview of conscientious objection in American medicine in his book *Conscientious Objection in Health Care: An Ethical Analysis*, in addition to providing his own philosophical beliefs on accommodating conscientious objections in health care.²⁵ Wicclair describes the various positions on the issue as falling on a spectrum, naming three points on the spectrum as generally representative of the most common theories of accommodating conscience in medicine.²⁶ At one end of the spectrum is the “incompatibility thesis,” which is the view that conscientious objections are incompatible with a health care provider’s professional obligations.²⁷ If an aspiring pharmacist is aware that being a pharmacist might require the dispensation of contraceptives, something that the aspiring pharmacist could not do in good conscience, then the incompatibility thesis would suggest that the aspiring pharmacist look for a different career.²⁸ Julian Savulescu is one of the most notable advocates of the incompatibility thesis. Savulescu argues that conscientious objections are incompatible with the professional obligations of

²⁵ Ibid.

²⁶ Ibid., 33.

²⁷ Ibid.

²⁸ Ibid.

healthcare.²⁹ On the other end of the spectrum is conscience absolutism, which is the belief that there should be no constraints on the ability of health care providers to conscientiously object.³⁰ E. Christian Brugger is an advocate of this view, based on the duty to follow one's conscience.³¹ Brugger goes so far as to say that the availability of services should reflect the composite of the beliefs of health care providers and that this is required by "rightful political toleration."³² In the middle is an approach of compromise, one that Wicclair himself endorses. This approach advocates for some constraints on the exercise of conscience of the health care provider while maintaining certain freedoms of conscience. This compromise allows for the freedom to conscientiously object only when defined professional obligations are being fulfilled.³³

Both the American Medical Association (AMA) and the American Congress of Obstetricians and Gynecologists (ACOG) have published guidelines for accommodating conscientious objections that are versions of Wicclair's compromise approach. The AMA writes about the value of a physician's right to conscientiously object, stating that the right is "important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely."³⁴ Accompanying this statement, though, is a list of limitations on a physician's right to

²⁹ Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332 (2006).

³⁰ Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis*. 34.

³¹ E. Christian Brugger, "Do Health Care Providers Have a Right to Refuse to Treat Some Patients?," *Christian Bioethics* 18, no. 1 (2012): 24.

³² *Ibid.*

³³ Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis*. 87.

³⁴ The American Medical Association, "Chapter 1: Opinions on Patient-Physician Relationships," <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf>.

conscientiously object that are intended to protect the rights of patients. The AMA writes that:

Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.³⁵

These limitations are not a hard and fast list of restrictions, but rather a somewhat vague list of circumstances in which a doctor might not be able to conscientiously object. The AMA also gives seven practical instructions for physicians following their conscience while practicing medicine:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- (d) Be mindful of the burden their actions may place on fellow professionals.

³⁵ Ibid.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.³⁶

The AMA is clear that physicians can only object if they can still fulfill their professional obligations. Based on the AMA's statement above, this may include making referrals, giving information on objectionable procedures, not discriminating according to sexuality or gender, meeting the requirements of informed consent, or considering the burden on the patient. These specific points are practical obstacles for CHIs; following the requirements of the ERDs as local bishops interpret them sometimes contradicts the professional obligations that the AMA outlines.³⁷

If the AMA resides somewhere on the middle of Wicclair's spectrum, the ACOG leans further towards the "incompatibility thesis" end of the spectrum. In other words, the ACOG imposes even tighter restrictions on physicians wanting to object to obstetric or gynecological care. The ACOG writes that

Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being

³⁶ Ibid.

³⁷ Making referrals for prohibited services are often not allowed in CHIs. The impact of the ERDs on informed consent will be discussed at length in Chapters 3, 4, and 6.

should be accommodated only if the primary duty to the patient can be fulfilled.³⁸

The language the ACOG uses is more direct, intimating that the ACOG has certain standards that must be followed in determining what is considered to be a negative health effect or what might perpetrate racial or socioeconomic inequalities. The ACOG uses the physician's primary duty as a hard standard that must be met. In the subsequent explanation of a physician's primary duty, the ACOG states the following requirements:

- (a) physicians must provide information about objected treatments or topics
- (b) access to treatment should not be impeded in "resource-poor areas"
- (c) physicians must provide prior notice of relevant objections if they involve standard and expected care
- (d) physicians have a duty to refer patients if they cannot provide a requested service
- (e) providers should work at an institution where coworkers can provide access to treatments or otherwise ensure access through referrals³⁹

Based on stipulation "e" alone, there is an obvious conflict between the ACOG's and the USCCB's conception of professional obligations. I discuss the conflict between the AMA's and the ACOG's guidelines and the USCCB's prohibitions in chapters 3, 4, and 6.

In the ERDs, the USCCB endorses a modified form of the incompatibility thesis; the USCCB does not hold that the individual conscience has no place in medicine,

³⁸ American Congress of Obstetricians and Gynecologists, "The Limits of Conscientious Refusal in Reproductive Medicine," <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine>.

³⁹ Ibid.

however, it does hold that a “correct conscience” will align with Church teaching on healthcare.⁴⁰ In this regard, it does not knowingly allow any individual employee to conscientiously object to the ERDs. The USCCB write that “within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.”⁴¹ Although there are some academics and physicians that strongly disagree with this conception of the rights of the individual conscience, it illustrates that the Church provides little latitude for a provider to object to the ERDs.⁴² This can be justified by making potential employees aware of the ERDs and requiring recognition from the employee that they must abide by the ERDs prior to hiring. Additionally, the professional obligations of a physician at a Catholic institution are drastically different according to the USCCB. The primary duty of a CHI employee is to carry out Jesus’ health care ministry as described by the bishops and the employees’ obligations originate from this duty.

Besides these differences in latitude for accommodating conscientious objections, the fundamental difference in the theory of care given at non-Catholic and Catholic hospitals is simply what is and is not considered morally permissible care. The AMA, ACOG, and USCCB all deem certain actions as unethical and prohibit a physician from carrying out those actions. All three organizations give high priority to patient autonomy, as long as a patient request does not venture into unethical territory.

⁴⁰ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services" 9.

⁴¹ *Ibid.*, 11.

⁴² Bernard M. Dickens and Rebecca J. Cook, "Conscientious Commitment to Women's Health," *International Journal of Gynecology and Obstetrics* 113 (2011).

Because of the Church's countercultural view on what constitutes good health, the Church also has countercultural views on what is considered morally right and wrong in reproductive medicine. There are a few key principles that are important to understanding the Church's positions on healthcare.

1. The Church teaches that human bodies are the product of divine design. The healthy, proper functioning of the organs of the body serve the proper nature function of the body. Treating these functions as pathological contradicts human nature, which is morally unacceptable.⁴³
2. Human life is sacred from conception until natural death.⁴⁴
3. It is never acceptable to aim to do an evil act, even if it achieves a good end. One may, however, do something with an unintended but foreseeable evil consequence.⁴⁵

Based on these principles, the Church prohibits contraception, sterilization, and intentional abortions. Based on the third principle, the principle of double effect, there are certain situations in which a patient may be effectively temporarily or permanently sterilized or may experience the loss of an unborn baby due to treatment, but which the Catholic Church considers are morally permissible. The USCCB recognizes the importance of patient autonomy and encourages good communication between providers and patients, as long as the care provided falls within the scope of what it

⁴³ Paul VI, "Humanae Vitae," http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html., Kevin D. O'Rourke and Philip Boyle, *Medical Ethics: Sources of Catholic Teachings*, 3rd ed. (Washington, DC: Georgetown University Press, 1999), 6.

⁴⁴ Ibid.

⁴⁵ *Catechism of the Catholic Church*, 2nd. ed., 1749, accessed February 1, 2017, http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a4.htm

considers to be ethical care.⁴⁶ The Church's philosophy of healthcare regarding specific issues in women's reproductive medicine will be discussed in depth in Chapter 3.

The AMA and ACOG have different views than the Church on what are ethical components of women's reproductive health. These organizations center their conception of ethical care on the rights of the individual patient rather than a transcendent standard from a religious tradition. Put simply, if a treatment option satisfies the four "universal" principles of biomedical ethics, then it is considered a viable and ethical option for that particular patient. Each professional organization has their own code of ethics that applies these four principles more specifically to the functions of their profession. These principles have become so universally supported in medical education that they are tested on the current version of the Medical College Admission Test, a test that every future doctor must take before being accepted to medical school in the US.⁴⁷ If patient autonomy is respected, the treatment provides a benefit that outweighs any potential risks, and the treatment is just in the distributive sense, it is considered to be ethical.⁴⁸ Contraceptives, sterilizations, and abortions can all qualify as ethical treatments according to these principles. In some cases, these treatments are considered medically necessary, many times based on the principle of nonmaleficence. Nonmaleficence requires that physicians advocate for and treat their patients in a way that tries to prevent harm from occurring.⁴⁹ If it is exceedingly

⁴⁶ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services" 9.

⁴⁷ The Association of American Medical Colleges, "What's on the Mcat Exam? Psychological, Social, and Biological Foundations of Behavior," https://aamc-orange.global.ssl.fastly.net/production/media/filer_public/ff/31/ff31b22d-418b-42b3-9776-425a382e8c73/mcat-psbb.pdf.

⁴⁸ Beauchamp and Childress, *Principles of Biomedical Ethics*, 225-82.

⁴⁹ *Ibid.*, 114-19.

dangerous for a woman to become pregnant, offering sterilization or other long acting reversible contraceptives is the standard of care, since it is an effective way to help the patient prevent pregnancy.⁵⁰ Similar reasoning can be used to justify contraceptives and certain non-elective abortions as medically necessary. Ultimately, if a treatment is legal, just, and more beneficial than harmful, it is usually considered ethical under these principles.

Secular medicine does not espouse one clear-cut philosophical definition of personhood. Instead, quality of life is often considered in making value judgments, especially on the margins of life.⁵¹ For example, an abortion can be offered as a treatment option for fetuses that have a fatal condition. This might be justified because the fetus will never live outside of the mother's womb; offering an abortion spares the mother the pain of childbirth and the fetus the pain of his or her condition. Since the fetus cannot be saved, some physicians and patients deem that the benefits of an abortion outweigh the risks and that makes it morally acceptable.⁵² This type of consequentialism is common in medical ethical decision making, although both the AMA and the ACOG do encourage a diversity of philosophical views among health care staff, provided that the staff can still fulfil their professional obligations.

⁵⁰ American Congress of Obstetricians and Gynecologists, "Sterilization of Women: Ethical Issues and Considerations," <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Sterilization-of-Women-Ethical-Issues-and-Considerations>.

⁵¹ Matthis Synofzik, "Measuring the Immeasurable? Quality of Life and Medical Decision Making," *AMA Journal of Ethics* 7, no. 2 (2005), <http://journalofethics.ama-assn.org/2005/02/fred1-0502.html>.

⁵² Frank A. Chervenak and Laurence B. McCullough, "An Ethically Justified Practical Approach to Offering, Recommending, Performing, and Referring for Induced Abortion and Feticide," *American Journal of Obstetrics and Gynecology* 201, no. 6 (2009), <http://www.sciencedirect.com/science/article/pii/S0002937810010410>.

Unfortunately, these ethical clashes come to a head when economic pressures force partnerships between Catholic and non-Catholic institutions. As of yet, there have been no successful strategies for dealing with these conflicts on a systematic level. There are only two results that are acceptable to the Church when these partnerships are negotiated; a non-Catholic partner is forced to abide by the ERDs in part or in whole or a “creative solution” is enacted.⁵³ Creative solutions allow non-Catholic and Catholic partners to work together, while the non-Catholic partner operates a separate system where the immoral services are provided. The purpose of employing these models is to create sufficient material separation between the Church and the provision of what the Church considers to be immoral services. Two such solutions are the “hospital within a hospital” system and the “hospital beside a hospital” system.⁵⁴ In the former, a specific section of the non-Catholic hospital is “carved out,” and run as a separate entity. Employees, finances, and services are kept separate from the larger hospital system. In the latter, the same set up is used, but the facility is constructed in a separate building on the same campus as the non-Catholic hospital.

In 2015, the Catholic Healthcare Association (CHA) published a document in its own *Health Progress* journal describing a complex, 4 phase process for entering into partnerships with non-Catholic institutions.⁵⁵ The flow chart that indicates what services are prohibited, tolerable, or able to be “carved out” in what situations is three pages long alone. In almost all partnership types concerning hospitals abortion is never permitted,

⁵³ Michael Panicola and Ron Hamel, "Catholic Identity and the Reshaping of Health Care," *Health Progress*, September - October (2015), <https://www.chausa.org/docs/default-source/health-progress/catholic-identity-and-the-reshaping-of-health-care.pdf?sfvrsn=0>.

⁵⁴ MergerWatch, "Hospital Mergers: Creative Solutions," <http://www.mergerwatch.org/creative-solutions/>.

⁵⁵ Panicola and Hamel, "Catholic Identity and the Reshaping of Health Care".

but sterilization and contraception may be “carved out” under certain circumstances. If the Catholic partner has sole or majority control over the partnership, the CHA permits that “the former owner or a new, non-CHCO entity (e.g, community foundation) may choose to arrange for and provide the carve-out medical interventions in non-CHCO majority-controlled and/or identified spaces/ buildings with no CHCO involvement.”⁵⁶ For Catholic partners in minority or managing roles, the carve-out method can be used if four conditions are met based on governance, finance, management, and performance, all of which measure the amount of cooperation the Catholic partner has in providing the prohibited services.⁵⁷

The term “carve out” in this CHA document does not specify what the arrangement should look like for the non-Catholic party, which is appropriate considering that the purpose of these arrangements is to have the Catholic party totally uninvolved in the provision of prohibited services. MergerWatch, however, picks up where the CHA leaves off and describes methods for this carving-out process. MergerWatch is a watch group that is dedicated to monitoring access to services prohibited by the Catholic doctrine, specifically by tracking mergers involving CHIs. The group offers the two previously mentioned “creative solutions” for maintaining access to reproductive services.⁵⁸ They also mention two case studies that exemplify the success of those solutions. On closer examination, however, neither of the case studies proves to be an example of lasting success. MergerWatch, along with both the American Civil Liberties Union (ACLU) and Catholics for Choice, repeatedly discuss the same two case studies for different reasons, so I will detail both cases here.

⁵⁶ Ibid., CHCO stands for Catholic Health Care Organization

⁵⁷ Ibid.

⁵⁸ MergerWatch, "Hospital Mergers: Creative Solutions".

The first case is that of Brackenridge Hospital in Austin, Texas, a hospital that eventually adopted the “hospital within a hospital” model after a merger with Seton Medical Center.⁵⁹ Brackenridge Hospital, a public hospital, accumulated a significant amount of debt by 1995. Seton Medical Center, run by the Daughters of Charity of St. Vincent de Paul, agreed to take control over the hospital. The CEO of Seton Medical Center noted in a letter that the aim of the merger was to “ensure the continuation of essential health care services, including trauma, women's and reproductive services, and children' services, for all citizens of Austin and Travis County, regardless of their financial means.”⁶⁰ Originally, the conditions of the merger were that Brackenridge would continue to offer reproductive services, but would discontinue abortions. Seton would be leasing the Brackenridge facilities, but Brackenridge would legally retain ownership and not have a Catholic identity. Employees performing prohibited procedures would not be Seton employees. Multiple ethicists, canon lawyers, and clergy were consulted during the initial negotiations. Barbara Wall Mann describes the justification of cooperation in her article about the deliberations:

When Magill wrote about Seton's situation, he argued, “The act of cooperation is justified when it occurs to achieve *a greater good or to avoid a more serious evil*” (emphasis original). In Seton's case, the more serious evil was the closing of the hospital and the resulting lack of health care to the poor. Specifically, “not doing good could be a serious dereliction of moral duty” by “forfeiting the valuable contribution of Brackenridge's health care to the community.” The greater good was that Seton could “extend its mission and values in the community . . . , continue its provision of indigent care,” protect “its witness to pro-life values . . . and maintain and strengthen its position in the health care market.”⁶¹

⁵⁹ Barbra Mann Wall, "Conflict and Compromise: Catholic and Public Hospital Partnerships," *Nurs Hist Rev* 18 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886734/#R59>.

⁶⁰ Ibid.

⁶¹ Ibid.

As this partnership gained attention, the Vatican's Congregation for the Doctrine of the Faith and the USCCB became involved. A final agreement acceptable to all parties was not reached for six years. The delays were mainly caused by both the Vatican's concerns for avoiding scandal and by local advocacy groups concerned with the loss of reproductive services in Austin. By 2001, the "hospital within a hospital" model was employed and the fifth floor of Brackenridge would become a fully functional and self-sufficient facility, even including a separate elevator. This allowed Brackenridge to be temporarily preserved, along with access to care for the indigent population of Austin.⁶²

Unfortunately, the fifth-floor "hospital" only lasted slightly longer than the negotiations themselves lasted. By 2012, the unit run by the University of Texas Medical Branch lost funding and closed its doors.⁶³ Starting in 2012, anyone seeking prohibited services would have to go to non-Catholic St. David's Hospital instead. St. David's is a thirty-minute drive by car and over an hour by public transportation from the original site of Brackenridge Hospital.⁶⁴ By the time of this writing, Seton Medical Center underwent another merger with Travis County's Central Health and became the foremost health system in central Texas.⁶⁵ It is the primary training site for the new University of Texas at Austin Dell Medical School. The controversy from the original arrangement has resurfaced as Seton Health continues to thrive as a part of Ascension Health, the USA's largest non-profit medical system. The ERDs are now enforced at government run hospitals as a result of the latest merger and medical

⁶² Ibid.

⁶³ Mary Tuma, "Questions of Church-State Separation at Dell Seton Medical Center," *The Austin Chronicle*, Jan 20 2017 2017. <https://www.austinchronicle.com/news/2017-01-20/questions-of-church-state-separation-at-dell-seton-medical-center/>).

⁶⁴ Estimated using Google Maps.

⁶⁵ Tuma, "Questions of Church-State Separation at Dell Seton Medical Center."

students at Dell Medical School must go to other institutions to receive training in prohibited procedures.⁶⁶ Reporters and local activists are calling the current arrangement into question because of the seemingly insufficient separation between Church and state, which may or may not eventually be judged unconstitutional.⁶⁷

The “hospital beside a hospital” model was tested in Kingston, New York. In the late 1990s, non-Catholic Kingston Hospital and Catholic Benedictine Hospital started engaging in merger negotiations, both because of economic pressures and at the request of a New York State commission dedicated to “rightsizing” health care in New York State.⁶⁸ Both hospitals were operating under sustainable capacity and offered duplicate services. Negotiations officially started in 2004, with the following four objectives:

1. the missions of both hospitals had to be preserved
2. a plan had to be developed to realign services to avoid duplication
3. abortions and sterilization services had to continue to be available to the community
4. neither hospital could appear to have taken over the other⁶⁹

A compromise was reached after an arduous negotiation process with both management boards, the state, and the Archdiocese of New York. Benedictine hospital remained Catholic; Kingston remained non-Catholic and was permitted to offer post-partum tubal ligations, contraception and relevant counseling, full ectopic pregnancy management, and miscarriage management.⁷⁰ The Church objected to the provision of non-post-

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Lois Uttley et al., "Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing the Ethical Challenges," *New York State Bar Association Health Law Journal* 17, no. 38 (2012): 3, <http://static1.1.sqspcdn.com/static/f/816571/23042588/1372882137057/Models+of+Catholic-secular+hospitals+mergers+in+NYS.pdf?token=mMQJyIGpZBE%2FygZV05%2Fcja8VYSk%3D>.

⁶⁹ Ibid., 4.

⁷⁰ Ibid., 5.

partum tubal ligations and abortions at Kingston Hospital, so an outpatient ambulatory surgery center was built in the parking lot of Kingston Hospital. The center, named Foxhall Ambulatory Surgery Center, had a separate management team and was considered a separate legal entity from Kingston Hospital. The staff for the center was also completely separate from that at Benedictine Hospital.⁷¹ The center was made possible by a large financial grant from New York State.⁷² It is interesting to note that the Church refused a “hospital within a hospital” solution in this case. The hospitals were operated under a secular entity named HealthAlliance of the Hudson Valley beginning in 2008, which coordinated the entire system and ensured that Benedictine and Kingston remained adequately separated. Unfortunately, even after a \$48 million-dollar investment from New York State, the system was not able remain financially viable. In early 2013, the Benedictine sisters relinquished control of their hospital to Health Alliance so that the two hospitals could consolidate into one non-Catholic hospital that offered all reproductive services.⁷³

Although these two cases are touted as successful models for mergers of Catholic and non-Catholic institutions, the success was not stable in either case. In one instance, a hospital surrendered its Catholic identity. In the other, the “carved-out” services were lost. Both agreements took years of deliberations and a monumental amount of money to complete, contributing to already significant resource inefficiency. In both instances, segments of the population were left alienated. The Catholic residents of Kingston, New York lost the institution where they could seek care according to their

⁷¹ Ibid.

⁷² Ibid.

⁷³ "Benedictine Sisters Agree to Relinquish Hospital Campus to Healthalliance of the Hudson Valley," *Daily Freeman News*, Feb 7 2013.
<http://www.dailyfreeman.com/article/DF/20130207/NEWS/302079956>.

beliefs. Women that want prohibited services in Austin, Texas must now travel a significantly farther distance to a neighboring hospital. This might be possible for some women, but impossible for those that do not have the resources to travel or that are brought to Seton for emergency care. In addition, the mode of healthcare that survives seems to depend more on the comparative financial strength of the Catholic or non-Catholic partner and does not necessarily reflect the needs or desires of the local populations. These situations are certainly not ideal and it seems that the expensive “creative solutions” don’t have much supporting evidence that they are feasible solutions after all. Even worse still, they do nothing to address the conflict experienced when women try and access prohibited services at any one of the 46 sole community hospitals that are Catholic in the US.⁷⁴ This demonstrates the need for a better solution to resolve competing interests between secular and Catholic medicine.

⁷⁴ Lois Uttley and Christine Khaikin, "Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report," (New York, NY: MergerWatch, 2016).

CHAPTER 2: THE PLACE OF CATHOLIC HOSPITALS IN US HEALTH CARE

Catholic hospitals in the US occupy a peculiar space in between the public and private sphere. Virtually all hospitals in the US are subject to a group of federal and state regulations in addition to criteria set by professional groups. These laws are practically enforced through leveraging of government funds, which are necessary for financial survival. These laws and criteria can conflict with the Ethical and Religious Directives (ERDs) that Catholic Healthcare Institutions (CHI) are required to follow in order to maintain their Catholic sponsorship. In this basic sense, CHIs straddle a line between a public service and private charitable and ministerial institutions with competing pressures for survival.

There are multiple factors that further complicate the Catholic hospitals' position. In some cases, Catholic hospitals are sole community hospitals, meaning that they are the only hospital within a 35-mile radius.¹ This means that in certain areas, Catholic hospitals have an effective monopoly on health care services. Additionally, economic pressures threatening hospitals' survival (both Catholic and non-Catholic) has led to an increased number of hospital mergers. As a result of these mergers, Catholic hospitals are acquiring an increasing proportion of the hospital beds in the US and are providing an increasing proportion of the nation's health care.² Furthermore, secular

¹ The criteria for sole community hospitals as defined by the Centers for Medicare and Medicaid services can be found here: Health Resources and Services Administration, "Sole Community Hospitals," <http://www.hrsa.gov/opa/eligibilityandregistration/hospitals/solecommunityhospitals/index.html>.

² Lois Uttley et al., "Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care," (New York, NY: American Civil Liberties Union and MergerWatch, 2013), 4.

hospitals that merge with Catholic hospitals are often required to adopt specific restrictions from the ERDs, effectively increasing Catholic influence in health care beyond the number of Catholic-sponsored hospitals.³

The complex position of American CHIs has repercussions for women's health care. The typical arguments of religious freedom and personal choice continue to fail to be satisfactory and are confusing when applied in these instances, which is reflected in the lack of feasible solutions for addressing these issues. Broadly speaking, the effective Catholic monopoly on a public service in certain areas reaches beyond issues concerning the freedom to practice religion. Conversely, patients do not necessarily have the right to demand a particular service from a private institution. Discussion needs to move away from these insufficient arguments and work towards identifying common ground. I will provide an analysis in this spirit of the ethical issues surrounding large scale Catholic health care and the protection of women in the US.

Origins

Catholic hospitals were first established in the US by religious orders to meet the needs of large populations of Americans that had no access to health care. Centuries later, there are still significant issues in the US concerning access to health care, but they have less to do with the physical presence of hospitals and doctors and more to do with accessibility to affordable health care. Catholic religious orders went into the newly explored frontiers of the country to help those that were suffering as a part of their religious practice. Healing the sick was not something distinct from their ministry,

³ Ibid.

but an integral part of their ministry. This was truly a work of charity; there is no doubt many would have died or suffered if not for their selfless efforts.⁴

As the original need that inspired Catholic health care facilities in the US was met, the structure of Catholic hospitals and health care organizations changed drastically. An increasingly well-established health care system in the US fell under an increasing number of government and professional regulations; standardized requirements for health care facilities and the necessary dependence on federal funds for financial survival led to a homogenization of facilities around the country. Meanwhile, in the 1960s, the Second Vatican Council opened positions of leadership to the laity.⁵ A simultaneous decline in the number and vitality of Catholic religious orders meant that there was shift from hospitals run directly by the Catholic Church and its religious orders to hospitals run by lay people under the guidance and sponsorship of the Catholic Church. The president of the Catholic Health Association reports that out of 630 Catholic hospital CEOs, only 4 are religious.⁶ Catholic hospitals began to lose their distinctiveness. Without nuns in habits roaming the hallways and with virtually every hospital in the US providing charity care, a person walking into a hospital today might not even realize they are in a Catholic institution unless they happen to glance at the mission plaque long enough to read Jesus' name or see a cross on the wall.

⁴ Wall, *American Catholic Hospitals : A Century of Changing Markets and Missions*, Chapter 1.

⁵ *Ibid.*, 6.

⁶ Colleen Dunne, "Challenges Ahead for Catholic Health Care, Keehan Says," *National Catholic Reporter*, October 17 2013. <https://www.ncronline.org/news/peace-justice/challenges-ahead-catholic-health-care-keehan-says>.

What Makes a Catholic Hospital Distinct?

In response to the perceived identity crisis, there is a growing body of literature on the distinct nature of Catholic health care. I will present a brief survey of this literature in order to put the current ethical quandary in context. The review will focus on the distinctiveness of Catholic hospitals and whether or not distinctive care translates to better care for patients. I use “Catholic healthcare institutions” to refer mainly to Catholic hospitals, although broader use of the term includes other health care facilities as well.

William Stempsey offers a convenient philosophical framework for understanding Catholic healthcare.⁷ He proposes that there are three components of Catholic healthcare that can be assessed. First is the mission of the institution, or the goals the institution strives to achieve. While there have been efforts by the Catholic Health Association (CHA) to put forth a centralized mission, there is still a wide variation in mission statements across CHIs. This variation is also reflected in the literature, with an assortment of propositions on the ideal Catholic healthcare mission.⁸ The second component is the identity of Catholic hospitals, which can be described as the qualities that exist in the hospitals distinct from the goals it might set through its mission statement.⁹ These qualities are reflected in the actions of the institution, its personnel, and the care that is given. Stempsey describes the relation between the first two categories, maintaining that “mission statements are ideal expressions of

⁷ William E. Stempsey, "Institutional Identity and Roman Catholic Hospitals," *Christian Bioethics* 7, no. 1 (2001): 6, doi:10.1093/chbi.7.1.3.3768.

⁸ These positions are discussed in the following section.

⁹ Kevin O'Rourke, "Catholic Hospitals and Catholic Identity," *Christian Bioethics* 7, no. 1 (2001): 16, doi:10.1093/chbi.7.1.15.3762.

institutional identity.”¹⁰ Third is the integrity of an institution, or how well the institution expresses its identity and strives toward achieving the goals set in the mission statement. Using this framework will clarify what is distinct about Catholic healthcare.

Mission

Since the rise in popularity and subsequent dominance of the corporate model for hospitals in the US, mission statements have been used to serve as a point of differentiation for Catholic not for profit hospitals.¹¹ Although there is great variation between mission statements of any of the 649 Catholic hospitals in the US, most contain common elements that are reflected in the Catholic Health Association’s (CHA) “Shared Statement of Identity for the Catholic Health Ministry.”¹² Indeed, this statement can be used as a rough representative of Catholic health care in the US. The statement reads:

We are the people of Catholic health care, a ministry of the church continuing Jesus’ mission of love and healing today. As provider, employer, advocate, citizen – bringing together people of diverse faiths and backgrounds – our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit. We work to bring alive the Gospel vision of justice and peace. We answer God’s call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable. By our service, we strive to transform hurt into hope. As the Church’s ministry of health care, we commit to: promote and defend human dignity, attend to the whole person, care for poor and vulnerable person, promote the common good, act on behalf of justice, steward resources, act in communion with the Church.¹³

¹⁰ William E. Stempsey, "Institutional Identity and Roman Catholic Hospitals," *ibid.* 3, doi:10.1093/chbi.7.1.3.3768.

¹¹ Carol Taylor, "Roman Catholic Health Care Identity and Mission: Does Jesus Language Matter?," *ibid.* 31, doi:10.1093/chbi.7.1.29.3767.

¹² Catholic Health Association of the United States, "U.S. Catholic Health Care".

¹³ "A Shared Statement of Identity".

There are a few elements worth noting in this statement. While couched in rhetoric specific to the Catholic Church, the “actionable items” of the mission are not necessarily unique to Catholic healthcare. These objectives, like acting with compassion, promoting wellness, and dedication to the vulnerable, can be found in many secular mission statements.¹⁴ The aspects of the “Shared Identity” that are Catholic- or Christian-specific are essentially philosophical, like treasuring every person, and considering every human to be a “unity of body, mind, and spirit.”¹⁵ This philosophical difference is theoretically at the core of the distinctiveness of CHIs. What does this distinctiveness look like if the “actionable items” are similar to those of non-Catholic hospitals? Does the unique philosophical and theological lens translate to truly distinctive care, or is Catholic healthcare only different because of its unique ethical restrictions in care?

Identity

The distinction, if present, lies in the identity of the Catholic hospitals, the focus of the second lens of analysis of Catholic health care from Stempsey’s framework. Catholic and non-Catholic hospitals can have very similar mission statements, as demonstrated with examples in Carol Taylor’s work, but the means of achieving that goal can be very different.¹⁶ The one tangible, coherent factor in the identities of Catholic hospitals is the adherence to the ERDs penned by the USCCB. Currently in its fifth edition, the document serves as a moral guide for CHIs and employees. In the preamble of the ERDs, the USCCB explicitly states that this guidance is needed in

¹⁴ Taylor, "Roman Catholic Health Care Identity and Mission: Does Jesus Language Matter?"

¹⁵ Catholic Health Association of the United States, "A Shared Statement of Identity".

¹⁶ Taylor, "Roman Catholic Health Care Identity and Mission: Does Jesus Language Matter?", 31.

response to the ever-changing state of health care in the United States.¹⁷ The USCCB also states that there are certain principles that remain constant throughout history, and that these principles guide a “contemporary understanding of the Catholic health care ministry.”¹⁸

The ERDs and the accompanying restrictions in health care are often the focus of public discourse. It is less well known that the ERDs also emphasize the importance of many uncontroversial principles of good health care. These include principles like the value of holistic health care, attentiveness to non-biological foundations of health, justice, human dignity, and well-ordered relationships.¹⁹ These principles are not unique to Catholic healthcare, but having these principles as a mandatory, integral part of a whole hospital system’s identity might be considered unique. Although the ERDs do not constitute the whole of Catholic identity in health care, they are the only tangible facet of that identity. The remaining facets of Catholic identity can only reliably be assessed in practice through perceived differences in the care provided to patients.

Integrity

The benefits of a Catholic identity can be assessed through the third lens of Stempsey’s framework, the lens of integrity. A Catholic identity can only influence patient care outcomes if the institution remains faithful to that identity and integrates it into their policies and practices. These outcomes can only be observed if a high level of integrity exists in a Catholic hospital. This is easier said than done; even if one was to look to patient outcomes to assess institutional integrity, which outcomes should he or

¹⁷ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services" 3.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

she be looking at? Kenneth R. White wrote about this challenge in 2000 and outlined the need for additional research in specific areas to assess the contribution of the Catholic identity to health care in the US.²⁰ Three of these areas are particularly relevant to the discussion at hand. White stipulates the need to “assess the impact of Catholic health care on the health status of targeted populations, compared with other provider ownership types, [...] evaluate the impact of Catholic health care on individual patient responses, [...] assess and evaluate organizational innovativeness, particularly as it relates to the adoption of alternative and complementary services.”²¹ In the time since, certain organizations and individual researchers have taken on this challenge and have attempted to assess the outcomes of a Catholic identity as White suggested and this is the subject of the following discussion.

One of the target populations outlined by CHA’s “Shared Statement of Identity” is the poor. Preferential option for the poor has long been a facet of Catholic social teaching and this facet also permeates Catholic identity in healthcare. In the ERDs, special care is taken to emphasize the right of all humans to adequate health care, especially for the “poor, uninsured, and underinsured.”²² Because Catholic hospitals occupy an increasing market share of US health care, Catholic hospitals have been put under scrutiny to see if they are fulfilling this particular goal. The MergerWatch Project and the American Civil Liberties Union (ACLU) wrote a joint report in 2013 that detailed an investigation into the charity care provided by Catholic not for profit

²⁰ Kenneth R. White, "Hospitals Sponsored by the Roman Catholic Church: Separate, Equal, and Distinct?," *The Milbank Quarterly* 78, no. 2 (2000):doi:10.1111/1468-0009.00169.

²¹ *Ibid.*, 231-32.

²² United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services".

hospitals in the US.²³ Both of these organizations have a history of being vehemently against Catholic influences in healthcare, motivated by an opposition to the restrictions of care stipulated by the ERDs. Despite this bias, their joint investigation reveals useful information.²⁴ They use two metrics to determine the relative level of charity care Catholic hospitals provide compared to other types of hospitals; the first metric is the total monetary value of care provided to patients that are unable to pay in comparison to a hospital's total gross patient revenue, and the second metric is the monetary value of care provided to Medicaid patients. The data for these metrics is provided by the Centers for Medicare & Medicaid Services (CMS), and is submitted by to the CMS by hospitals.

Although this report was compiled with the intention to show only negative aspects of Catholic health care for a targeted reason, the data itself is collected from an unbiased, factual source. As per the data, Catholic non-profit hospitals provide an average level of charity care, and provide the least amount of services to patients with Medicaid relative to total revenue compared to other hospital types.²⁵ Charity care is the total care charged that the hospital does not bill for and does not expect to receive back. Patients that have Medicaid, or government subsidized health insurance, generally make up the poorest segments of the American population. Measuring these two types of care can give a decent picture of how well hospitals care for the poor in their areas.

²³ Uttley et al., "Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care."

²⁴ For a respectable analysis of the weaknesses of the report, see Lawrence J. Nelson, "Aclu V. Catholic Health Care," in *Conscience & Catholic Health Care: From Clinical Contexts to Government Mandates*, ed. David E. DeCosse and Thomas A. Nairn (Maryknoll, New York Orbis Books, 2017), 125. None of the weaknesses surround the actual methodology used to compile data.

²⁵ Uttley et al., "Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care," 13.

According to the report, public hospitals provide roughly double the charity care and receive double the Medicaid reimbursements as both non-profit and for-profit hospitals.²⁶ The comparison between Catholic non-profits and public hospitals are less useful considering the vast difference in manner of funding and organization, but the comparison between Catholic and other non-profits is more useful. Catholic hospitals perform roughly the same amount of charity care as other secular and religious non-profit hospitals, which amounts to 2.8 percent of total gross revenue. On the other end of the data, for-profit hospitals provide charity care that totals 2.0 percent of their total gross revenue, a .8 percent difference from Catholic non-profit hospitals. CHIs, however, provide less care to Medicaid patients than any other type of hospital, with only 13.4 percent of gross revenue coming from Medicaid reimbursements.²⁷ Other religious and secular non-profits respectively totaled 14.8 percent and 14.3 percent of gross revenue in Medicaid reimbursements. For profit-hospitals totaled 14.7 percent, and public hospitals totaled 18.4 percent.

This data shows that while CHIs aren't necessarily lagging behind in providing for the poor, they are average at best compared to other non-profits. To put this in perspective, if all Catholic hospitals were replaced with any other not for profit hospitals, the total charity care provided would stay the same and more Medicaid patients might be served. This may not be for lack of trying. CHIs must remain financially competitive with other hospitals to stay open, meaning that they may not be able to provide significantly more charity care while staying open. The current configuration of Catholic healthcare may not allow CHIs to pursue their mission in a

²⁶ Ibid.

²⁷ Ibid., 13.

truly distinctive way. To the credit of the Catholic healthcare system, this has not gone unnoticed and concerted efforts are being made to improve the amount of charity care provided. Stemming from Pope Francis' call for Catholic services to return to missionary roots and re-centralize their focus on the poor and vulnerable, Catholic health care systems and their CEOs have publicly stated their commitment to increasing the amount of charity care they provide.²⁸ Whether this is a financially feasible endeavor remains to be seen.

In regards to White's second topic in need of assessment, the impact of Catholic health care services on patient responses, the data is variable and inconclusive. One study carried out by David Foster concluded that Catholic non-hospitals outperformed any other hospital ownership type.²⁹ The measures used in this study revolved around quality of care, efficiency, and consumer satisfaction, but only one of the eight data categories represented individual patient responses. So, if Catholic hospitals are truly providing better care by some measures, it might not translate to patients' perceptions of distinctive care. Although this is important to know about Catholic hospitals, this does not sufficiently address the gap in knowledge that White presented.

Another study published in the *Health Care Management Review* looked to compare Catholic and non-Catholic hospitals *only* in terms of patients' perception of care.³⁰ The data was taken from the "Hospital Consumer Assessment of Healthcare

²⁸ Jayne O'Donnell and Laura Ungar, "Pope Pushes Catholic Hospitals, Clinics to Do More to Help Poor," *USA Today*, September 24 2015.

<http://www.usatoday.com/story/news/nation/2015/09/23/pope-pushes-catholic-hospitals-clinics-do-more-help-poor/72616728/>.

²⁹ David Foster, "Differences in Health System Quality Performance by Ownership," in *Research Brief* (Center for Healthcare Improvement, 2010).

³⁰ Ann Kutney-Lee et al., "Distinct Enough? A National Examination of Catholic Hospital Affiliation and Patient Perceptions of Care," *Health Care Management Review* 39, no. 2 (2010): 134-44, doi:10.1097/HMR.0b013e31828dc491.

Providers and Systems” (HCAHPS) survey, which is a survey that the CMS requires all hospitals to give to their patients. Out of ten categories, Catholic hospitals performed better at a statistically significant level in three categories and performed worse at a statistically significant level in two categories.³¹ This suggests that on the level of patient perceptions, the distinction between Catholic and non-Catholic is negligible. While quality of care is assuredly a very important arena of healthcare in which Catholic hospitals do well, patient perceptions should also be considered given the ministry-oriented nature of Catholic health care. It should be noted that the variables measure patient perceptions in the general sense and not patient perceptions related to the ministry-related aspects of Catholic health care. Data showing the comparison of patient expectations and patient perceptions of Catholic healthcare would be useful, but this remains a gap in the literature. At the time of this writing, there is only limited evidence that shows that women are largely unaware of the reproductive restrictions at Catholic hospitals.³² There also seems to be a lack of quantifiable data in comparing innovativeness of Catholic and non-Catholic hospitals. The data that does exist indicates that “stigmatized and compassionate care services” do not differ between the two categories.³³

³¹ Ibid.

³² Maryam Guiahi, Jeanelle Sheeder, and Stephanie Teal, "Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care," *Contraception* 90 (2014): 429-34.

³³ Kenneth R. White, JW Begun, and W Tian, "Hospital Service Offerings: Does Catholic Ownership Matter?," *Health Care Management Review* 31, no. 2 (2006): 99-108; Kenneth R. White, TH Chou, and R Dandi, "Catholic Hospital Services for Vulnerable Populations: Are System Values Sufficient Determinants?," *ibid.* 35 (2010): 175-86, doi:10.1097/HMR.0b013e3181cafa20.

In summary, the available data shows that the contributions of Catholic non-profit hospitals may not differ drastically from secular non-profits. This data has been corroborated by written accounts of the health care providers that work in both environments. For example, Dr. Glenn G. Wood laments the practical homogenization of religious and secular hospitals he has observed throughout his career.

As a practicing pediatrician for twenty years, I have worked in Methodist, Episcopalian, Presbyterian, Catholic, and secular hospitals in three major cities. Their mission statements varied widely from the so-called Christian hospitals serving in Jesus' name to the secular hospitals promising to provide good health care without regard to creed, race, or religion, or something to that effect. [...] All of the secular hospitals that I have been associated with over my 20 years of practice have had a staff chaplain or priest and most have had chapels that are equivalent in size and beauty to those in the Christian hospitals. Where is the distinctiveness? Even in the area of abortion services, at least in the community of Austin, Texas where I practice, no hospitals provide abortion services except occasionally the county hospital that happens to be run by the local Catholic hospital. Such services are contracted out so that no employees of the Catholic hospital are directly involved. Where is the true distinctiveness?³⁴

Theoretically, if all Catholic hospitals in the US were replaced by secular or other religious non-profit or public hospitals, the available data shows that there would not be a tangible change in the health care provided to Americans, even for the poor. Of course, it is necessary to recognize the Church's financial contribution to healthcare in the US. Additionally, many of the positive aspects of the American health care system cannot be separated from its religious and Catholic history. Despite this, the homogenization of Catholic and secular hospitals needs to be addressed considering what is at stake in defending a Catholic presence in American health care.

³⁴ Glenn G. Wood, "Should We Be Concerned About the Content of Mission Statements for Christian Hospitals?," *Christian Bioethics* 7, no. 1 (2001): 106-07, doi:10.1093/chbi.7.1.105.3763.

The Ideal Catholic Healthcare Institution

Is homogenization of Catholic and secular hospitals good, bad, or a neutral byproduct of economic pressures? This question concerning Catholic institutions' departure from the ideal manifestation of the Catholic healthcare mission is important to address. If any solution to this ethically difficult issue is going to be successful, one must consider the direction that these institutions should take in the future to best accomplish their goals.

The common thread that unites discussions of an ideal Catholic health care institution is the balance between serving a pluralistic society and maintaining a uniquely Catholic identity. This debate is often couched in secular-friendly descriptions of social justice on one end of the spectrum and in Catholic-specific counter-cultural societal witness on the other. Scholars' arguments vary on where they believe the ideal Catholic institution should fall on that spectrum. Some, like Thomas Shannon, believe that reproductive restrictions are given an inaccurately central position in Catholic hospital merger practices, reflecting a one sided approach to Catholic identity.³⁵ Shannon argues that if a merger requires a choice between a Catholic hospital associated with scandalous reproductive services or no hospital at all, that a commitment to social justice should be given priority and that the Catholic institution should remain open so that care remains accessible to the public.³⁶ Shannon critiques the precedence given to abortion and contraception in merger deliberations, as this can leave the commitment to social justice concerning the post-natal at the wayside.³⁷ He

³⁵ Thomas A. Shannon, "Living the Vision: Health Care, Social Justice and Institutional Identity," *ibid.* doi:10.1093/chbi.7.1.49.3771.

³⁶ *Ibid.*, 56-59.

³⁷ *Ibid.*, 58.

expresses this concern in “Living the Vision: Health Care, Social Justice and Institutional Identity”:

The reason that I am concerned about this is that while the reproductive issues are important, they may consume the majority of the time and energy that negotiations require and occupy a locus of privilege that I would argue they should not have. Additionally such prioritizing of reproductive ethics serves to confirm the suspicion, already present among many, that fidelity to magisterial teaching on reproductive ethics is central to Catholic identity. Recall the emphasis on the role of the Bishop as teacher to help resolve identity issues previously discussed. A more important direction would be the one suggested in the mission statement above: to continue to promote wellness and the health status of the community.³⁸

His concern is not unfounded, considering the prioritization in the material isolation of select reproductive services in the merger negotiations presented in Chapter 1.³⁹ He later clarifies his point, stating that discussions about reproductive health care must occur at some point later on in the negotiations, but that preserving access to care should be a higher priority in cases where access is threatened, as this is a “larger social justice issue” than selective isolation of prohibited reproductive practices.⁴⁰

On the other hand, some scholars believe that Catholic hospitals as they currently exist betray their roles as ministerial arms of the Catholic Church for the sake of financial survival. For Corinna Delkeskamp-Hayes, much of the literature concerning the mission of Catholic hospitals falls short by neglecting the inseparable spiritual component of that mission, which is “further unification of humans with God.”⁴¹ More specifically, Delkeskamp-Hayes argues that a call for holistic patient care is insufficient

³⁸ *Ibid.*, 57.

³⁹ See page 21.

⁴⁰ Shannon, "Living the Vision: Health Care, Social Justice and Institutional Identity", 58.

⁴¹ Corinna Delkeskamp-Hayes, "Christian Credentials for Roman Catholic Health Care: Medicine Versus the Healing Mission of the Church," *ibid.* 126, doi:10.1093/chbi.7.1.117.3770.

without recognizing “the welcome possibility that God’s plan may involve spiritual growth not just as a welcome addition to bodily well-being but, at least in particular cases, as achieved through bodily suffering.”⁴² Delkeskamp-Hayes concludes that a truly Catholic identity, encompassing spiritual care of both patients and employees, is necessarily mutually exclusive with many of the mission statements found in Catholic hospitals that hold top quality care as equally or more important than serving the poor both physically and spiritually. As she succinctly phrases it, “the church cannot hope to successfully compete on the market of quality health care and at the same time do justice to her pastoral calling.”⁴³ So, for Delkeskamp-Hayes, Catholic hospitals as they currently exist in the US are not truly carrying out Christ’s healing mission, and enforcement of the ERDs is not sufficient to be faithful to that mission. For institutions to claim to carry out the church’s healing mission, the structures of those institutions must change drastically.⁴⁴

H. Tristram Engelhardt names this ideal Catholic institution described by Delkeskamp-Hayes as a traditional Christian healthcare institution and argues that this is the state that Christian institutions have originated from.⁴⁵ This is compared to “post-traditional” Christian healthcare institutions, which replace the embodiment of Jesus’ healing ministry in a holistic sense with an emphasis on social justice. Engelhardt gives a poignant comparison between the two types of Christian institutions.

The differences can be appreciated in terms of conflicting answers to the question posed by Jesus to Simon Peter, “But ye, who do ye say that I am?” (Matt 16:15). The traditional Christian health care institution: in its

⁴² Ibid., 124.

⁴³ Ibid., 137.

⁴⁴ Ibid., 137-39.

⁴⁵ H. Tristram Engelhardt, “The Dechristianization of Christian Health Care Institutions, or, How the Pursuit of Social Justice and Excellence Can Obscure the Pursuit of Holiness,” *ibid.* 153, doi:10.1093/chbi.7.1.151.3769.

corporate life, such an institution proclaims Peter's answer to Christ's question, "Thou art the Christ, the Son of God, the living One" (Matt 16:16). The traditional Christian health care institution in its corporate life should explicitly embody the recognition that the most important metaphysical and moral truth is the Incarnation, the good news of which the institution should attempt with all its energy to bring to all that it encounters.

The post-traditional Christian health care institution: in its corporate life, the institution implicitly gives a different answer to Christ's question, namely, "You are the prophet of social justice, whose message affirms universal human dignity, an answer that can be appreciated by all, independently of their religious commitments." Such an institution may affirm its historical connections with traditional Christianity, while attempting to provide quality care to its patients, respect human dignity, and realize a preferential concern for the poor and the underserved, insofar as resources permit, all within a moral language accessible to all.⁴⁶

Engelhardt continues with a discussion of these two institutions in light of the tensions between traditional Christianity and cosmopolitan liberal culture.⁴⁷ He approaches the heart of the difference between the ideal, traditional Christian institution and a secular institution, giving the following explanation:

Traditional Christian and liberal cosmopolitan appreciations of the moral issues ingredient in reproduction, dying, and death are to each other anti-moralities. The traditional Christian recognizes abortion as the murder of unborn children, suffering as an opportunity to gain humility, and physician-assisted suicide as a form of assisted self-murder. In contrast, the liberal cosmopolitan regards abortion and physician-assisted suicide as elements of responsible human choice, while also considering the humiliation involved in suffering as an offense against human dignity. The traditional Christian understanding of life collides with the immanent goals of the cosmopolitan liberal. Traditional Christian health care institutions look beyond medical health to focus on union with God as the only goal in terms of which charity, justice, and mercy have their right sense and significance. Secular health care institutions look to the claims of this world. Finally, traditional Christian morality requires setting limits that the liberal cosmopolitan must find offensive. Traditional Christian health care institutions will not only refuse to provide care that many hold to be theirs by right. They also implicitly reprove those seeking such interventions by recognizing those endeavors as immoral.⁴⁸

⁴⁶ Ibid., 152-53.

⁴⁷ Ibid., 154.

⁴⁸ Ibid.

This is Engelhardt's expression of the ideal level of integrity that a Christian (and Catholic) healthcare institution should exhibit. Without this integrity, the mission fails. In Engelhardt's words, when traditional Christian institutions are secularized or become post-modern, "traditional moral prohibitions can then only appear as legalistic or external moral constraints, to be legalistically circumvented so that health care institutions can get about the business of discharging their obligations in social justice."⁴⁹ Engelhardt finally hints at the same judgment that Delkeskamp-Hayes makes in her work, which is that the current configuration of the healthcare system is restricting the Catholic healthcare mission. Engelhardt opines that if a Catholic institution acts with integrity, that they will be the subject of "secular scandal":

Health care institutions of a traditional Christian character should be committed first to excellence in spiritual care and only second to excellence in providing medical and psychological care. If their robustly traditional spiritual commitments pose a stumbling block to attracting highly skilled health care workers or produce a shrinking patient base, traditional Christian health care institutions should be willing to shoulder these costs. Their focus should be on charity in the sense of providing for the needs of others out of a love towards neighbor framed within a prior and directing love to God. Such institutional commitments can only give secular scandal. For those that have been secularized, giving less than the best health care in order to serve transcendent goals can be an unjust misdirection of energies.⁵⁰

While Shannon attests that maintaining access to services is a central priority, Engelhardt suggests that expansion, or even maintaining a financially viable practice, cannot be prioritized over the Christian healthcare mission in its entirety; partial conceptions of that mission are not sufficient, even if it is the only way to remain financially viable.

⁴⁹ Ibid., 157.

⁵⁰ Ibid., 159-60.

Clarke Cochran, in “Institutional Identity; Sacramental Potential: Catholic Healthcare at Century’s End,” recognizes the tensions in the future of Catholic healthcare represented by Shannon’s, Delkeskamp-Hayes’, and Engelhardt’s responses to the problem of Catholic identity.⁵¹ He names three tensions that plague CHIs in the context of the current healthcare system. The first is internal tension, which is general tension over “structure and mission” that plagues the Church itself and its ecclesial branches.⁵² The second, external tension, is the tension experienced when deciding “whether to assert a strong Catholic identity that distinguishes them, or whether to advance the elements in common that facilitate cooperation.”⁵³ This second tension is especially evident in the comparison between Shannon’s and Engelhardt’s work. The last is tension between “good citizenship” and “societal transformation.”⁵⁴ It is the tension CHI’s face to contribute to society’s well-being, perhaps by focusing on common elements, or to work towards social transformation.⁵⁵ Cochran continues about his description of the third tension:

If Catholic hospitals are to work within the new institutional framework of health care, they must reconcile that with the demand not to give to Caesar what is God’s. That is, to be a hospital today is implicitly to support the uses that society makes the hospital’s modern kind of health care. It is implicitly to favor the existing medical paradigm, which owes little to the Christian healing narrative.⁵⁶

So, Cochran also suggests that the corporate hospital model may not be functional for the Catholic healthcare mission, at least not how it did (and still does) exist. Cochran

⁵¹ Clarke E. Cochran, "Institutional Identity; Sacramental Potential: Catholic Healthcare at Century's End," *ibid.*5 (1999).

⁵² *Ibid.*, 32.

⁵³ *Ibid.*, 33.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

offers a sacramental Catholic social theory to help address the tensions he describes and later offers an ideal vision of Catholic healthcare:

To be a sacrament is more than to represent, but it is surely not less, and the idea of representation is crucial to the institutional challenge today. Another way of putting this is in terms of witness. Whatever the demands of the institutional challenges of modern healthcare, no Catholic institution is justified unless it represents or reflects the Kingdom of God; that is, institutions are to be “icons” of Christ (Zizioulas, 1985, pp. 138ff). The political, policy, and institutional task of the Church is to represent a different vision of the way the world truly is and, in aspiration, can be, a vision through the lens of the crucified and resurrected Lord.⁵⁷

Cochran considers the current state of the Catholic healthcare system in terms of his sacramental theory. For Cochran, an institution cannot be considered a CHI unless the institution embodies Christ in action, not simply in abstraction. He explains how many current CHIs fail this qualification:

In this regard abstractions won't do. The Church cannot point to justice without being just. Hospitals cannot point to compassion without being compassionate. Catholic healthcare cannot point to principles without embodying the Christ who animates all principles. So there must be real people (and real institutions, structures through which real people witness in the world) ministering to other real people, mutually encountering Christ. Therefore, Catholic healthcare institutions really must be different and distinctive. If Catholic hospitals look like any other hospitals, they represent not Christ, but the medical system. If Catholic hospitals are different only in their refusal to perform certain procedures, they represent only one face of Christ.⁵⁸

Cochran's judgments in the context of his sacramental theory are riveting; while calling for this sacramental version of witness before society, he critiques the one-sided nature of the distinctiveness of Catholic care manifested as restrictions in care. In other words, Cochran says that if the most distinctive thing about Catholic healthcare is the care

⁵⁷ Ibid., 34-35., taken from J. D. Zizioulas, *Being as Communion: Studies in Personhood and the Church*, St. Vladimir's Seminary Press, Crestwood, New York. (1985)

⁵⁸ Ibid., 35.

restrictions, then this is not full sacramental representation of Christ. The very facet of Catholic healthcare identity that some claim is vital for societal witness fails to be sufficient.⁵⁹

Cochran, after this judgment about contemporary CHIs, gives a prescription for the future of Catholic healthcare based on his sacramental theory:

Although some Catholic hospitals should continue to exist, it may be time for the Church to focus on other forms of healthcare that better model the sacramental encounter. These might be neighborhood clinics for abused children and battered wives, hospices for the dying, AIDS ministry, inner city clinics for those without health insurance, clinics in immigrant labor camps, rehabilitation centers, addiction treatment facilities, and outpatient mental health centers. New forms of institutional ministry need capital as much as creativity. Catholic hospitals represent extraordinarily large pools of capital. Some hospitals have already been sold and the proceeds used to establish community foundations to fund other forms of health ministry. Given that prices for hospital acquisitions may have started falling, it could be time to sell a number of hospitals while the selling is good, with the proceeds dedicated to funding the start-up of different forms of care.¹¹ However, it should also be noted that many of these small clinics benefit from strong linkages to flourishing modern hospitals. The issue of whether to sell or to increase community outreach ministry through the hospital is prudential. Which alternative, in a given context, best fulfills the responsibility of Catholic healthcare as a sacrament of Christ?⁶⁰

Although Cochran gives many options for what sacramental healthcare might look like outside of the corporate hospital model, he makes two suggestions to help hospitals implement sacramental healthcare. The first is to increase revenues in order to provide more charity care and the second is that founding religious orders should “instantiate their charisms” in the lay leadership, so that the leadership consists of those that have a “living faith in Christ.”⁶¹ Ultimately, there is no evidence to suggest that this might be feasible within the context of the current corporate configuration. To the contrary, the

⁵⁹ Ibid., 29.

⁶⁰ Ibid., 38.

⁶¹ Ibid.

evidence collected earlier in this chapter suggests that this is a fool's errand. With financial viability being a necessary priority for operation and with the decimation of founding religious orders, these two tasks might be insurmountable. It is intriguing to contemplate whether a CHI could ever enact Cochran's sacramental theory while maintaining a mainstream corporate model.

Even among these varied positions, the consensus is that the Church should maintain a presence in American health care in some form and that Catholic healthcare must become more distinctive. There is a general awareness that Catholic hospitals are not operating at their full potential as ministerial arms of the Church, even if there are disagreements on what full potential might look like. The last common theme running through these works is that the current configuration of Catholic healthcare may prevent the Church from continuing Jesus' healing ministry in its fullest sense. Unless the status quo is disrupted, true distinctiveness might never be achieved.

Legal Issues in Catholic Health Care

Over the past few years, the ACLU has brought an onslaught of legal cases against Catholic hospital systems, CHI employees, and the USCCB, all related to the restrictions in women's reproductive health. These cases are highly politicized and polarizing, with much of the American left demanding unfettered access to all legal reproductive services and much of the American right demanding unlimited exercise of religion. While the cases are much more complex than these binaries in reality, public discourse often relies on the binaries, making fair and productive discussions difficult to encounter.⁶² These cases are very recent, some of which are still pending in state and

⁶² Lawrence J. Nelson, "Aclu V. Catholic Health Care," in *Conscience & Catholic Health Care: From Clinical Contexts to Government Mandates*, ed. David E. DeCosse and Thomas A. Nairn (Maryknoll, New York Orbis Books, 2017), 133.

federal courts. While public commentary abounds, the literature is sparse. One ethicist and legal expert, Lawrence J. Nelson, has been able to publish an even-keeled assessment of two of the major cases pursued by the ACLU. I will discuss his analysis in this section, along with my own analysis of other cases not mentioned by Nelson. The goal of this discussion is not only to provide further understanding of these cases, but to show the implications for the future of Catholic healthcare in the US.

The two cases discussed by Nelson are *ACLU v. Trinity Health* (2015) and *Means v. USCCB* (2015).⁶³ Both cases were brought by the ACLU because of the care one woman, Tamesha Means, experienced while miscarrying at a Catholic hospital in Michigan. Nelson provides a detailed overview of the medical facts of the case, as was presented to the court. The excerpt is a synthesis of facts from Ms. Means' patient file and of medical facts given by experts in the case. Although lengthy, reading these details is informative when compared to Means' own description of her perception of the care that she received, so I will include the entire excerpt here:

According to the complaint filed by Ms. Means's ACLU lawyers, the following describes the basic facts of her interactions with Mercy Health Partners hospital (MHP) in Michigan in 2010. Means sought emergency care at MHP on December 1 because she was experiencing contractions. MHP performed an ultrasound which showed that she was at 18 weeks of gestation, that her fetus had a heartbeat, and that she has a low amniotic fluid index. MHP diagnosed her with preterm premature rupture of membrane (PROM) and informed her that her fetus was not yet viable.

The patient was given pain medication and told to return eight days later for her regularly scheduled prenatal visit. She returned home under the impression that there was a chance her fetus could become viable and she could continue her pregnancy. In fact her condition usually results in fetal death either in utero or shortly after birth.

Ms. Means returned to MHP in the early morning of the following day with symptoms of pain (10 on a 10-point scale), bleeding, and a temperature of 100.4. The attending physicians suspected she had chorioamnionitis, a bacterial infection affecting the fetal membranes and

⁶³ Ibid.

amniotic fluid. After her fever reduced, she was again sent home and advised to return if her fever rose or her contractions became unbearably painful.

Ms. Means returned to MHP later that same day with regular contractions and severe pain. While MHP was in the process of discharging her again, she began to deliver spontaneously and underwent a breech birth. Her baby died a few hours later. The placental pathology report indicated that Ms. Means had acute chorioamnionitis and acute funisitis (inflammation of the umbilical cord) at the time of birth. On none of these visits did MHP inform her of the serious risks to her health if she continued the pregnancy, of the hospital's policy forbidding termination on its premises, of the extremely low likelihood that the fetus could survive, or of the option of terminating her pregnancy at a different hospital. Her complaint alleges that if she had known all of this, she would have terminated her pregnancy.⁶⁴

In both legal cases, the ACLU argues that the restrictions enforced by the ERDs cause the provision of substandard care specifically in miscarriage management. The standard of care for premature PROM includes counseling on realistic fetal outcomes, counseling on the risks and benefits of accepting or rejecting immediate delivery, and offering immediate delivery. Nelson argues that even if MHP (part of the Trinity Health system) refused to offer the termination, that the standard of care required informing Ms. Means of her options available elsewhere so that she could make an informed decision about her own healthcare.⁶⁵ Nelson concludes that the ACLU is right in this case “in principle,” since MHP did not counsel Ms. Means in the manner required by the standard of care or the principle of informed consent.⁶⁶

This recognition, however, does not mean Trinity Health or the USCCB is legally liable for negligence. In fact, both cases were dismissed by the courts. In *Means v. USCCB*, the case was based on the negligence of the USCCB specifically in Means' case. In *ACLU v. Trinity Health*, the ACLU sued on behalf of its members, stating that

⁶⁴ *Ibid.*, 128-29.

⁶⁵ *Ibid.*, 130-31.

⁶⁶ *Ibid.*

the health system's policies violate the Emergency Medical Treatment and Active Labor Act (EMTALA).⁶⁷ There are three main federal laws that are the focus of these deliberations:

1. Emergency Medical Treatment and Active Labor Act (EMTALA) - EMTALA requires American hospitals that accept funds from the Medicare program to provide emergency examination and treatment to anyone that presents with a medical emergency, even if they cannot pay for the services. Hospitals are also required to stabilize a patient in an emergency. The patient may not be transferred without stabilization unless the hospital is not capable of providing the care or if the patient requests a transfer.⁶⁸
2. Religious Freedom Restoration Act (RFRA) - The RFRA prevents any burdens on a person's exercise of religion, unless the action serves a "compelling government interest" and it is also the "least restrictive means" of serving that particular interest.⁶⁹
3. First Amendment of the U.S. Constitution - The relevant part of first amendment of the U.S. Constitution reads "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."⁷⁰

While EMTALA seems to suggest that a CHI would be required to perform an emergency, life-saving termination, the RFRA and First Amendment protect religious exercise, including objection to performing abortions. It has not yet been clearly

⁶⁷ *Ibid.*, 131.

⁶⁸ Centers for Medicare & Medicaid Services, "Emergency Medical Treatment & Labor Act (Emtala)," <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/>.

⁶⁹ *Religious Freedom Restoration Act*

⁷⁰ National Constitution Center, "Amendment I,"

<https://constitutioncenter.org/interactive-constitution/amendments/amendment-i>.

determined which federal law supersedes the other. Nelson makes the astute observation that “the constitutionality of federal conscience protection laws have not yet been vigorously tested, and they do not clearly shield objectors from participation in an emergency abortion. If they did, the USCCB would not be lobbying diligently for the passage of the CPA.”⁷¹ Both cases were dismissed because of legal requirements having to do with time of injury in relation to the case, jurisdiction, and the way evidence was presented. Eventually, the ACLU or others might present a case where the legal requirements are met and the court would have to decide how far the protections of the RFRA and First Amendment extend. If it is ruled that emergency abortions must be provided in the interest of public health, this would put the entire Catholic healthcare system in legal jeopardy.

The ACLU is also serving as counsel in *Chamorro v. Dignity Health*, challenging the prohibition of tubal ligations after C-sections at Mercy Medical Center Redding (MMCR), a Catholic hospital in California.⁷² A tubal ligation is a permanent form of sterilization that is safest to perform immediately after a C-section birth. Because the aim of the intervention is contraceptive, the procedure is prohibited by the ERDs at CHIs. In Rebecca Chamorro’s case, her obstetrician requested permission for

⁷¹ Nelson, "Aclu V. Catholic Health Care," 134-35., The CPA here refers to the Conscience Protection Act of 2016, which would increase existing protections for those that object to participating in abortions. It was not passed and was resubmitted to congress as the Conscience Protection Act of 2017., Secretariat of Pro-Life Activities, "The Need for the Conscience Protection Act of 2017: Questions and Answers," United States Conference of Catholic Bishops, <http://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/The-Need-for-The-Abortion-Non-Discrimination-Act.pdf>.

⁷² "Rebecca Chamorro and Physicians for Reproductive Health V. Dignity Health; Dignity Health D/B/a Mercy Medical Center Redding First Amended Complaint for Declaratory and Injunctive Relief and Nominal Damages," (Superior Court of the State of California for the County of San Francisco, 2016).

the tubal ligation at MMCR and was denied due to the ERDs.⁷³ The other nearest hospital that could perform a tubal ligation after a C-section is more than 70 miles away, which would take more than two hours of travel to reach for Chamorro.

Originally, the case was pursued on the basis of sex discrimination, which was dismissed since MMCR also denies permanent sterilization procedures for men.⁷⁴

Now, however, the case is being pursued because the tubal denial allegedly violates a California law that prevents a corporate entity from enforcing medical decisions based on non-medical criteria.⁷⁵ MMCR in the past has selectively given permission for certain tubal ligations, one of which was granted after the ACLU threatened to sue. That particular request was initially denied according to the ERDs, but subsequently granted. It is highly unlikely that the hospital's review board found that the tubal ligation was suddenly acceptable according to the ERDs after the threat of a lawsuit. More realistically, it appears that legal troubles are influencing the care provided at MMCR. This evidence is being used to show that MMCR is breaking California state law; since they are arbitrarily granting permission for certain tubal ligations, they could be found to be violating the law prohibiting corporate decisions based on non-medical criteria. The outcome of this case is still pending. Since the original complaint was made, the California Medical Association (CMA) filed to intervene and join the plaintiffs. The CMA is made up of 41,000 physicians, so the challenges for CHIs in California are only increasing.

In summary, there is a legal gray area that exists concerning the rights of women and the rights of CHIs in these instances. The matter is complicated by the intersection

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Ibid, 3. Cal. Bus. & Prof. Code §§ 2032, 2052, 2400.

of various state and federal laws that involve the distinction between private and public, the consequences of the utilization of public funds, and the freedom to practice religion. Further, the allegedly illegal refusals made by Catholic hospitals are protected under other laws depending on the state and treatment in question.⁷⁶ Elizabeth Sepper, one of the preeminent legal scholars on the subject has been publically quoted explaining the practical consequences of such legal conflict.

“In many states, if a Catholic hospital were to kill a woman because they did not provide her with proper miscarriage management, they would not face liability,” Sepper noted. “It’s one thing to say, in order to protect one’s religious beliefs and convictions about when life begins, we’re going to allow you to step away from a situation, to not perform an abortion in most situations. But to say that you could actually kill someone or seriously injure them and face no consequences for that seems a step too far.”⁷⁷

While Sepper’s statements to the media fail to make the morally significant distinction between actively, unjustifiably killing a person and letting a person die by refusing to participate in immoral acts, the statement accurately reflects the views of those that are advocating against the place of Catholic healthcare in the US. The matter is certainly not settled for these groups simply because no cases have yet been successful.

As these cases are publicized, additional evidence might come to light that would make a difference in how these cases are pursued. For example, *Means v. USCCB* was dismissed because the plaintiff did not have a present injury and the statute

⁷⁶ Elizabeth Sepper, "Taking Conscience Seriously," *Virginia Law Review* 98 (2012): 1509-15, doi:10.2139/ssrn.1888375.

⁷⁷ Samantha Lachman, "Lawsuits Target Catholic Hospitals for Refusing to Provide Emergency Miscarriage Management," *The Huffington Post*, June 10 2016. http://www.huffingtonpost.com/entry/catholic-hospitals-miscarriage-management_us_5759bf67e4b0e39a28aceea6.

of limitations for medical malpractice had passed.⁷⁸ The plaintiff, Tamesha Means, states that during her crisis, she was not aware that her case was being mismanaged. Ms. Means describes the events that occurred and the treatment options that were withheld from her.

When I was 18 weeks pregnant, my water broke and I began to miscarry. I rushed to the only hospital in Muskegon County, Michigan, where it was clear to the doctors at the time that the pregnancy wasn't going to make it. But rather than telling me that, the doctors at Mercy Health Muskegon sent me home and told me to rest. They told me that I should try to wait at home for nine days and that everything would be OK.

I tried to do as they said, but the pain made it impossible. I started bleeding profusely and returned to the hospital the next day. Again, they told me to go home. The pain persisted and I developed a fever. I went back to the hospital again – the third time in 48 hours – and begged for help. As they prepared the discharge paperwork for my third visit, I went into labor. Only as I was giving birth – with the baby actually coming out of me – did the hospital admit me.

They delivered the baby, who died a few hours later. Thankfully, I was able to recover and leave the hospital and go back to my life, but it never should have come to the point where that was even a question. [...] It didn't have to be this way. Doctors there could have told me that my child had no chance of survival. They could have told me that continuing the pregnancy at this point put my health and life in extreme danger. They could have completed the miscarriage and terminated the pregnancy, sparing me days of unnecessary pain, suffering and infection. But they withheld this information and endangered my life because of their religious beliefs.⁷⁹

As a result of the care she received Ms. Means experienced significant physical and emotional pain, which doctors claim was preventable and could have led to Ms. Means' death.⁸⁰ This case was dismissed based on the technicality of the law, not because the

⁷⁸ Curtis Skinner, "Appeals Court Rejects Michigan Woman's Lawsuit over Catholic Hospital Care," *Reuters*, September 8 2016. <http://www.reuters.com/article/us-michigan-catholic-idUSKCN11E30W>.

⁷⁹ Tamesha Means, "Catholic Hospitals Shouldn't Deny Care to Miscarrying Mothers Like Me ", *The Guardian* (2016), <https://www.theguardian.com/commentisfree/2016/feb/23/catholic-hospitals-abortion-womens-health-care-miscarrying-mothers>.

⁸⁰ Molly Redden, "Abortion Ban Linked to Dangerous Miscarriages at Catholic Hospital, Report Claims," *ibid.*, February 18. <https://www.theguardian.com/us->

Catholic hospital was found to be in compliance with current standards of care. As the ACLU ramps up efforts to collect data regarding women's experiences in Catholic hospitals and general awareness of current standard of medical care for issues like miscarriage management, the information available to courts might change. The ACLU is currently suing the Center for Medicare and Medicaid Services for access to complaints against CHIs due to the ERDs.⁸¹ In the lawsuit, the ACLU presents evidence of the existence of multiple complaints against just one CHI about miscarriage management.⁸² If the ACLU gains access to all similar complaints, it is not unreasonable to expect a slew of problematic legal challenges for CHIs in the US. One cannot consider the future of Catholic healthcare without considering the imminence of legal challenges to the Catholic healthcare mission.

The Crux of the Issue

The data in this chapter collectively suggests that there is little that distinguishes Catholic hospitals from other non-profit hospitals in practice. While the Catholic healthcare mission may be quite distinctive in theory, it seems there are obstacles to giving distinctive care in practice. Economic pressures and increased regulations encourage hospital homogenization. Pastoral care can be found in any kind of hospital in the US, not just religious hospitals. Levels of charity care are the same across all non-profit hospitals. Legal and societal pressures are making it harder for the Catholic ministry to be pursued in its fullness. Despite this grim outlook on the distinctive quality

news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners.

⁸¹ "American Civil Liberties Union V. Department of Health and Human Services; Centers for Medicare & Medicaid Services Complaint," ed. United States District Court for the Southern District of New York (2016).

⁸² Ibid.

of Catholic healthcare, the number of Catholic hospitals continues to rise, even when the numbers of comparable institutions drop.⁸³

Catholic hospitals are in the throes of ever-increasing secularization and loss of distinctiveness. In order for the Catholic healthcare ministry to survive, they must remain economically competitive. The more CHIs pursue economic viability, the harder it is to maintain the true essence of the Catholic healthcare ministry. As the Catholic healthcare mission becomes diluted, there is less reason to defend the place of Catholicism in American healthcare, especially in the light of the ethical conflicts in accessing reproductive health care. To forge a way forward in dealing with this complex issue, three more topics need to be discussed. The first is the ethical assessment of issues related to the ERDs, which is the subject matter of the following chapter. The second is the potential for harm to women should the current system be allowed to continue. The third are the practical obstacles to the Catholic healthcare ministry in context of the current configuration of the American health care system. Carrying out these discussions and shedding light on all related areas of concern will allow for a more nuanced strategy in dealing with these ethical issues.

⁸³ Uttley and Khaikin, "Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report."

CHAPTER 3: THE ETHICAL AND RELIGIOUS DIRECTIVES IN AMERICAN HEALTHCARE

The Ethical and Religious Directives (ERDs) are a list of 72 directives published by the United States Conference of Catholic Bishops (USCCB) that address several key areas of concern in the provision of Catholic health care. The document is focused on how Catholic institutions should function in the context of a largely secular environment that is often at odds with Catholic social teachings. The first section address the social responsibilities of Catholic health care, which are to “promote and defend human dignity,” care for the poor, contribute to the common good, to provide responsible stewardship over limited resources, and to refuse to provide unethical services.¹ The second section outlines pastoral and spiritual responsibilities; the directives in this section deal with practical concerns in providing sacraments in a hospital setting.² The directives in the third through fifth sections are the most controversial in secular medicine. These sections address patient-provider relationships, care at the beginning of life, and care at the end of life respectively. The third and fifth sections will be discussed in depth, as they have practical consequences for women seeking care in Catholic hospitals. First, I am going to provide a brief overview of the relevant aspects of Catholic Social Teaching and how this has led to the development of the current version of the ERDs. Subsequently, I will discuss practical considerations of the ERDs and assess how they are enacted and enforced in hospitals in the US.

¹ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," (2009), 10.

² *Ibid.*, 14-17.

Catholic Social Teaching and the Directives

One of the biggest struggles faced in carrying out the Catholic healthcare ministry is the application of thousands of years of tradition and scripture to contemporary moral issues in healthcare. Where Catholic Social Teaching (CST) or scripture do not provide explicit guidance on contemporary issues, the Church clergy applies general principles from the Catholic tradition to come to a conclusion regarding official Church teachings. This, in theory, helps Catholic hospitals and healthcare providers to understand various issues in medical ethics, informed by the Catholic Social Tradition.

Although Bishops' teachings are authoritative, even on issues in contemporary medicine, the application of the principles of CST to contemporary healthcare is not always clean and clear. As time passes, knowledge grows and situations change. These factors only contribute to already complicated deliberations in these applications. This is evident in the fact that the ERDs are currently in their fifth edition.³ Because of this, it is worthwhile to provide a brief overview of the principles of CST that inform the ERDs and other Church teachings on healthcare. I will also include major developments in Church teachings on these issues, as many come before or separately from the ERDs themselves.

Human Dignity

The Catholic view of the human person originates from scripture.⁴ Christians believe that humans have been “created by God in his own image and likeness,” and that the human soul is God’s direct creation.⁵ Because of this personal relationship with

³ Ibid.

⁴ O'Rourke and Boyle, *Medical Ethics: Sources of Catholic Teachings*, 4.

⁵ Ibid.

God, every individual person is sacred and is to be accorded dignity and respect in a way that is commensurate with this value. This has a few consequences for how one can morally act toward another human being, especially with regards to healthcare. First, murdering another human being is an unjustifiable evil, since this contradicts the value of God-given life. Second, every human life has the same value by virtue of their relationship with God, regardless of any differences that might exist between us. Third, this inherent value of human life requires that we treat each other in ways that reflect that value, and certain forms of medical interventions might not respect that value.⁶

Given these principles, it is not surprising that delineating the boundaries of human life has always been of interest. Identifying these boundaries has practical consequences for what medical treatments are considered licit. Knowledge about the beginning of human life has varied over time, causing debates over the ensoulment of an embryo or fetus in the past. With the discovery of human fertilization from a sperm and egg cell in the late 1800s, the distinction between ensouled and unensouled fetuses was abandoned.⁷ Although the Church does not make a definitive determination about the precise moment when personhood begins, the Church is clear on the position that human life is sacred from conception, and garners all the dignity and protections of a person from conception.⁸ The Church does not consider any “changeable factors” to have any bearing on personhood, so the value of human life is independent of age, condition, location, development, or mental or physical ability.⁹ Although I have

⁶ Ibid.

⁷ United States Conference of Catholic Bishops, "Respect for Unborn Human Life: The Church's Constant Teaching," <http://www.usccb.org/issues-and-action/human-life-and-dignity/abortion/respect-for-unborn-human-life.cfm>.

⁸ Ibid.

⁹ Ibid.

described a long, convoluted historical debate in very simple terms, this is why even very early interference with a zygote or embryo is considered by the Church as the murder of an innocent human life. This view is reaffirmed in many Church documents, such as the *Declaration on Procured Abortion* and *Evangelium Vitae*.¹⁰

The inherent value of human life, which cannot be separated from the human body, has ramifications for actions taken on the body. Since Aristotle and Aquinas, the Church has drawn on the principle of totality, that is, parts of a body do not have any moral standing outside of the body which they serve. If a part of the body is diseased, and removing this body preserves the health of the body, then this removal is justified.¹¹ If, however, the body part is not diseased and serves the health of the body, it is not justified to remove it. Pius XII expanded on this principle as applied to medical ethics.¹² Although he appealed to this principle to provide the justification for removing diseased organs, he also used the principle to reaffirm the immorality of permanent direct sterilization.¹³ Since the principle prohibits the removal of any healthy organ that serves the natural function of the body, sterilization is prohibited.

These views form the basis for many of the Directives. Here are just two examples of where these views on human nature and human dignity are called on as the foundation of relevant Directives:

¹⁰ Sacred Congregation for the Doctrine of the Faith, "Declaration on Procured Abortion," http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19741118_declaration-abortion_en.html, John Paul II, "Evangelium Vitae," https://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.

¹¹ Saint Thomas Aquinas, *Summa Theologiae*, (Charlottesville, Virginia: InteLex Corporation, 1993). Q. 65, A. 1.

¹² O'Rourke and Boyle, *Medical Ethics: Sources of Catholic Teachings*, 415-16.

¹³ *Ibid.*, 416.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.¹⁴

Catholic health care ministry witnesses to the sanctity of life “from the moment of conception until death.” The Church’s defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church’s commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.¹⁵

Community and Pursuit of the Common Good

The Church has a strong tradition on teaching about human communities and how they relate to government, the economy, and the collective well-being of all human beings.¹⁶ This teaching has been derived from scripture, specifically in the way Jesus describes how people should deal with each other.¹⁷ The Church teaches that loving each other as Jesus instructed means being concerned with each other’s welfare, which is ensuring “the needs that the person could not attain by himself or herself.”¹⁸ This was reaffirmed by Pope John XXIII in *Pacem in Terris*, 11 in 1963, when he stated that medical care is a human right.¹⁹ This is reflected in the ERDs: “Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized

¹⁴ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services."

¹⁵ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

¹⁶ O'Rourke and Boyle, *Medical Ethics: Sources of Catholic Teachings*, 6-8.

¹⁷ *Ibid.*, 6.

¹⁸ *Ibid.*, 7.

¹⁹ Pope John XXIII, "Pacem in Terris " http://w2.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_11041963_pacem.html.

when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.”²⁰ These principles about human rights based on beliefs about community and the dignity of humans provide the foundation for CST on social justice and the preferential option for the poor. These, as applied to healthcare, require responsible stewardship of resources. This is also reflected in the ERDs:

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.²¹

The concept of right-ordered relationships within the community are also relevant to the ERDs. The Church, over thousands of years, has drawn on the theme of the connection between sexuality in marriage from scripture to inform its teachings.²² Based on the lessons about sexuality and marriage from scripture, the Church teaches that sexuality is good and necessary for human fulfillment in the context of a marriage between a woman and man.²³ The Church also teaches that marriage is sacramental, as Jesus “made marriage a sacrament of his relation with the Church and a source of grace.”²⁴ Procreation, as the result of conjugal love, is how humans participate in God’s creation. Procreation and sexuality cannot be separated from one another; this

²⁰ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services" 10.

²¹ Ibid.

²² O'Rourke and Boyle, *Medical Ethics: Sources of Catholic Teachings*, 11-12.

²³ Ibid.

²⁴ Ibid., 11.

separation causes “injury” to the image that God created us in.²⁵ Marriages, understood in this way, provide the concrete with which to build society. Kevin O’Rourke, in writing about the values that provide the foundation for Catholic medical ethics, describes this belief succinctly: “Implicit in sexual activity therefore is the important and difficult responsibility to procreate children and educate them about the values of Christian life.”²⁶ This understanding of relationships between community, marriage, sexuality, and procreation provide the basis for many of the reproductive-related prohibitions of the ERDs. This is reflected in the preamble to many of these Directives aimed at reproductive care:

The Church’s commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being.²⁷

Based on the locations of all of the relevant passages of the ERDs, which are the preambles of sections leading to the actual Directives, there is a clear indication that the Directives themselves are firmly rooted in the CST. There are, however, debates about how the ERDs can be best formulated to carry out the Catholic healthcare ministry in the CST. These debates will be one of the subjects of Chapter 5. In subsequent discussions about navigating ethical conflicts between Catholic and secular ethics, I

²⁵ Ibid., 13.

²⁶ Ibid., 14.

²⁷ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services" 23.

will assume that the US Church will always adhere to CST. In these discussions, I will highlight where the debates exist about the ERDs, in hopes of presenting where the Directives might exhibit better fidelity to the CST and might prevent certain obstacles to the Catholic healthcare ministry.

On the Role of Catholic Health Care Institutions in the Church

One of the important functions of the ERDs is to explicitly define the role of Catholic health care institutions (CHIs) in the US. The USCCB describes CHIs as expressing “the healing ministry of Christ in a specific way within the local church.”²⁸ As such, the USCCB confirms that the diocesan bishop has responsibilities as “pastor, teacher, and priest” to the CHIs within their respective diocese. As part of those responsibilities, local bishops make decisions on cases that do not fall neatly under the proscriptions of the ERDs as the final authority of hospital ethics boards. Additionally, CHIs and their employees are subject to the relevant Canon Laws.²⁹ Outlining the role of CHIs in this way clearly delineates CHIs as ministerial arms of the Church.

Many of the criticisms of CHIs originate from this foundation. Catholic hospitals are expected to function as arms of the Church, and yet they provide a service in a manner that sometimes requires their use by the public.³⁰ Because of this context, the ordinary arguments of freedom of religion and personal autonomy are not satisfactory. For example, personal religious beliefs and exercises are protected under federal laws like the Religious Freedom Restoration Act and the First Amendment of

²⁸ Ibid., 8.

²⁹ Ibid., 12-13.

³⁰ This is the case when a CHI is a sole community provider, or if a person is taken to a Catholic hospital in an emergency without being given a choice over a non-Catholic hospital.

the U.S. Constitution. When these laws are applied to the exercise of religion in CHIs that serve a diverse population, protecting those exercises necessarily impacts others' health and lives. In these cases, protecting religious exercises means protecting the right to impact another person's health due to beliefs they may not share. A specific set of circumstances make this true. Sometimes, Americans have no choice but to receive care from a CHI; whether the CHI is a sole community provider or if an unconscious patient is brought to a CHI in an emergency, not everybody is able to choose the option of receiving secular health care. Even if a patient willingly walks through the doors of a CHI, the patient might be making a choice between Catholic healthcare and serious injury or death, meaning that the patient is forced to choose Catholic care to preserve his or her life.

CHIs are not wholly private or public in the way those words are commonly understood. This is where Catholic health care is different from other institutions within Catholicism, like education. Catholic schools in the US are truly private schools in every sense of the word. Citizens are not forced to send their children to Catholic schools; it is the parents' choice to enroll their children in a private Catholic school over a secular public school. While it is true that the secular education option may be so poor that parents feel pressured to send their children to Catholic school, there is always still the public, secular option.³¹ In practice, there are also sometimes other viable options such as secular private schools, schools in other religious traditions, and boarding schools for those that can afford such an education for their children. Even if non-

³¹ There is no federal law ensuring access to free public education, but the Tenth Amendment of the Constitution transfers that power to individual states, each of which have individually guaranteed public education through 12th grade. The Fourteenth Amendment does, however, ensure equality of public education across the country.

Catholic children are sent to Catholic school, it is highly unlikely that they would face the same immediate consequences as some non-Catholic patients at a CHI. Parents can always have discussions with the child about the differences between Catholic beliefs and their own; the child may also form their own opinions about what they learn and what they are taught by their family. If a woman is forced to seek care at a CHI during a miscarriage, she might be seriously injured or worse due to another person's or corporation's religious practices.³²

In this way, Catholic education and health care are not comparable in their current forms. It does not seem right to force women to make health care choices according to Catholic principles, but it also does not seem right to force Catholic hospitals to perform actions they consider to be an unjustifiable evil. This tension is due to the peculiar space that CHIs occupy as a functional public-private hybrid. I will discuss the details of specific directives from the ERDs through this lens, focusing on the consequences for women's health care in the US.

The Patient-Provider Relationship

The expository portion of the third section of the ERDs describes the ideal patient-provider relationship. Strikingly, a majority of this portion could be read out of a secular textbook on physician-patient interactions without seeming out of place. Indeed, it seems to focus on the prime importance of patient autonomy. The first portion reads as follows:

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires,

³² Victoria Ward, "Pregnant Woman Dies in Ireland after Being Denied an Abortion," *The Telegraph*, November 15 2012. <http://www.telegraph.co.uk/news/worldnews/europe/ireland/9679840/Pregnant-woman-dies-in-Ireland-after-being-denied-an-abortion.html>.

among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.³³

On the surface, this statement is compatible with secular medical ethics and its focus on patient autonomy. The difference is apparent, however, once the following qualification is made:

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.³⁴

This qualification of the patient-provider relationship raises questions about patient autonomy. First, the USCCB makes the statement that once a patient accepts care at a CHI, there is an implicit acceptance of the Church's commitment to its views and values. This in and of itself is problematic if the patient is not aware that the institution is Catholic or how a Catholic healthcare mission might impact their care. If these things are not freely communicated to the patient, how is it possible for the patient to implicitly accept them? How can autonomy be respected if patients remain unaware of these facts?

³³ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 18.

³⁴ *Ibid.*, 19.

The concept of autonomy and its prioritization in relation to other concerns is widely debated within medical ethics, but it is a legal requirement in clinical practice to provide enough medical information to a patient so that they might make their own decisions through the lens of their own belief system.³⁵ All 50 U.S. states have some version of a law requiring informed consent in medical practice, meaning that the patient is always given the relevant facts and counseling to enable them to make their own medical decisions.³⁶ This system is not perfect, given that “facts” are sometimes more subjective than physicians realize and that patient counseling can be inherently biased towards the physician’s own belief system.

Additionally, American physicians are taught to use an ethical framework that has its own criticisms.³⁷ Doctors rely on the four bioethical principles discussed in Chapter 1: respect for autonomy, nonmaleficence, beneficence, and justice.³⁸ In this system, physicians disclose all ethical and medically relevant options to the patient. To date, this is the best way American doctors can serve a pluralistic population; they rely on a secular but broad standard for conveying information so that the patient might be able to make their own decision according to their own beliefs. Physicians may refuse to provide some types of care in many circumstances, but they must at the very least inform the patient that the option is available if it stands to benefit the patient medically, will not harm the patient or any others, and is just in the distributive sense.³⁹

³⁵U.S. Department of Health & Human Services, "What Are My Health Care Rights and Responsibilities?," U.S. Department of Health & Human Services, <https://www.hhs.gov/answers/health-care/what-are-my-health-care-rights/index.html>.

³⁶ Ibid.

³⁷ Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity", 36-37.

³⁸ Beauchamp and Childress, *Principles of Biomedical Ethics*, 57-272.

³⁹ There are restrictions on the ability to refuse in practice. See Chapter 1 for a discussion on the limits of conscientious objection in medicine, page 11.

There is some variation allowed within this system. American physicians are an increasingly diverse group that come from different religious traditions and different closely held beliefs. In practice, most legislature and professional regulations follow something at least similar to Mark Wicclair's "compromise approach." This approach dictates that providers' conscientious objections and religious beliefs should be accommodated within reason, but that there are "justifiable ethical constraints on the exercise of conscience."⁴⁰ Wicclair demonstrates that most health professional groups in the US already follow some form of this approach, in which providers are given as much autonomy to conscientiously object as possible while still trying to protect the health of patients.⁴¹ Generally, this means that as long as you can provide continuity of care for a patient and that you are not acting in a discriminatory manner, you may refuse to provide a service based on religious beliefs or an otherwise conscientious conviction.

The specifics of this allowance are incredibly complex, hinging on multiple state and federal laws and varying by professional group and specific procedure or treatment. The overarching motivation, though, is that diversity in the health care workforce improves patient outcomes and diversity should be preserved insofar as it does not compromise the care that a patient receives.⁴² This includes religious diversity. For this reason, legal and professional standards attempt to serve as an all-encompassing standard of ethics in medicine. This standard itself is secular in the sense that its language is devoid of an explicitly religious tradition, but it is not accurate to consider this standard to encourage the absence of religion, since one of the main goals of the

⁴⁰ Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis*. 87.

⁴¹ *Ibid.*, 43-85.

⁴² Association of American Medical Colleges, "Diversity and Inclusion - Initiatives," Association of American Medical Colleges, https://www.aamc.org/initiatives/diversity/179816/facts_and_figures.html.

standard is the accommodation of as many religious traditions as possible and within reason.

The Catholic healthcare system is immune to the legally defined practice of informed consent concerning ERD-prohibited treatments; that is in practice, free exercise of religion supersedes the legal requirement to inform patients about ERD-prohibited treatment options. It would be unfair to say that CHIs do not allow patients to make their own decisions; informed consent is practiced within the scope of care that CHIs do provide. According to secular legal standards, the wording of the ERDs prevents patients from being fully informed so that they might make their own value decisions about contraception or termination in emergency situations. In some of these emergency situations, CHIs have a very good reason to withhold information. According to Catholic beliefs, offering a termination while the fetus is still miscarrying but still alive is the moral equivalent of unjustifiably killing any other person that walks into the Emergency Department. This is a significant point of tension for CHIs as legal battles continue to bubble to the surface.

Catholic doctors might plausibly argue that they practice informed consent and that by not counseling a patient on contraceptives or termination as a treatment option for miscarriage, they are only giving the ethical and medically relevant options to their patient. While this is true, it is easy to imagine this argument being extended beyond acceptable boundaries. How can this argument be limited so that it does not impact patient safety or public health? If a physician that is a Jehovah's Witness refuses to order a blood transfusion for a dying patient, the physician must promptly transfer care to another physician so that the order can be made. This would fall under acceptable accommodations, so long as the employer would be willing to staff this physician

during shifts when others would be available to order a transfusion. If, however, the physician refused to transfer care, this would be an egregious violation of the principles of nonmaleficence and autonomy and this would not be an allowable accommodation. Now, imagine if there were a private Jehovah's Witness hospital that did not allow blood transfusions to occur at all. If a patient was taken to this hospital in an emergency and died because a blood transfusion was withheld due to religious prohibitions, this would be considered malpractice and illegal patient abandonment under EMTALA. This is a theoretical situation in which a religious standard is imposed on a patient unwillingly that results in the death of the patient.

This is an extreme example, where theoretical institutional religious beliefs severely impede the function of the institution. On the other hand, in very few extreme situations, this is what is at stake in Catholic hospitals in the US. In certain circumstances, people must choose whether to cooperate with what the Church considers to be an unjustifiable evil or allow a patient to die or be seriously injured.⁴³ The USCCB in writing the ERDs are very clear that employees of CHIs must never choose to cooperate with unjustifiable evil in these situations, although they fail to address the potential consequences for patients in making that choice. In secular conceptions of medical ethics, where those treatments are not considered intrinsically evil, withholding those treatment options from patients may cross the line into impermissible accommodation of religious beliefs.⁴⁴ Despite this, Catholic institutions are allowed to continue operating in this manner. Without making a judgment on which

⁴³M. Therese Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital," in *Origins* (Catholic News Service, 2011)., Ward, "Pregnant Woman Dies in Ireland after Being Denied an Abortion."

⁴⁴ This is precisely why impending legal battles brought by the ACLU are worrisome for the future of Catholic healthcare.

moral standard is correct in any given situation, it is necessary to recognize that this inconsistency exists. There are multiple points of comparison where this inconsistency becomes apparent, the specifics of which are made explicit in the last few sections of the ERDs.

Care at the Beginning of Life

In both the third and fourth sections of the ERDs, there are directives that stipulate specific prohibitions of treatment options in women's health care. The first concerns female victims of sexual assault:

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.⁴⁵

In the practical sense, this directive prohibits the administration of emergency contraception (EC) to sexual assault victims in some circumstances. Although the USCCB states that a female victim does have the right to prevent conception that results from rape, the matter is more complicated. The most commonly discussed emergency contraceptive is levonorgestrel, given in either one or two doses. Scientists and ethicists have attempted to determine whether levonorgestrel acts to prevent pregnancy by preventing ovulation, preventing fertilization, or preventing implantation of an early embryo. The results have been contradictory; some studies say that there is no evidence

⁴⁵ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 21-22.

that levonorgestrel works to prevent implantation, and yet others state that there is no other mechanism that explains the data obtained. There is no consensus that levonorgestrel does not prevent an early embryo from implanting and this is a source of complication for the Church and Catholic bioethicists.⁴⁶ Some scientists have tried to assess if ovulation can be prevented while allowing an early embryo to implant, but none have proven successful so far.⁴⁷

There are two schools of thought on the practical consequences of directive 36, outlined by an article titled “Emergency Contraception and Sexual Assault” in an issue of *Health Progress* published by the Catholic Health Association (CHA). The first is called the “ovulation approach,” and proponents of this approach advocate for the requirement to test victims to see if they have ovulated recently before administering emergency contraception.⁴⁸ Those that support this approach argue that this is the only way to ensure that emergency contraception does not act as an early abortifacient by preventing a fertilized ovum from implanting in the victim’s uterus. Others support a “pregnancy approach,” and argue that simply testing for pregnancy is sufficient precaution to take to prevent intentional early abortion.⁴⁹ The merits of either argument are not important for the purposes of this discussion, but the confusion that is generated by the lack of consensus is important. It is up to individual bishops to choose how to interpret this directive as faithfully as possible. The data suggests that CHI practices are

⁴⁶ Kathleen Mary Raviele, "Levonorgestrel in Cases of Rape: How Does It Work?," *Linarce Quarterly* 81, no. 2 (2014).

⁴⁷ *Ibid.*

⁴⁸ Ron Hamel and Michael R. Panicola, "Emergency Contraception and Sexual Assault," *Health Progress* 83, no. Number 5 (2002): 13.

⁴⁹ *Ibid.*, 17.

as variable as these interpretations; some CHIs prohibit even discussing EC with rape victims, while others have pharmacies that will dispense EC to patients that request it.⁵⁰

This directive, and more specifically how the local bishop interprets the directive, has the potential to significantly alter the care a woman receives after a sexual assault. This is especially true if a particular CHI is a sole community provider or if the patient is otherwise unable to obtain emergency contraception in a timely manner. In one study published in *The American Journal of Public Health*, 12 CHIs in a 28 hospital sample prohibited discussion of EC with rape victims.⁵¹ Even though emergency contraception (EC) is now available in the US over the counter, a female rape victim would have to know that it is available on her own to obtain it. By prohibiting the discussion of treatment options with patients, the patients never have the option to seek the treatment, even if it is available elsewhere.

In these circumstances, denying a woman access to EC after sexual assault in effect nullifies the ability of a woman to choose how to cope with the consequences of her rape according to her own conscience and beliefs. This is more significant than simply refraining from participating in immoral acts; these actions impose institutional or provider beliefs on the patient in a way that has grave potential consequences. There are other religious traditions committed to the preservation of human dignity that do not uphold the idea that life begins at conception, but rather that life begins at or after implantation. For women that hold these beliefs, EC may be the only attempt that they could take to prevent pregnancy. If access to EC is impeded, a woman might have to

⁵⁰ Steven S. Smugar, Bernadette J. Spina, and Jon H. Merz, "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," *American Journal of Public Health* 90, no. 9 (2000): 1373.

⁵¹ Ibid.

make a most impossible choice between committing an evil act or living with a sustained version of the torture she experienced during the assault. Beyond this, the current literature cautions health care providers against withholding information from patients, as it may damage the trust that is the foundation of the patient-provider relationship.⁵²

Despite this, it is not reasonable to expect the Catholic Church to cooperate with the destruction of what it deems to be invaluable human life. The USCCB does state that “it is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures.”⁵³ This seems to be a step in the direction toward open communication with patients, but does this translate to increased patient knowledge of ERD-based restrictions? The literature suggests women are generally not aware of what restrictions exist at CHIs.⁵⁴ Further, working in a discussion about Catholic beliefs on EC might be difficult for a patient that has just experienced the trauma of a sexual assault. Again, there is a seemingly impossible conflict between the well-being of the public and the rights of the Church, stemming from the peculiar role of CHIs in the US.

In the fourth section, the USCCB introduces Church teaching on sex and reproduction and states multiple directives based on these principles. The Church teaches that sex is only moral in the context of a marriage between two people that are

⁵² Nathan A. Bostick et al., "Report of the American Medical Association Council on Ethical and Judicial Affairs: Withholding Information from Patients: Rethinking the Propriety of "Therapeutic Privilege", *The Journal of Clinical Ethics* 17, no. 4 (2006).

⁵³ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services".

⁵⁴ Guiahi, Sheeder, and Teal, "Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care."

open to the possibility of having children. Procreation should never be severed in any purposeful way from the sexual act and any attempt to disrupt the “unitive and procreative” act is immoral.⁵⁵ Married couples may, however, attempt to delay or space children using natural family planning methods, during which a couple abstains from having sex during a woman’s fertile window. These principles, in conjunction with the belief that life begins at conception, provides the foundation for the Church’s views on the morality of abortion, contraception, and sterilization. These views are explicitly stated as directives to guide CHIs in ethical decision-making. Directives 45, 47, 48, and 49 all deal with the impermissibility of abortion and with the question of what types of treatments constitute direct abortions.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.⁵⁶

This directive very obviously precludes the possibility of performing elective abortions at CHIs, but what of other types of abortion? It is useful at this point to look at the Catholic tradition of moral decision making, since restrictions on abortions and other treatments that lead to fetal demise are underpinned by this tradition. The Church states that intending to do an intrinsically evil act is never morally permissible. Directly intending, desiring, or approving of something evil constitutes formal cooperation and is

⁵⁵ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 24.

⁵⁶ *Ibid.*, 26.

never allowed.⁵⁷ The Church allows that one might still be involved in an evil act, but may not intend or approve of the act. This is considered material cooperation. The USCCB states that not even material cooperation in abortion services is permissible, so CHIs are prohibited from partaking in any action that might contribute to the possibility of a direct abortion.⁵⁸ This is the basis of the opposition to making referrals mandatory for prohibited services. Making a referral for a patient to obtain an abortion with another institution or provider could be considered material cooperation in the act of abortion, which is strictly prohibited under the ERDs. Even further, the USCCB cautions CHIs against “the danger of scandal,” or giving the impression that a Catholic institution condones a particular immoral act, even if it is not the intention to give such an impression.⁵⁹

The other Church teaching relevant to the discussion at hand is the principle of double effect. This principle states that it is acceptable to pursue a good end with a foreseeable but inevitable bad consequence, as long as that consequence is not intended. It does not, however, allow for a good end to be pursued through evil means.⁶⁰ There are four conditions for an action to be considered acceptable under the principle of double effect:

- 1 The act itself must be morally good or at least indifferent.

⁵⁷ Rev. Thomas R. Kopfensteiner and Rev. James F. Keenan, "The Principle of Cooperation," *Health Progress* 76, no. 3 (1995).

⁵⁸ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services."

⁵⁹ *Ibid.*

⁶⁰ Catholic University of America, "New Catholic Encyclopedia," (Washington DC: Catholic University of America, 2003), 1021.

- 2 The agent may not positively will the bad effect but may permit it. If he could attain the good effect without the bad effect he should do so. The bad effect is sometimes said to be indirectly voluntary.
- 3 The good effect must flow from the action at least as immediately (in the order of causality, though not necessarily in the order of time) as the bad effect. In other words, the good effect must be produced directly by the action, not by the bad effect. Otherwise the agent would be using a bad means to a good end, which is never allowed.
- 4 The good effect must be sufficiently desirable to compensate for the allowing of the bad effect.⁶¹

Although Catholics may never formally or materially cooperate in providing abortions, Catholics may perform an action that causes the death of a fetus as a foreseeable yet unavoidable consequence of that action. According to the four conditions of the principle of double effect, this is only allowable when there is a proportionately good reason for doing so, such as saving a pregnant woman's life. The Church operates on a definition of abortion that does not encompass the death of a fetus in such a scenario.

This allowance is explicitly stated in directive 47:

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.⁶²

Theoretically, this provision ensures that the safety of pregnant women in emergencies while ensuring appropriate protection of the fetus in medical decision making.

⁶¹ Ibid.

⁶² United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 26.

Practically, there are many cases that involve a great deal of uncertainty for the health of both the mother and child that do not fall neatly under the provisions given. The qualification of “proportionately serious pathological condition” can be questioned, both by the health care provider and members of the ethics board. This is especially apparent in cases like previable premature rupture of membranes (P-PRM), in which losing the previable fetus is not preventable. Letting the miscarriage proceed naturally may make a woman vulnerable to life-threatening infections, but a woman’s condition may not be considered “proportionately serious” unless she is battling a dangerous infection. In these cases, the difference between receiving treatment from a Catholic and non-Catholic hospital is potential infection and the accompanying side effects, or worse.⁶³

Directive 48 concerns the same principles, but applied to ectopic pregnancies, or pregnancies that occur outside of the uterus. The USCCB states in directive 48 that “in case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.”⁶⁴ Ectopic pregnancies are not viable outside of a few extremely rare exceptions and can be extremely dangerous. They often occur in fallopian tubes, which have much less space for a developing embryo than does a uterus. When the embryo starts to grow, the fallopian tube can rupture and lead to life-threatening bleeding for the woman.

The standard of care depends on how advanced the pregnancy is and if the fallopian tube is still intact, but the goal is to end the pregnancy as safely as possible

⁶³ Lori R. Freedman, Uta Landy, and Jody Steinauer, "When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals," *American Journal of Public Health* 98, no. 10 (2008).

⁶⁴ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 27.

while attempting to preserve a woman's fertility.⁶⁵ There are multiple ways to achieve this goal. If a woman presents with evidence that the ectopic pregnancy is resolving on its own, the woman can choose expectant management as her course of treatment. This means that the woman would be observed closely for symptoms of tubal inflammation or rupture until the pregnancy is spontaneously reabsorbed. This is only a medically viable treatment option for women who present with declining pregnancy hormones and for women who are willing to accept the risk of tubal rupture.⁶⁶ If expectant management is not a viable treatment course, a methotrexate injection is the next treatment considered. The injection causes the separation of the fetus from the tube (or other organ outside of the uterus where the fetus is located) and terminates the pregnancy.⁶⁷ This treatment option can only be used if the fallopian tube is intact, and may not be preferred if the fetus has a heartbeat or has reached a certain size. The benefits to treating an ectopic pregnancy with methotrexate are preserving fertility, preventing injury to the fallopian tube, and avoiding the risks of surgery.

If the ectopic pregnancy cannot be resolved with methotrexate, surgical intervention is necessary.⁶⁸ There are two types of surgical intervention: salpingostomies and salpingectomies. A salpingostomy involves making an incision in the fallopian tube and removing the ectopic pregnancy. This method can be done laparoscopically through a small incision, and comes with lower risks from surgery than does a salpingectomy. A salpingectomy involves removal of a portion or the whole

⁶⁵ Angel M. Foster, Amanda Dennis, and Fiona Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," *Women's Health Issues* 21, no. 2 (2010).

⁶⁶ Vicken P Sepilian and Ellen Wood, "Ectopic Pregnancy Treatment & Management," <http://emedicine.medscape.com/article/2041923-treatment#d14>.

⁶⁷ Ibid.

⁶⁸ Ibid.

fallopian tube or ovary containing the ectopic pregnancy. This method comes with additional risks and potential loss of fertility, but may be necessary if the tube has already ruptured or if the patient suffers from recurrent ectopic pregnancies in the same location.⁶⁹

In a CHI, the only permissible treatments for ectopic pregnancy are expectant management and a salpingectomy. These treatments don't have the intention of destroying the fetus, but only of resolving the health crisis at hand. Methotrexate injections and salpingostomies directly intend to destroy the fetal tissue, which constitutes a direct abortion and is impermissible. In essence, this means that a woman presenting with an ectopic pregnancy only has the two most risky options to choose between. The woman is only able to choose between expectant management (if eligible) and risk a tubal rupture or an emergency salpingectomy and potentially lose her fertility or become injured. In cases where a woman's ectopic pregnancy might be managed with a simple injection, the woman instead must undergo invasive surgery and might lose her fertility.⁷⁰

These are potentially grave consequences that must be considered. This is especially true considered the emergent nature of many cases of ectopic pregnancy; if a woman is brought to a Catholic hospital in an ambulance, she is virtually stripped of a chance to preserve her fertility and avoid unnecessary risk. It is still not reasonable to force a CHI to cooperate in a direct attack on a fetus for whatever reason, but it also may not be reasonable to expect women to risk their health and lives without a difference in outcome for their child. This is not a simple choice between protecting

⁶⁹ Ibid.

⁷⁰ Foster, Dennis, and Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study."

pre-natal life or protecting women; this is more accurately a choice of two paths that lead to the same outcome, one carrying more physical risk, and the other being morally problematic for the Church. Both paths have significant consequences for all parties involved.

Care in Reproductive Medicine

Finally, the USCCB addresses fertility with directives 52 and 53. Directive 52 addresses the moral impermissibility of contraception, stating that “Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church’s teaching on responsible parenthood and in methods of natural family planning.”⁷¹ Practically speaking, this means that employees of CHI may not be permitted to counsel patients on the use of contraceptives specifically for contraceptive purposes. According to Article 15 of *Humanae Vitae*, contraceptives may be prescribed or taken with the intention to alleviate disease if no other treatment option is available that does not impede fertility.⁷² This is reaffirmed in directive 53, in which the USCCB states that “direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.”⁷³ These directives are based on the Catholic teaching that the purpose of sex is both unitive and procreative, and that

⁷¹ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 27.

⁷² Paul VI, "Humanae Vitae".

⁷³ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 27.

it is immoral to separate sex from its procreative purpose.⁷⁴ Although this Church teaching is clear, there are multiple dimensions to the issue of contraceptive use that make directives 52 and 53 particularly controversial and ethically challenging.

The first point of controversy is that contraception has been so widely debated that some within the Catholic hierarchy disagree on the justification for the teaching. Some find the distinction between avoiding children using NFP and avoiding children using contraception to be unsatisfactory.⁷⁵ There are reports of Catholic women being reassured in their use of contraceptives, even when approval is not possible from a position within the Catholic Church.⁷⁶ By most recent polls, 98 percent of Catholic women that have had sex have used artificial contraception at one point and 86 percent do not think using contraception is immoral.⁷⁷ One would be hard pressed to find a more widely disregarded teaching of the Catholic Church, among both the laity and the hierarchy. It is important to note that the Church's current teaching on contraception was only reaffirmed when Paul VI rejected the findings of the Pontifical Commission on Birth Control in 1966, which had recommended that contraception should not be considered intrinsically evil, but rather a variation of the natural family planning methods that were already accepted as licit.⁷⁸

⁷⁴ Paul VI, "Humanae Vitae".

⁷⁵ William Henry Shannon, "The Papal Commission on Birth Control," in *The Lively Debate: Response to Humanae Vitae* (New York: Sheed & Ward, 1970).

⁷⁶ Frank Bruni, "Be Fruitful, Not Bananas: Pope Francis, Birth Control, and American Catholics," *The New York Times*, <http://www.nytimes.com/2015/01/25/opinion/sunday/frank-bruni-pope-francis-birth-control-and-american-catholics.html>.

⁷⁷ *Ibid.*, Rebecca Riffkin, "New Record Highs in Moral Acceptability," Gallup, <http://www.gallup.com/poll/170789/new-record-highs-moral-acceptability.aspx>., Rachel K. Jones and Joerg Dreweke, "Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use," Guttmacher Institute, <http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf>.

⁷⁸ Shannon, "The Papal Commission on Birth Control."

Despite this controversy, Catholics are supposed to live according to the teaching of the Catholic Church and Paul VI rejected the permissibility of the use of contraception other than natural family planning. The controversy surrounding the history of this teaching does not make this issue exempt from the same challenge that resurfaces throughout this discussion, which is the challenge to avoid cooperating in evil while not causing unnecessary harm to women that do not share the beliefs of the Catholic Church. This controversy does, however, make it more difficult to attempt to strike a balance between both concerns. If a large majority of Catholic women do not voluntarily submit to the Church's teaching on birth control, it becomes harder to expect non-Catholic women to accept that there may not be sufficient access to traditional or emergency contraception because their sole community provider happens to be a CHI. The Church cautions against the scandal of facilitating or cooperating with the provision of contraceptives, but it appears that the scandal already exists.

Even more complicating, the Catholic Church considers certain contraceptives to be early abortifacients. The medical community largely recognizes the start of pregnancy as implantation, while the Catholic Church considers fertilization as the start of pregnancy.⁷⁹ There are certain methods of contraception that may act by preventing a fertilized egg from implanting in the uterus, which constitutes an early abortion according to the Catholic Church. These include progesterone-only contraceptives, emergency contraception, and intrauterine devices (IUD).⁸⁰ Even if history had taken a different course and artificial contraception was deemed moral for married couples,

⁷⁹ National Catholic Bioethics Center, "Abortion, Contraception, and Responsible Parenthood," National Catholic Bioethics Center, http://www.ncbcenter.org/files/3814/4916/3459/NCBCsummFAQ_AbortionContraceptionParenthood.pdf.

⁸⁰ Ibid.

these particular methods would still be immoral as early abortifacients until proven that they do not interfere with implantation of an early embryo.

Luckily, most requests for contraception are not an emergency and in many situations women that request contraception can gain access to a prescription through other means. Emergency contraception can also be purchased over the counter in the US as previously mentioned, although it is sometimes more expensive without a prescription due to regulations on insurance coverage of emergency contraception. Despite this, there are still situations involving this directive in which women might experience unintentional harm if receiving care at a CHI. Some women will decide with their physicians that a sterilization is in their best interest due to the potential danger in becoming pregnant while afflicted with certain diseases. This is clearly prohibited in the ERDs. Further, these sterilizations are often performed after a cesarean section, so that the patient is only subjected to one round of anesthesia and potential complications instead of two.⁸¹ If a patient has previously discussed this option with her physician but ends up delivering at a CHI, she will not be able to obtain that sterilization without the additional risks of undergoing a second surgery. When patients are denied a tubal ligation, they are at increased risk of unplanned pregnancy, which can have significant implications for a woman's health and overall quality of life. One study that followed patients that were denied a tubal ligation found that almost half of them became pregnant within a year.⁸²

⁸¹ Debra B. Stulberg et al., "Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences," *Contraception* 90 (2014).

⁸² *Ibid.*, 423.

Consistency in Ethics

A matter of consistency compounds the difficulties that have already been discussed. Although the ERDs and the CHA give the appearance of a unified and coherent Catholic healthcare system, there are variations in the interpretation of the ERDs across CHIs. There are reports of CHIs providing illicit services or counseling, both intentionally and mistakenly. Hospitals' level of communication with the local bishop can be telling of how strictly the CHI follows the ERDs. Conversely, the potential consequences for not adhering to the ERDs also depend on this relationship. In any given hospital system, access to prohibited health care services can depend on the temperament of the bishop, the physicians, and the lay leaders of the hospital. There has been an effort as of late to assess the variability that exists in practices among CHIs. The data that exists tends to be qualitative and not generalizable, but is still revelatory.

Emergency Contraception

Unsurprisingly, there is variability in when and how emergency contraception is offered to patients in the emergency departments of CHIs. A study conducted by a team at the University of Pennsylvania set out to find if CHIs were offering emergency contraception counseling or prescriptions. Not only did the team find varying policies among CHIs, but they also found that individual providers were willing to provide counseling on emergency contraception even when prohibited. Of the 28 CHIs in the sample, 12 prohibited CHI employees from discussing emergency contraception with rape victims. Out of those 12 CHIs, 8 expressed that rape victims would still get relevant information about emergency contraception through other means.⁸³ In those 8

⁸³ Smugar, Spina, and Merz, "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," 1373.

CHIs, the victims would either be given information directly by an employee that would ignore the ERDs, would be referred to another department or provider, or would receive the information from a rape counselor. In the other 4 CHIs, the victim is required to ask about emergency contraception specifically in order to receive the information that cannot be provided at that particular CHI. At these institutions, rape victims may never be aware that emergency contraception is an option for preventing pregnancy as the result of rape. Interestingly, the prescription of emergency contraception for rape victims is only prohibited at 7 of the 27 CHIs. Five of these 7 also belong to the first group of CHIs that prohibit discussion of emergency contraception with rape victims. One CHI has a policy where a physician may prescribe emergency contraception on a personal prescription pad as long as the hospital's name is not on the pad. The same hospital also had pre-signed prescriptions for emergency contraceptives, in case of a situation where the physician on call objected to prescribing emergency contraception for a rape victim.⁸⁴ The research team found just as much variability in the policies of CHI pharmacies. Pharmacies in 17 of the CHIs were prohibited from dispensing emergency contraception. In one of these, the inpatient pharmacy was prohibited from dispensing, but the outpatient pharmacy in the same institution was not. In another CHI, the pharmacy could fill prescriptions for emergency contraception only for rape victims.⁸⁵

Management of Ectopic Pregnancies

Managing ectopic pregnancies is different from deciding to prescribe emergency contraception because there is a very clear protocol for physicians in CHIs to follow in

⁸⁴ Ibid.

⁸⁵ Ibid., 1374.

treating ectopic pregnancies. Despite this, the available data suggests that there is a wide variation in practices at CHIs. A team led by Dr. Angel M. Foster tried to assess this variation by interviewing physicians at a sample of 16 hospitals, including both long-standing and some recently merged Catholic hospitals.⁸⁶ Half of the hospitals are subject to the ERDs. Physicians from three hospitals reported the unavailability of methotrexate for ectopic pregnancy management, although many others stated they did not know what treatment options were or were not available for treatment at their institution.⁸⁷ Because of the limited sample size, it is difficult to ascertain the differences in formal policies regarding ectopic pregnancies. The physician interviews, however, reveal many “workarounds” meant to circumvent the restrictions imposed by the ERDs. Physicians expressed frustration in not being able to give methotrexate to patients presenting with ectopic pregnancies, fearing that a delay in intervention would potentially harm the patient. Out of fear for the well-being of patients, one doctor reported giving methotrexate in secret and off the record to patients. Others report transferring patients to other institutions so that they could receive a methotrexate injection. One of the doctors reported that her colleagues offer counseling on methotrexate and referrals for the service in secret.⁸⁸ Perhaps most interesting of the first-hand accounts is the physician who describes using ectopic pregnancy treatment as an opportunity to provide an otherwise illicit tubal ligation, choosing to perform a salpingectomy because the patient did not want any more children.⁸⁹

⁸⁶ Foster, Dennis, and Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," 105.

⁸⁷ *Ibid.*, 106.

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*, 107.

The physicians reported a wide array of different protocols for documenting the non-viability of the ectopic pregnancy, including but not limited to “documenting that the pregnancy was extrauterine and/or ruling out a heterotopic pregnancy, to establishing that cardiac activity was absent and/or that embryonic death had occurred.”⁹⁰ Many in the sample expressed fear for the well-being of patients because of the extra delay that these procedures cause and concerns about the additional health care costs incurred by these procedures. One physician expressed such concern over this documentation, that they suggested that they might subject a patient to potentially unnecessary surgery to confirm the diagnosis. The doctor explains that “If we were worried enough [that the pregnancy would be “viable”] we might take them to surgery because you can do a diagnostic surgery and if they don’t have an ectopic, you can stop the surgery. We would talk to the anesthesia folks first so they don’t give anything that is contraindicated in pregnancy.”⁹¹ Even though the ERD’s prohibition of treatment with methotrexate or a salpingostomy is clear, the actual practice of managing ectopic pregnancies in CHIs ethically is not.

Physicians also expressed frustration over the lack of clarity surrounding restrictions and guidelines. In the absence of formal regulations, physicians reported informal communication of institution norms, notions of approval or disapproval from administrators, and implicit assumptions as replacements.⁹² Only a few physicians stated knowledge of any means of enforcement, which is not surprising considering the lack of explicit or formal guidelines. Conversely, some physicians reported being watched by administrators for adherence to the ERDs. Nurses in one hospital are trained

⁹⁰ Ibid., 106.

⁹¹ Ibid.

⁹² Ibid.

to ask physicians questions that ensure they are following the ERDs.⁹³ The overarching theme unifying the data is a lack of formality in propagating and enforcing the ERDs in ectopic management, which affects doctor-patient relationships and may affect patient outcomes.

Tubal Ligations

Similarly, the prohibition against tubal ligations for the purposes of sterilization is clearly prohibited according to the ERDs. The data suggests, though, that there is still variable access to tubal ligations in CHIs. Dr. Debra B. Stulberg conducted a study to assess the level of access that exists for tubal ligations in CHIs. Dr. Stulberg's two main findings were that tubal ligations are allowed in certain circumstances, and that access to the procedure reflects changes in the bishop or archdiocese at any given moment.⁹⁴ She describes the various ways that tubal ligations can be offered in her summary of the data. The first is what she calls a "partial workaround," or a system in which one operating room in a CHI is sold to a nonreligious entity not under the authority of the Church.⁹⁵ Dr. Stulberg quotes the explanation of this system by one of her interviewees:

"...it's vastly complicated, but I'll keep it only stupidly complicated. All c-sections between 7:00a.m. and 5:00p.m. are staffed by clinic ambulatory surgery personnel, whether they need a tubal or not. And after 5:00p.m., we try and maintain a call team of ambulatory surgery personnel that will come in from outside the hospital to cover the c-sections that require tubals... We have not been able to maintain a call team for every night, and weekend. So, at this point, we have maybe 60% of the nights and weekends covered. So... if you want your tubes tied, you're basically playing, you know, Russian Roulette as to whether you'll get your operation done."⁹⁶

⁹³ Ibid.

⁹⁴ Stulberg et al., "Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences," 422.

⁹⁵ Ibid., 425.

⁹⁶ Ibid.

This “partial workaround” comes with the danger of scandal, or of the appearance that the Catholic Church condones the practice of sterilization, which is something that the bishops of the Church warn against. Some object to these types of workarounds on the grounds that they exceed acceptable levels of cooperating with evil. After all, for this type of behavior to proceed, there must be a great deal of close cooperation between the CHI and secular hospital. Despite this, it does indeed occur in certain CHIs.

Stulberg found that even within the same CHI under the same bishop, access to ligations was variable. The hospitals just described previously experienced this exact phenomenon. Before the arrangement was made to sell an operating room to a secular hospital, physicians were allowed to perform ligations after C-sections. The first change after instating the prohibition against tubal ligations was allowing the physician to perform the ligation, but requiring the nurse and other staff to “disengage” and not assist in the procedure. The operating room was only sold to the secular hospital after the bishop decided that more separation was needed.⁹⁷ Another physician describes increased regulation of ligations after the election of Pope Benedict XVI. Ten years prior, if the physician sat with the ethics committee and petitioned to perform a ligation for a patient that would be in danger if she became pregnant, it was usually granted. At the time of the writing, the physician lamented that petitioning for an exception was no longer an option for patients.⁹⁸

Miscarriage Management

The USCCB’s stance on abortion is the most widely known prohibition of the ERDs. Elective abortions are never allowed at a CHI, but treatments that might kill an

⁹⁷ Ibid., 426.

⁹⁸ Ibid.

unborn baby are allowed if necessary to save the life of the mother. Unfortunately, the application of these rules is not so clearly defined. According to the ERDs, a pregnant woman must have a “proportionately serious pathological condition” to proceed with a treatment that will potentially kill the fetus.⁹⁹ Discerning what qualifies as a proportionately serious pathological condition can be dangerous for a CHI employee. Early on in a miscarriage, a pregnant woman might not have symptoms severe enough to qualify as “proportionately serious,” but nothing can be done to halt the impending death of the unborn child. For an intervention to be justified, physicians must delay management until the pregnant woman’s symptoms worsen or for the fetus to lose its heartbeat, both increasing the risk of injury or death for the mother.¹⁰⁰ Standards of care call for management of the miscarriage as soon as it is confirmed to prevent life-threatening complications, but the ERDs directly contradict this, calling for a delay until the situation is sufficiently precarious.

According to a manual intended to help Catholic ethics committees, previable premature rupture of membranes (P-PROM), which results in an inevitable miscarriage, is not sufficient reason to treat the miscarriage and hasten the death of the child.¹⁰¹ Other Catholic ethicists, however, suggest that when the child is doomed and treatment can prevent serious illness in the mother, treatment is licit.¹⁰² CHIs each have their own criteria, formal and informal, for approving a treatment in order to save a pregnant woman’s life. A team led by Dr. Lori Freedman set out to discover how these guidelines

⁹⁹ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 26.

¹⁰⁰ Freedman, Landy, and Steinauer, "When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals," 1775.

¹⁰¹ Ibid.

¹⁰² Ibid., 1776.

differed between CHIs and what implications they had for miscarrying women. Sure enough, Freedman found varying criteria for miscarriage treatment at different CHIs, accompanied by different “workarounds” by physicians employed at CHIs. The physicians interviewed from 5 different CHIs all reported difficulties in getting treatment approved when the unborn child still had a heartbeat.¹⁰³ What varied between CHIs was how sick the patient was allowed to become before treatment was granted. One physician stated that the only way the committee would approve an abortion of a fetus with a heartbeat was if the mother would die imminently without intervention, and that even women who are bleeding and completely dilated might not qualify for intervention.¹⁰⁴

On the other end of the spectrum, one physician recounted that a nun on the ethics committee counseled him on using strategic language such as “inevitable abortion” and “maternal complications” in order to increase the chances that an intervention would be approved. Regardless of how strict a particular ethics committee was, the physicians reported the use of certain strategies to get their patients lifesaving care. One physician recounted physically severing an umbilical cord to stop the fetal heartbeat so that he could proceed with treatment, because his patient was in imminent danger of death and yet the committee refused to permit treatment. After that case, he quit his job at that CHI since he felt that he could not continue to put patients in grave danger. Another doctor had to send an unstable patient in an ambulance 90 miles away because it was less risky than letting the patient progress until the fetus died naturally. A third doctor refused to perform an ultrasound to look for a heartbeat of a fetus that was

¹⁰³ *Ibid.*, 1777.

¹⁰⁴ *Ibid.*, 1776.

being miscarried at 14 weeks gestation. Even when the nurse questioned if she ever checked for a heartbeat, she pushed back, knowing that doing so would delay necessary treatment for the patient.¹⁰⁵

After considering the variations in enforcement of the ERDs in women's health care, a visible pattern emerges. First, the bishops presiding over a particular CHI and the relationship between a bishop and CHIs can have a significant influence on how the ERDs are enacted and enforced; this is one cause of significant variation between CHIs.¹⁰⁶ Second, individual ethics committees employ different methods of meeting a bishop's expectations of fulfilling the ERDs in practice.¹⁰⁷ Third, employees that disagree with the directives in practice repeatedly break from the directives in covert ways, sometimes explicitly violating a rule and other times via a 'workaround' that may fulfill the letter of the law but not the spirit. All three of these factors contribute to problems both for women and for Catholic healthcare as a whole.

Inconsistency among CHIs is problematic for several reasons. For patients, it is hard to know what to expect when trying to access reproductive or emergency services. Data shows that women are largely unaware of the restrictions in care they might face at CHIs and that they would expect a full range of legal services at Catholic hospitals.¹⁰⁸ When women go to CHIs for their care, whether through insurance restrictions, geographic restrictions, an emergency, ignorance of a Catholic identity, or simply by choice, they are most likely unaware of what kind of care awaits them. Facing

¹⁰⁵ *Ibid.*, 1777.

¹⁰⁶ Evidence of this variation from the bishops' perspective will be discussed in Chapter 4 and 5.

¹⁰⁷ Evidence of this from the management's perspective is discussed in Chapter 5.

¹⁰⁸ Guiahi, Sheeder, and Teal, "Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care."

unexpected barriers in conjunction with health challenges has the potential to compound negative health outcomes for women. Considering the best-case scenario, women have to spend additional time, effort, and health care dollars seeking out additional resources if they have them at their disposal. Conversely, considering the worst-case scenario, women are not aware of the restrictions in care they are receiving, are not being fully informed, and are suffering injury or death based on the diocese in which they fall ill.

For doctors, a lack of clear and formal regulations instills fear over practicing according to accepted standards of care. Sometimes, as supported by the studies mentioned earlier, physicians are forced to choose between their livelihood and the dictates of their conscience. While the American state and federal governments have enacted multiple pieces of legislation to protect conscientious objectors in secular institutions, physicians are not protected at CHIs due to the special deference given for religious entities. This makes it easy for physicians to be tempted to work around the system and provide the care they believe is necessary for patients that may not be moral according to the ERDs. This is particularly problematic for the Church; their employees might be working against the very mission they are trying to carry forward.

Some have called for “ethics audits” of CHIs to ensure that the ERDs are being faithfully followed to address these problems.¹⁰⁹ The only practical way to accomplish this in the current system would be at a diocesan level. Performing audits at this level would not address the differences in interpretations among bishops, nor would it alleviate the stress and hostility physicians may feel in being forced to choose between following the ERDs and their consciences. Additionally, unless restrictions are made

¹⁰⁹ Ron Hamel, "Catholic Identity, Ethics, and Audits: Threat or Opportunity?," *Health Progress* 94, no. 1 (2013).

both clear and public, patients will still not be aware of the barriers to certain services they face at CHIs. For these reasons, ethics audits would not be the panacea for unification that is desperately needed in Catholic health care.

Discouragingly, it seems that under the current system, unification in this sense may not be practical or possible. In order to address these issues, the structure of Catholic healthcare in the US must be modified. Considering the magnitude of such an undertaking, it should be determined whether there is truly a need for this change. Are the potential benefits of an upheaval of the status quo proportionately desirable? The only way to answer this is to assess how and why women are being harmed by the problems presented in this chapter. The goal of the next chapter will be to attempt this assessment to inform any recommendations for the future of Catholic healthcare in the US.

CHAPTER 4: CATHOLIC HEALTHCARE'S IMPACT ON WOMEN

As discussed in Chapter 2, Catholic Healthcare Institutions (CHIs) in the US are ministerial arms of the Catholic Church, providing care in the moral tradition of the Catholic Church. If the ultimate goal for CHIs is to provide healing for the body and soul, then CHIs should at least be wary of any avoidable harm they impart on women. According to the Catholic Catechism, one should not commit an evil act to achieve a good end. Additionally, an intrinsically evil act is always evil regardless of the circumstances.¹ When a non-evil act has an evil but foreseen, unintended consequence, the act may still be performed under certain circumstances as outlined by the principle of double effect.² These principles together provide the basis for many of the care restrictions stipulated by the Ethical and Religious Directives (ERDs).³ These principles provide a framework for Catholics to operate within when making medical decisions in an ethical way and in accordance with Catholic principles. Because the Catholic Church does not subscribe to moral relativism, the ERDs are considered to be sound ethical practices for everyone, not just Catholics.⁴ Despite this, many in American pluralistic society disagree with the United States Conference of Catholic Bishops (USCCB) on what constitutes moral medical practice in regards to women's health care. When a clash exists between the moral choices of patients, providers, and CHIs, there is an opportunity for patients to be harmed. Even when the ERDs are employed perfectly,

¹ *Catechism of the Catholic Church*, 2nd. ed., 1753, accessed February 1, 2017, http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a4.htm.

² See page 72.

³ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services."

⁴ *Catechism of the Catholic Church*, 2nd. ed., 1950-1986, accessed February 1, 2017, http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c3a1.htm.

this does not preclude women from being harmed. Perpetrated harm to women would not necessarily justify forcing CHIs to perform what they perceive as unjustifiable evil acts, but it is necessary to continually assess if harm is being done. This assessment could allow CHIs to try to minimize harm to those that do not share in its principles, while still remaining steadfast in its goals and commitments. If a sound resolution exists, it will help to avoid situations in which the CHIs and CHI employees must choose between participating in what the Church regards as evil acts and harming women. The Church and its institutions will never choose to knowingly do what it regards as evil, which may leave women at risk of being harmed.

To come to a resolution, opportunities for harm must be identified and discussed. The most challenging obstacle to completing this task is the lack of available data. Put simply, if a woman is unaware she is being harmed, she cannot report the incident. This obstacle only adds to the necessity of such an assessment; if women truly are being harmed, we must find out both how they are being harmed and how often they are being harmed. If a woman spends ten days in the intensive care unit after suffering complications from a miscarriage caused by an ERD-related treatment delay, she might not know that the complications were preventable. The harm done, however, could be immense. Because of these difficulties, it is difficult to gauge how often this may be happening to women who seek care at CHIs through choice or necessity. Due to increased awareness about Catholic restrictions and associated community activism, more women are coming forward to report harm they believe to be caused by Catholic policies. Physicians, some of which are well informed on the differences between standard medical practices and practices at CHIs, are reporting harm done to patients that they believe to be immoral or unethical. Although the rates at which these events

occur are unknown, it is still useful to identify which situations present opportunity for harm to women at CHIs. If these situations can be identified, this will assist in determining potential resolutions to these ethical dilemmas.

Harm and Suffering

At this point, before delving into case studies, I would like to take the opportunity to explore the concept of harm. What might be considered harm under a secular conception of medical ethics is not necessarily consistent with harm under a Catholic conception of medical ethics. For example, under a secular conception, not counseling a patient on artificial contraceptive methods after a history of medically-difficult unplanned pregnancies might be considered harmful; the physician has missed the opportunity to help the patient space pregnancies (if requested and desired by the patient) in a way that might prevent worse health outcomes. Under Catholic social teaching, recommending that a woman alter her natural reproductive cycles with artificial methods that come with their own slew of potentially harmful side effects is in and of itself harmful. Establishing what is meant by “harm” is important for carrying the conversation forward.

The Church has a large body of beliefs on the concept of suffering that are countercultural. In American medicine, physicians and other health care providers aim to alleviate suffering in all instances allowed under the four principles of medical ethics. Suffering is viewed as something to be avoided, although there are ethical constraints physicians must act within when trying to alleviate suffering. Although Catholic physicians may be motivated to alleviate suffering for patients out of compassion, alleviating suffering is not always the first priority in Catholic medicine. According to

the Church, suffering can have a redemptive purpose for Catholics. This is reflected in the Catechism, in an explanation of how Catholics can participate in Christ's sacrifice:

The cross is the unique sacrifice of Christ, the "one mediator between God and men". But because in his incarnate divine person he has in some way united himself to every man, "the possibility of being made partners, in a way known to God, in the paschal mystery" is offered to all men. He calls his disciples to "take up [their] cross and follow (him)", for "Christ also suffered for (us), leaving (us) an example so that (we) should follow in his steps." In fact Jesus desires to associate with his redeeming sacrifice those who were to be its first beneficiaries. This is achieved supremely in the case of his mother, who was associated more intimately than any other person in the mystery of his redemptive suffering. Apart from the cross there is no other ladder by which we may get to heaven.⁵

Catholic beliefs about the origins and purpose of suffering are relevant to the ERD's restrictions. This is especially true in discussions surrounding end of life care, but is also relevant when discussing women's healthcare. As demonstrated by the literature discussed in this chapter, the ERDs may cause women to suffer when they would not suffer at a non-Catholic institution and when they would not choose to endure this suffering based on their own personal beliefs.

Moving forward in this discussion, I may refer to negative health outcomes due to Catholic healthcare policies interchangeably as harm or as suffering. Neither word is meant to indicate moral fault to one party or another, it only means to indicate that a woman experienced a negative health outcome due to Catholic policies. If, however, the word harm is used in recounting patient experiences, it is important to recognize that this is how the woman or health care provider perceives their experiences, as harm.

⁵ *Catechism of the Catholic Church*, 2nd. ed., 618, accessed February 1, 2017, http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a4.htm.

Treating Women with Previably Pregnancies

As mentioned in Chapter 3, physicians and ethics boards at CHIs use the principle of double effect to determine the proper course of care when a pregnant woman presents with pregnancy related complications. Employing the principle of double effect is certainly helpful in trying to discern what is right and wrong on a philosophical and theological level, but there are practical challenges to using the principle. First, the medical team needs to determine whether a fetus is viable or previable. If there is a chance that a fetus can survive outside of the womb, then killing that fetus as a side effect of treatment before attempting to deliver cannot be justified under the principle of double effect. Everything must be done to try to deliver the fetus before treatment to save the baby's life. Unfortunately, viability is not a cut and dry delineation in clinical practice, but rather it is a range in gestational ages past which a fetus might possibly survive. There have been isolated reports of babies being born as early as the 21st week of gestation and surviving, but cases where the baby survives are exceedingly rare.⁶ Today, viability is considered to be a "gray zone."⁷ Infants born before 23 weeks that weigh less than 500g are not expected to survive. Most infants born after 25 weeks that weigh at least 600g will survive and about half survive without any severe, long-lasting complications due to premature birth. Infants born between 23 and 25 weeks that weigh between 500 and 600g are born in the "gray zone" of

⁶ "World's Tiniest Babies: How Are They Now?," CBS News, <http://www.cbsnews.com/pictures/worlds-tiniest-babies-how-are-they-now/>; Amanda Cable, "The Tiniest Survivor: How the 'Miracle' Baby Born Two Weeks before the Legal Abortion Limit Clung to Life against All Odds," The Daily Mail, <http://www.dailymail.co.uk/femail/article-1021034/The-tiniest-survivor-How-miracle-baby-born-weeks-legal-abortion-limit-clung-life-odds.html>.

⁷ I. Seri and J. Evans, "Limits of Viability: Definition of the Gray Zone," *Journal of Perinatology* 28 (2008).

viability.⁸ Survival is possible in the “gray zone”, but not probable. It is not possible to certainly delineate viability for any one pregnancy and this can make medical decision making difficult.

Second, the requirement for the good effect to be proportionate to the bad effect translates in practice to what Freedman and Stulberg term the “curative” approach to treatment as opposed to the “preventative” approach to treatment.⁹ In other words, health care practitioners in Catholic hospitals are often required to wait for the patient to progress to a state of infection or have some other life threatening complication in order to justify treatment that will likely kill the baby, rather than taking action in hopes of preventing such a life-threatening situation.¹⁰ This requirement of proportionality is not clearly defined in a practical sense. Indeed, it would be very difficult to define a set of parameters in which a mother could be considered sick enough to warrant treatment that would terminate her pregnancy, since there are so many variables and individual health concerns to consider. Because of this, some doctors or ethics boards may wait until the mother becomes too ill to save, or suffers severe injury as a result of a delay in care.¹¹

These decision makers might be consciously or unconsciously influenced by a fear of violating the ERDs and suffering the accompanying consequences, causing them to delay care even though treatment is indicated both medically and ethically. In this vein, there are reports that demonstrate that miscarriage treatment at some CHIs are

⁸ Ibid.

⁹ Lori R. Freedman and Debra B. Stulberg, "Conflicts in Care for Obstetric Complications in Catholic Hospitals," *American Journal of Bioethics Primary Research* (2012): 10.

¹⁰ Ibid.

¹¹ Ibid., Ward, "Pregnant Woman Dies in Ireland after Being Denied an Abortion."

dependent on the presence of a fetal heartbeat.¹² Even when a woman is so proportionately ill that treatment would be indicated according to the ERDs, some ethics committees have been reported to require a further delay until the fetal heartbeat ceases or until the woman is transferred to a non-Catholic hospital.

These grey areas are the source of potential harm for pregnant women seeking care at CHIs according to reports from both patients and doctors as reported in the literature. There are three main problems with employing the principle of double effect to care of mothers with previsible pregnancies in a Catholic health care setting. First, the principle of double effect is subject to the interpretation of individuals on ethics committees, meaning that treatment is sometimes prohibited in situations in which the risk to the mother's life is high. Second, ethics committees sometimes rely on transferring patients to other hospitals in order to circumvent making a decision about a pregnancy in the "gray zone."¹³ Third, the ultimate authority of ethics committees at CHIs is the local bishop according to Directive 37 and this comes with its own ethical challenges.¹⁴

Because of the existence of the "gray zone," physicians have to make decisions while evaluating multiple factors about their patients' health, and these decisions draw on many years of training at an advanced level. Even though local bishops do not necessarily have this training, they are still the ultimate authority on the course of care a patient receives. There can be conflicts between physicians and clergy, as they might

¹² Freedman, Landy, and Steinauer, "When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals."

¹³ Freedman and Stulberg, "Conflicts in Care for Obstetric Complications in Catholic Hospitals," 14.

¹⁴ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services."

disagree on the application of the principle of double effect.¹⁵ This is especially true if a physician has limited experience with advanced medical ethics or Catholic theological beliefs, as clergy and physicians might lack sufficient common ground for a constructive discussion of a case. Even physicians that attend religious services regularly and are active in their faith community report as many conflicts with CHIs and clergy as non-religious physicians, so this conflict can occur even when physicians agree with Catholic principles of health care.¹⁶ Perhaps the most ethically-intriguing facet to consider is that due to the structure of Catholic healthcare, clergy are making the final medical decisions for women that are not Catholic. Fourth, physicians are often pressured, both directly and indirectly, to make decisions that risk a pregnant woman's health and life to make sure they are not violating the ERDs.¹⁷ They are sometimes encouraged to go against their conscience and what they would consider to be appropriate application of the principle of double effect because of the ethical ambiguity of certain cases. Lastly, even when the principle of double effect is applied correctly according to the local bishop, a woman might still lose her life.¹⁸

Case Study 1 – Presence of Fetal Heartbeat in Cases of Certain Demise

In one qualitative study done on miscarriage management at Catholic hospitals, a physician recalls a request received to accept a miscarrying patient from a CHI.¹⁹

¹⁵ Freedman and Stulberg, "Conflicts in Care for Obstetric Complications in Catholic Hospitals."

¹⁶ Debra B. Stulberg et al., "Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies," *American Journal of Obstetric Gynecology* 207, no. 73 (2012): e1-5.

¹⁷ Ibid.

¹⁸ Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital."

¹⁹ Freedman, Landy, and Steinauer, "When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals."

Upon the physician's recommendation that the patient be treated at the CHI since she was not in stable condition, she received pushback from the CHI. The physician reported her experiences in the study.

"Because the fetus was still alive, they wouldn't intervene. And she was hemorrhaging, and they called me and wanted to transport her, and I said, "It sounds like she's unstable, and it sounds like you need to take care of her there." And I was on a recorded line, I reported them as an EMTALA [Emergency Medical Treatment and Active Labor Act] violation. And the physician [said], "This isn't something that we can take care of." And I [said], "Well, if I don't accept her, what are you going to do with her?" [He answered]. "We'll put her on a floor [i.e.. admit her to a bed in the hospital instead of keeping her in the emergency room]; we'll transfuse her as much as we can, and we'll just wait till the fetus dies."²⁰

When a woman is actively hemorrhaging, she is in grave danger. Even though this is the case, the CHI would not approve treatment for the miscarriage. This demonstrates the first practical problem with applying the principle of double effect, which is that hospitals and ethics boards will often delay care even though the woman is already at risk of injury or dying. Ethics boards will use specific criteria to determine the proportional amount of risk and these criteria vary between hospitals, committees, and bishops. The previously mentioned study found that one of these criteria is often the absence of a fetal heartbeat, virtually eliminating the allowance for prompt treatment miscarrying mothers when the fetus has no chance of survival.²¹ The amount of risk a woman is forced to assume in miscarriage treatment is dependent on which CHI she happens to be admitted to, and ultimately, this may lead to injury or death for that woman.

²⁰ Ibid., 1776-77.

²¹ Ibid.

Case Study 2 – Varied Interpretations of Proportionate Pathologies

In 2009, a pregnant 27-year-old woman presented to St. Joseph's Hospital in Phoenix with complications related to pulmonary hypertension.²² She was 11 weeks along in her pregnancy and her symptoms continued to worsen. According to reports, the woman tried to avoid conception due to her pulmonary hypertension, but once she conceived she chose not to terminate based on her Catholic beliefs.²³ Doctors advised her about the risks of carrying her pregnancy to term, but the patient persisted in her decision to try and carry the baby to term. By the 11th week, her symptoms worsened and she descended into cardiogenic shock accompanied by right-sided heart failure. Doctors concluded that if she continued her pregnancy she would almost certainly die. The situation was complicated by the fact that there is no cure for pulmonary hypertension, and that the life-threatening symptoms the patient was experiencing were directly caused by the pregnancy exacerbating the effects of pulmonary hypertension.²⁴ The physicians, patient, and ethics board all decided that the only option was to evacuate the patient's uterus, judging that the placenta was the pathological cause of disease in this patient and that the removal of the placenta was justified. Sister Margaret McBride, a nun that led the ethics committee, gave approval for the termination. The termination went forward, and the patient lived.²⁵

After some time, the Bishop of the Phoenix Diocese, Bishop Thomas Olmsted, learned about the termination and condemned the act as an elective abortion.²⁶ Bishop

²² Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital."

²³ *Ibid.*, 538.

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ "Statements from the Diocese of Phoenix and St. Joseph's," *The Arizona Republic*, <http://archive.azcentral.com/community/phoenix/articles/2010/05/14/20100514stjoseph0515bishop.html#ixzz4Uzsj6Gxz>.

Olmsted excommunicated Sr. McBride and stripped St. Joseph's Hospital of its Catholic sponsorship.²⁷ Ultimately, Bishop Olmsted did not come to the same conclusion as Sr. McBride based on the principle of double effect, which was the classification of the termination as a permissible indirect abortion. Conversely, M. Therese Lysaught published a moral analysis of the case on the request of Catholic Health Care West, supporting the ethics board's decision.²⁸ Bishop Olmsted, however, reinforced in his statements the view that a pregnancy can never be pathological and that it may never be terminated to ameliorate the risks of pregnancy. This is stipulated in a statement he gave to The Arizona Republic regarding the incident and subsequent excommunication of Sr. McBride.

"I am gravely concerned by the fact that an abortion was performed several months ago in a Catholic hospital in this Diocese. I am further concerned by the hospital's statement that the termination of a human life was necessary to treat the mother's underlying medical condition. An unborn child is not a disease. While medical professionals should certainly try to save a pregnant mother's life, the means by which they do it can never be by directly killing her unborn child. The end does not justify the means. Every Catholic institution is obliged to defend human life at all its stages; from conception to natural death. This obligation is also placed upon every Catholic individual. If a Catholic formally cooperates in the procurement of an abortion, they are automatically excommunicated by that action. The Catholic Church will continue to defend life and proclaim the evil of abortion without compromise, and must act to correct even her own members if they fail in this duty. We always must remember that when a difficult medical situation involves a pregnant woman, there are two patients in need of treatment and care; not merely one. The unborn child's life is just as sacred as the mother's life, and neither life can be preferred over the other. A woman is rightly called 'mother' upon the moment of conception and throughout her entire pregnancy is considered to be 'with child.' The direct killing of an unborn child is always immoral, no matter the circumstances, and it cannot be permitted in any institution that claims to be authentically Catholic. As our late Holy Father, Pope John Paul II, solemnly taught in his encyclical 'The Gospel of Life,' a 'direct abortion, that is, abortion willed as an end or as a means, always

²⁷ Barbara Bradley Hagerty, "Nun Excommunicated for Allowing Abortion," National Public Radio, <http://www.npr.org/templates/story/story.php?storyId=126985072>.

²⁸ Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital."

constitutes a grave moral disorder, since it is the deliberate killing of an innocent human being' (The Gospel of Life #62). The Ethical and Religious Directives for Catholic Healthcare Institutions (ERDs) are very clear on this issue: 'Catholic health care ministry witnesses to the sanctity of life from the moment of conception until death. The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy.' (ERD, Part Four, Introduction) The ERDs further state that 'Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion. ... Catholic health care institutions are not to provide abortion services even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.'" (ERD 45).²⁹

In his statement, Bishop Olmsted very publically reinforces the notion that the right course of action was to allow the mother to progress naturally, even if that caused her death. The ERDs claim to protect both mother and child, giving them equal value in decision making when secular medical ethics does not afford equal protection.³⁰ Bishop Olmsted's statement is significant, because it demonstrates that clergy in charge of CHIs and their ethics boards are willing to lose both mother and child for the sake of adhering to the ERDs, even when saving one is possible. This demonstrates the last practical problem with applying the principle of double effect to women's healthcare, which is the potential for loss of life even when applied correctly according to the Church clergy.

St. Joseph's Hospital also published a statement for The Arizona Republic, defending the decision Sr. McBride made concerning the case:

At St. Joseph's Hospital and Medical Center, our highly-skilled clinical professionals face life and death decisions every day. Those decisions are guided by our values of dignity, justice and respect, and the belief that all

²⁹ "Statements from the Diocese of Phoenix and St. Joseph's".

³⁰ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services."

life is sacred. We have always adhered to the Ethical and Religious Directives for Catholic Health Care Services as we carry out our healing ministry and we continue to abide by them. As the preamble to the Directives notes, 'While providing standards and guidance, the Directives do not cover in detail all the complex issues that confront Catholic health care today.' In those instances where the Directives do not explicitly address a clinical situation - such as when a pregnancy threatens a woman's life - an Ethics Committee is convened to help our caregivers and their patients make the most life-affirming decision.³¹

This statement is an example of the most troubling conflict that a CHI in the US can encounter. Should a CHI strive to save lives when possible, even when this requires a morally ambiguous decision to be made? Should St. Joseph's have let this patient die to stay true to the ERDs and the Diocesan Bishop's authority? In this case, saving a life and staying faithful to Catholic teaching were mutually exclusive, according to the local Bishop. Is this really what the Catholic Church wishes to say, that secular and Catholic healthcare are incompatible in this sense? I will return to this particular concern later in this thesis. Unless a change is made in the structure of Catholic healthcare, this conflict will continue to present itself. A year after Sr. McBride's excommunication, Bishop Olmsted allowed her recommunication into the Church under a specific set of circumstances, all of which reflected that the Bishop's stance condemning the decision did not change.³²

Case Study 3 – Authority of Clergy to Make Medical Decisions

In another qualitative study performed by Dr. Lori Freedman and Dr. Debra Stulberg, a doctor recalls a case where a woman presented a twin molar pregnancy.³³ A

³¹ "Statements from the Diocese of Phoenix and St. Joseph's".

³² Zoe Ryan, "Excommunicated Sister Finds Healing," *National Catholic Reporter* 2011. <https://www.ncronline.org/news/people/excommunicated-sister-finds-healing>.

³³ Freedman and Stulberg, "Conflicts in Care for Obstetric Complications in Catholic Hospitals," 7-8.

molar pregnancy is when there is a cluster of abnormal cells in the uterus that rapidly divide.³⁴ If molar pregnancies are allowed to progress, there is an increased risk of preeclampsia, hemorrhage, and cancer.³⁵ In this case, there was also a viable fetus in the uterus, which is what characterizes the case as a twin molar pregnancy. The standard of care for treating any molar pregnancy is to evacuate the uterus and provide chemotherapy because of the grave danger to the woman.³⁶ When the patient presented with vaginal bleeding and the managing physician requested to treat the woman in a CHI via uterus evacuation and chemotherapy, the ethics committee denied her request.³⁷

In recounting her story for the study, the managing physician explained “‘the clergy who made the decision Googled molar pregnancy.’ Based upon this search, ethics committee members ruled, ‘There’s a possibility that she could actually have a viable pregnancy [because] there have been cases where a child was born.’ Thus, the ethics committee identified treatment of this molar pregnancy as equivalent to abortion or ‘a termination.’”³⁸ The committee demanded that the patient be moved to another hospital, even though she was hemorrhaging from the molar pregnancy and there was great risk attached to delaying patient care and transporting the patient.³⁹ The physician recalled a comment from the ethics board, a member of which stated that “‘if we were the only hospital, maybe we would do it, but we’re not. There are other hospitals.’”⁴⁰

This case demonstrates the third practical challenge in applying the principle of double effect, in that the clergy in charge of making a decision about this woman’s care

³⁴ Ibid.

³⁵ Ibid., 8.

³⁶ Ibid., 7-8.

³⁷ Ibid., 8.

³⁸ Ibid.

³⁹ Ibid., 7-8.

⁴⁰ Ibid., 9.

conflicted with physicians about the assessment of the situation. The clergy member put this woman at unnecessary risk of injury or death because a Google search led to a questionable representation of the weight of the good and bad effects of an indirect abortion in this case. In addition, the ethics board determined that the presence of an additional hospital justified the transfer of the patient, which is not logical. This demonstrates the second problem with applying the double effect principle to care of pre-viable pregnancies: the use of neighboring hospitals to circumvent difficult ethical decisions.⁴¹ If an indirect abortion was found to be medically necessary, the Catholic hospital should have provided the necessary care. If the ethics committee felt this was an elective abortion, there should be no reason it would ever happen in that hospital and the existence of neighboring hospitals would be irrelevant. The comment about the availability of the other hospital more realistically reflects that the indirect abortion could have been justified as a medically necessary intervention according to the ERDs, but rather than make a decision that might come under scrutiny from the Church, it was easier for the committee to transfer the patient to a facility that does not have any such restrictions. This inability to make a difficult decision for fear of violating the ERDs delayed care and put the patient at risk. This practice is an unacceptable interpretation of the ERDs and principle of double effect and effectively provides an irresponsible way for Catholic hospitals to eschew medical and ethical responsibility for patients.

Case Study 4 – Pressure to Refrain from Treatment

A physician in the same study recalls a patient that presented with ruptured membranes (P-PROM) at 19 weeks, which signifies the initiation of a miscarriage.⁴²

⁴¹ Ibid., 14.

⁴² Ibid., 9.

The fetus also suffered from a lethal heart anomaly that would have required surgical intervention at birth, the earliest survivor of which was born at 32 weeks.⁴³ The doctor and patient agreed on the course of treatment, which included induction of labor.⁴⁴ The medical justification for this treatment is to preventatively avoid infection for the mother, which could be life threatening.⁴⁵ After the ethics committee at that particular hospital learned about the case, both the managing physician and consulting physician were called to explain themselves. In recalling this experience, the consultant physician said, “there were two members of the committee who were very vocally sort of accusing us of carrying out an elective abortion. And I said, you know, ‘There was nothing elective about this. This woman didn't choose to have her membranes rupture at 19 weeks. She didn't choose to have a baby with the most severe form of congenital heart disease. There was nothing elective about this.’”⁴⁶ Because a gestational age of 19 weeks is approaching the fringes of the “gray zone,” the ethics board would have required expectant management of the miscarriage, even though there was no hope of saving the fetus and a delay in care meant risking the woman’s life.⁴⁷ This is one situation in which a woman was put at risk of harm with no benefit to the unborn child; delaying care for a miscarrying woman when the fetus has no chance of survival only works to satisfy the ethics committee. The patient assumes the risk of such a decision, and there is no benefit to the unborn child. Miscarrying women are paying the price of adherence to the ERDs, even though they may not be Catholic and may not be aware that a Catholic bishop is making the final decision on her course of treatment. This case

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Seri and Evans, "Limits of Viability: Definition of the Gray Zone."

is also a good demonstration of the last problem mentioned in the introduction to these cases, which is the pressure that health care professionals face to make decisions that put women at risk for the sake of following the ERDs.

Treating Victims of Rape

As already explained, the permissibility of dispensing emergency contraception to rape victims at a CHI is not clear. What is clear is that there are CHIs that refuse to provide EC and associated counseling to rape victims. The primary opportunity for harm hinges on the time sensitive nature of EC treatment. There are two types of EC currently prescribed; one is effective up to 72 hours after unprotected sex and the other is effective for up to 120 hours after the event.⁴⁸ Despite the timeframe in which EC might be effective, studies show that it is most effective within the first 12 hours after unprotected sex.⁴⁹ If rape victims brought to CHIs are not informed of the option to take EC, treatment may be delayed or not sought at all. A pregnancy that results from rape can be life altering, not only because of an unplanned pregnancy, but also because the traumatic event becomes sustained over months or years. This is especially true for women that believe that taking EC is moral but that seeking an abortion after implantation is immoral, considering their only opportunity to protect themselves from pregnancy is in the first 72 hours after a rape. There have been efforts to make EC more widely available in the US and it is now available over the counter with no age restrictions.⁵⁰

⁴⁸ Michele C. Bosworth, Patti L. Olusola, and Sarah B. Low, "An Update on Emergency Contraception," *American Family Physician* 89, no. 7 (2014).

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

Despite the increased ease in obtaining EC, education remains an obstacle that cannot be overcome by changing prescription laws. Many states have recognized this, and 18 have enacted laws requiring hospitals to provide either counseling EC or EC itself to women who have been raped.⁵¹ The standard of care for a victim of rape includes EC, along with prophylaxis for sexually transmitted diseases and collection of forensic evidence.⁵² A patient may refuse any or all treatment if she is competent to make decisions about her care, but this requires that the patient is informed about her potential treatment options, along with consequences for accepting or refusing treatment.⁵³ Because some CHIs have a policy prohibiting counseling on EC, the legal standard of care is not met at these institutions. This potentially puts women in harm's way and may profoundly affect the rest of their lives.

Case Study 1 – Lack of Informed Consent

In 1984, a 21-year-old woman named Kathleen Brownfield presented to Daniel Freeman Marina Hospital in California after having been raped.⁵⁴ The police brought her to the Catholic hospital after she reported the rape. Kathleen was denied EC after her mother asked if there was a treatment to prevent pregnancy, and EC was not available over the counter at the time.⁵⁵ Kathleen was not told that she needed to take

⁵¹ Ibid.

⁵² The American College of Obstetricians and Gynecologists, "Committee on Health Care for Underserved Women: Sexual Assault," <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Sexual-Assault>.

⁵³ Smugar, Spina, and Merz, "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims."

⁵⁴ Dorothy Townsend, "Rape Victim Sues Hospital for Refusing 'Morning after Pill'," *The LA Times*, June 27 1985. http://articles.latimes.com/1985-06-27/local/me-10830_1_catholic-hospital.

⁵⁵ Ibid.

EC within 72 hours if she wanted to pursue that treatment. She was discharged with instructions to see a primary care provider for reassessment within two days, but since the event occurred on a Saturday, she was not able to see her doctor until the following week. Although Kathleen did not become pregnant, she opted to sue the hospital for not providing care consistent with the standard of treatment for rape once she learned that she had missed her opportunity to proactively prevent a potential pregnancy.⁵⁶

According to the attorney that filed the case, Kathleen was only seeking to change EC prescription practices at Catholic hospitals and was not seeking damages.⁵⁷ Kathleen described her motivation for pursuing the case, stating that “It wasn't until the next Wednesday that I received any further medical advice. . . . By then it was too late to receive a morning after pill and I didn't have a choice in the matter.”⁵⁸ Kathleen, who was a Catholic college student at the time, also commented to the press that “she does not believe estrogen prophylaxis treatment is analogous to abortion.”⁵⁹ The outcome of the case confirmed that women who do not receive “complete post-rape counseling and the right to choose a post-rape antipregnancy treatment” had the right to sue the hospital where she sought care.⁶⁰ The courts of California agreed in 1989 that not providing counseling or access to EC constitutes potential harm to a woman that has been raped, but education about and access to ECs in emergency rooms still remains variable.⁶¹

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ John M. Goldenring and Gloria Allred, "Post-Rape Care in Hospital Emergency Rooms," *American Journal of Public Health* 91, no. 8 (2001): 1169.

⁶¹ Steven S. Smugar, Bernadette J. Spina, and Jon H. Merz, "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," *ibid.* 90, no. 9 (2000).

Case Study 2 – Emotional Harm And Its Long-term Effects

Lori Boyer's case is similar to Kathleen Brownfield's in that she was denied emergency contraception after she was raped. Boyer, however, wanted to bring attention to her case not because she was in danger of pregnancy due to barriers to access of EC, but because of the emotional trauma she endured after her rape as a result of the physician's religious objection to EC provision.⁶² After a hospital rape counselor informed Boyer about EC and its time constraints, Boyer requested the pill from her physician.⁶³ The manner with which he refused to provide the medication or a referral to another physician had a profound impact on Boyer, described in a piece reported by NBC News.

Dr. Gish looked up. He was a trim, middle-aged man with graying hair and, Boyer thought, an aloof manner. "No," Boyer says he replied abruptly. "I can't do that." He turned back to his writing.

Boyer stared in disbelief. *No?* She tried vainly to hold back tears as she reasoned with the doctor: She was midcycle, putting her in danger of getting pregnant. Emergency contraception is most effective within a short time frame, ideally 72 hours. If he wasn't willing to write an EC prescription, she'd be glad to see a different doctor. Dr. Gish simply shook his head. "It's against my religion," he said, according to Boyer. (When contacted, the doctor declined to comment for this article.)

Boyer left the emergency room empty-handed. "I was so vulnerable," she says. "I felt victimized all over again. First the rape, and then the doctor making me feel powerless." Later that day, her rape counselor found Boyer a physician who would prescribe her EC. But Boyer remained haunted by the ER doctor's refusal — so profoundly, she hasn't been to see a gynecologist in the two and a half years since. "I haven't gotten the nerve up to go, for fear of being judged again," she says.⁶⁴

⁶² Sabrina Rubin Erdely, "Doctors' Beliefs Can Hinder Patient Care," NBC News, http://www.nbcnews.com/id/19190916/ns/health-womens_health/t/doctors-beliefs-can-hinder-patient-care/#.WaL6kLGZPyV.

⁶³ Ibid.

⁶⁴ Ibid.

This case is unique, in that it showcases the harm that can be done to a woman even if a refusal (personal or institutional) is justified and not necessarily opposed by the patient. Because EC is available in the US over the counter, the physical barrier to access EC has been greatly diminished. This does not mean that opportunity for harm has been eradicated. Being a competent health care provider, especially a Catholic one, requires that a person is cared for on all levels and not only for physical ailments. To the credit of the USCCB, the ERDs stipulate that rape victims should be treated with the utmost compassion. Unfortunately, compassion is difficult to standardize or assess, and the obligation to withhold EC treatment and/or counseling has the potential to leave many women feeling vulnerable and scarred like Lori Boyer.

Consequences of Barriers to EC

The longer the USCCB refrains from publishing more authoritative guidance on the use of EC, the more risk women are subjected to after being raped. The most obvious risk is pregnancy. Although the chances of becoming pregnant as the result of rape are low, it could be dangerous when a woman is unprepared to become pregnant for a multitude of reasons. A child that has been raped but that has already started puberty may suffer dangerous complications from carrying a pregnancy while still small in stature.⁶⁵ Depending on how she reacts to the news of becoming pregnant and the ensuing path that was forced on her, a woman's mental health and life may be at risk.⁶⁶ Whether for personal reasons or other external pressures, a woman may seek to abort the child conceived in rape. If she is successful, she has to endure whatever physical or

⁶⁵ Michael K. Magill and Ryan Wilcox, "Adolescent Pregnancy and Associated Risks: Not Just a Result of Maternal Age," *Am Fam Physician* 75, no. 9 (2007).

⁶⁶ Dean G. Kilpatrick, "The Mental Health Impact of Rape," <https://mainweb-v.musc.edu/vawprevention/research/mentalimpact.shtml>.

mental trauma accompanies the abortion.⁶⁷ If she isn't successful, her life is radically changed by being forced to carry a pregnancy to term.⁶⁸ She may have to come to terms with putting a child up for adoption or she may have to rearrange her entire life to care for the child. In some parts of the US, a woman that chooses to keep a child conceived in rape may be forced to give her rapists parental or other visitation rights, ensuring her continued encounter with the trauma of her rape.⁶⁹ If she chooses neither of these options, she may feel compelled to try and continue with an abortion without a doctor's guidance, risking both her life and jail time in certain states.⁷⁰ These consequences cannot be ignored. Particularly troubling is that these consequences may depend on something as simple as geographical boundaries of dioceses. Having what little choice that exists removed from a woman's control may compound the violence she experiences. This does not necessarily mean the Catholic Church must contribute to what it sees as unjustifiable evil acts, but it should acknowledge the violence being done to women in this way.

⁶⁷ While there is insufficient evidence to suggest that post-abortive women experience mental health issues at greater rates compared to other women, there is evidence that suggests that post-abortive women with a history of depression may be at increased risk of mental health issues related to abortion., Brenda Major, Catherine Cozzarelli, and Luynne Cooper, "Psychological Responses of Women after First-Trimester Abortion," *Arch Gen Psychiatry* 57, no. 8 (2000).

⁶⁸ Henry McDonald, "Woman Denied Abortion in Ireland 'Became Pregnant after Rape'," *The Guardian*, August 18 2014. <https://www.theguardian.com/world/2014/aug/18/ireland-woman-forced-caesarean-pregnant-rape-friend>.

⁶⁹ Caitlin Nolan, "Pregnant through Rape, Women Are Forced to Share Child Custody with Their Attackers," Inside Edition, <http://www.insideedition.com/headlines/15130-pregnant-through-rape-women-are-forced-to-share-child-custody-with-their-attackers>.

⁷⁰ Molly Redden, "'Please, I Am out of Options': Inside the Murky World of DIY Abortions," *The Guardian*, <https://www.theguardian.com/us-news/2016/nov/21/home-abortions-emails-secret-world>.

Contraceptives Complications

As mergers occur, institutional affiliations and sponsorships change rapidly. Doctors affiliated with these institutions may come under the purview of the ERDs with or without patients' knowledge. What is especially perplexing is when a doctor has affiliations with both Catholic and non-Catholic institutions. In these cases, a patient may only have access to contraceptives if they see their physician during a planned private office visit, but not at the CHI. If a provider does not have a private office or admitting privileges at another institution, then that provider may be prevented from prescribing contraceptives or performing contraceptive procedures on patients at all. Confusion resulting from unknown restrictions and the potential need for additional surgery are opportunities for women to be harmed via secondary effects of the ERDs.

Case Study 1 – Barriers to Oral Contraceptives

Oral contraceptives are widely used by American women to prevent pregnancy. Catholic American women use oral contraceptives at the same rate as non-Catholics, even though the Church deems use of contraceptives to be immoral.⁷¹ They have become an expected part of gynecological services in the US and many women are unaware of the Catholic restrictions against contraceptives.⁷² Unexpected barriers to contraceptives can be a significant inconvenience for women, especially those whose insurance plans cover only physicians at CHIs as in network. The chance of injury or death due to difficulty in obtaining oral contraceptives for pregnancy prevention

⁷¹ Riffkin, "New Record Highs in Moral Acceptability"., Jones and Dreweke, "Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use".

⁷² Guiahi, Sheeder, and Teal, "Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care."

purposes is remote. Discussing the ethical issues surrounding these restrictions is important, however, there are more pressing opportunities for harm to women that must be considered.

Pregnancy prevention is only one of a long list of indications for oral contraceptives. Physicians will prescribe oral contraceptives to lessen heavy menstrual bleeding, to alleviate severe menstrual cramps, to manage polycystic ovarian syndrome, to manage endometriosis, to prevent migraines, and to treat hormone-related acne in women.⁷³ All of the listed conditions are related to pathological abnormalities in hormone levels or reproductive tissue; many times, the best treatment for regulating these abnormalities is adjusting the hormone levels directly. For example, when treating endometriosis, oral contraceptives provide an effective way to lessen the severity of the symptoms a woman may be experiencing.⁷⁴ Other oral treatments for endometriosis are accompanied by a higher risk for side effects and surgery has shown to be ineffective for long-term pain relief.⁷⁵

In Catholic healthcare, the principle of double effect allows for treating certain conditions with oral contraceptives if there are no other less harmful treatments that preserve fertility. While this in theory allows physicians to treat women with oral contraceptives in certain circumstances, access is not guaranteed when necessary according to current literature:

For example, obstetrician gynecologists routinely treat acute bleeding with hormonal contraceptives, but physicians noted that not having these medicines in stock delayed or disrupted a patient's urgent medical care. One obstetrician-gynecologist explained: "Say you have...a 45-year-old

⁷³ Carrie Armstrong, "ACOG Guidelines on Noncontraceptive Uses of Hormonal Contraceptives," *Am Fam Physician* 82, no. 3 (2010).

⁷⁴ *Ibid.*

⁷⁵ The American College of Obstetricians and Gynecologists, "Endometriosis," <https://www.acog.org/Patients/FAQs/Endometriosis#can>.

who comes in [at three in the morning] with heavy bleeding and irregular periods. The most common approach to stopping her bleeding is to give her high-dose birth control pills for a short period of time. So, that became very difficult... 'cause they didn't have them in stock. I won't say it's impossible to get them, because like the head pharmacist knows where there's three secret packs, and if you happen to manage to find the head pharmacist at [that hour], you can. But it's nearly impossible to get birth control pills to treat heavy bleeding."⁷⁶

In this circumstance, a physician describes why women might not receive prompt treatment for heavy bleeding, despite the theoretical permissibility of prescribing oral contraceptives in this case. If there are cases where oral contraceptives are both moral according to the ERDs and indicated as the preferred treatment option, then there should be no justification for having hospital policies that cause delays in obtaining oral contraceptives.

Case Study 2 – Barriers to LARCs

Long-acting reversible contraceptives (LARCs) are not only gaining popularity among women in the US, but are becoming the focus of public health initiatives focused on reducing the rate of unplanned pregnancies, especially in low-income communities. Every year, federal and state governments in the US spend billions of dollars on births, abortions, and miscarriages that are the result of unplanned pregnancies.⁷⁷ By increasing the accessibility of LARCs like intrauterine devices (IUDs), the contraceptive shot, and the contraceptive implant, some state governments have reduced Medicaid costs by a

⁷⁶ Debra B. Stulberg, Rebecca A. Jackson, and Lori R. Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities," *Perspectives on Sexual and Reproductive Health* 48, no. 3 (2016): 115.

⁷⁷ Christopher Ingraham, "Unplanned Pregnancies Cost Taxpayers \$21 Billion Each Year," *The Washington Post*, March 3 2015. https://www.washingtonpost.com/news/wonk/wp/2015/03/03/unplanned-pregnancies-cost-taxpayers-21-billion-each-year/?utm_term=.57a00101ef0e.

significant amount.⁷⁸ Colorado saved more than six times the amount of their initial investment in covering IUDs on Medicaid in just three years due to a reduction in unplanned pregnancies.⁷⁹ Other states are following suit, not only pushing for LARC coverage through Medicaid, but also increasing education efforts to increase utilization of LARCs. In Texas, specifically, public health officials are trying to increase the availability of post-delivery IUD insertion. This program became a priority for Texan officials after funding was cut for organizations associated with the provision of abortions, such as Planned Parenthood.⁸⁰ This slash in funding also affected organizations' ability to provide LARCs to low-income women in Texas, increasing the risk of unintended pregnancy in an already financially vulnerable population.⁸¹

Despite the concerted effort to make LARCs more widely available in states like Texas, states that see the highest expenditures due to unintended pregnancies in the county, significant barriers still exist; not least among these are prohibition of administering LARCs at CHIs. This presents a unique consequence of building a barrier in access to LARCs; while CHIs accept federal funding in the form of Medicaid reimbursement, they refuse to participate in certain initiatives that help ration healthcare dollars overtime. This puts an increased strain on the Medicaid system. In this instance, Catholic healthcare dollars are used to block access to LARCs for low-income women, which stymies attempts to address the levels of unplanned pregnancy in this particularly vulnerable population.

⁷⁸ Shefali Luthra, "To Curb Unintended Pregnancy, States Turn to IUDs - in the Delivery Room," *Kaiser Health News*, October 21 2016. <http://khn.org/news/to-curb-unintended-pregnancy-states-turn-to-iuds-in-the-delivery-room/>.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

None of these facts necessarily lead to a good moral reason that CHIs should start providing LARCs. Again, the Church believes that some LARCs have the potential to be early abortifacients, so they would never be permissible unless proven otherwise. Even if they were proven to act prior to conception, using artificial contraception is still considered immoral, although with less grave consequences than early abortifacients. The relevant ethical paradox here is that CHIs claim to care for the vulnerable and use government funds from Medicaid and Medicare to assist in those endeavors, but they also sometimes impede the efficient use of those government funds so that more of the vulnerable might be served. This paradox rests on conflicting views about what it means to serve the vulnerable in a medical capacity.

Barriers to Sterilization

Tubal ligations, or the blocking or severing of a woman's fallopian tubes, is a permanent form of female sterilization.⁸² Tubal ligations are more effective at preventing pregnancy than almost all contraceptives, with intrauterine devices (IUD) and contraceptive implants being similarly effective. Ligations are rated by the CDC as one of the most effective contraceptive methods.⁸³ They are often sought by women that cannot risk getting pregnant for health-related reasons, women that have decided they are done having children, or women that have tried other methods of contraception without success in preventing pregnancy.⁸⁴

⁸² The American College of Obstetricians and Gynecologists, "Sterilization by Laparoscopy," <https://www.acog.org/Patients/FAQs/Sterilization-by-Laparoscopy>.

⁸³ Centers for Disease Control and Prevention, "Effectiveness of Family Planning Methods," U.S Department of Health and Human Services, https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/contraceptive_methods_508.pdf.

⁸⁴ Ibid.

Although a woman may have medical reasons for seeking a tubal ligation, the primary goal is always to impede her own fertility and for this reason ligations are not morally permissible under the ERDs. Regardless of how compelling a woman's reason is to never become pregnant, the Church always regards the separation of sex and procreation as immoral. In these cases, the Church advises that the woman abstain from sex or practice natural family planning (NFP). Proponents of NFP tout its effectiveness and maintain that it is the only "natural" option for pregnancy prevention. For Catholics, this pregnancy prevention method is deemed moral, since it does not require altering a woman's natural ovulatory cycle nor does it necessarily separate the act of sex from procreation. Couples using NFP abstain from engaging in sex (and procreation) during fertile periods, while couples using other contraceptive methods sterilize fertile sex, effectively separating sex and procreation.⁸⁵

With perfect use, various methods in NFP have been shown to be as effective if not more effective than other contraceptive methods.⁸⁶ Despite these reported success rates, NFP is much harder to use than other contraceptives, so pregnancy prevention with typical use has a comparable success rate to the withdrawal method, at an estimated 24 percent failure rate.⁸⁷ NFP involves monitoring one or more of the following based on the method being used: basal body temperature, cervical mucus, and menstruation. Based on these measurements that are taken daily, a couple abstains from sex for a certain amount of days during specific times in a woman's ovulatory cycle.

⁸⁵ Office of Population Affairs, "Fertility Awareness (Natural Family Planning)," US Department of Health & Human Services, <https://www.hhs.gov/opa/sites/default/files/natural-family-planning-fact-sheet.pdf>.

⁸⁶ James Trussell, "Contraceptive Failure in the United States," *Contraception* 83, no. 5 (2011).

⁸⁷ *Ibid.*

The act of monitoring one's cycle in such a manner is time consuming, as are the classes and research necessary to successfully use NFP.

There are two major obstacles to using NFP for pregnancy prevention; the first obstacle is the amount of time a woman must refrain from having sex and the second is the amount of time and attention that must be paid to detecting biological signs of ovulation. For those that believe artificial and non-artificial methods of intending to prevent pregnancy are morally equivalent, any benefits NFP might provide over other hormonal or non-hormonal contraceptives may not be worth the time investment or opportunity for mistakes in tracking ovulation. This is doubly true when considering women who cannot afford to get pregnant for health reasons; a mistake in tracking ovulation charting could be injurious or deadly.

Women may not be aware of certain health conditions that make pregnancy dangerous until they are pregnant. Once life-threatening symptoms appear in one or more pregnancies, a physician will discuss contraceptive options with the patient. Although there are multiple possible courses of action, the goal is generally to prevent pregnancy on a permanent basis. An effective way to accomplish this is to perform a tubal ligation after a Cesarean section (C-section). This prevents the woman from having to undergo a second surgery or procedure to perform the ligation; this not only saves money and other medical resources, but also saves the woman from being exposed to the risks and pain of surgery twice in a short period of time.⁸⁸ Additionally, a woman can be protected from pregnancy immediately after giving birth if the tubal ligation is performed after delivery, which is preferred in these circumstances. If the

⁸⁸ Debra B. Stulberg et al., "Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences," *ibid.*90 (2014): 425.

surgery is not performed immediately following surgery, that would mean undergoing additional surgery while caring for a newborn child and risking becoming pregnant in the interim.

When a woman makes plans for a tubal ligation before delivery, these plans are often made based on the assumption that the woman will give birth at a particular hospital. A woman may be taken to the closest hospital despite her plans, however, in certain obstetric emergencies like unexpected membrane rupture. If she is taken to a CHI, then she will not be able to have a tubal ligation in the same visit as her delivery, missing a vital opportunity to obtain the tubal ligation. Additionally, if a patient is only covered by her insurance to deliver at CHI's, she may not be able to obtain a tubal ligation at all.

Case Study 1 – Unexpected Delivery and Tubal Ligations

Barriers to tubal ligations can cause harm by preventing the performance of the procedure concurrent with a surgical delivery. If a woman cannot risk getting pregnant due to health reasons, and she is forced to deliver her child at a CHI due to her particular circumstances, she is in effect forced to undergo two surgeries to obtain the tubal ligation. This happened to Jennafer Norris in 2014, when she started to experience symptoms of severe preeclampsia at 30 weeks.⁸⁹ According to a report published by the ACLU, Jennafer experienced a “rare birth control failure” and only became aware she was pregnant when she was eight weeks into the pregnancy.⁹⁰ Jennafer started to

⁸⁹ Julia Kaye et al., "Health Care Denied: Patients and Physicians Speak out About Catholic Hospitals and the Threat to Women's Health and Lives," American Civil Liberties Union; MergerWatch, https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

⁹⁰ *Ibid.*, 19.

experience symptoms of preeclampsia, which she recognized from her first two pregnancies. She was put on bedrest and hoped to carry her pregnancy for as long as possible, but at 30 weeks she started experiencing life threatening symptoms related to preeclampsia.

Jennafer was scheduled to deliver by C-section, and she requested a tubal ligation at the time of the delivery— for obvious reasons, she could not risk getting pregnant again. But the hospital refused. While Jennafer’s physician was sympathetic, she explained with regret that she was bound by the Catholic hospital’s policy prohibiting sterilization. The only alternative, the hospital staff informed Jennafer, was to be treated at another hospital. The Norrises were outraged: The nearest hospital was 30 minutes away, Jennafer was in horrible pain and so dizzy that she could hardly see, and her medical team had warned her repeatedly that she could have a stroke or seizure at any moment. Jennafer and Jason decided that they could not risk it, and she went ahead with the delivery at the Catholic hospital.⁹¹

While it can be argued that tubal ligations are not necessary and always optional, this does not diminish the potential benefits of a tubal ligation for some women. This also does not diminish the potential dangers in not procuring a tubal ligation for these women. After a rare birth control failure, like in Jennafer’s case, a tubal ligation might be the only method of contraception that provides reasonable assurance in preventing a dangerous pregnancy. While abstinence is technically an option Jennafer could take, making the tubal ligation optional in theory, this would come at great cost to her relationship with her husband.

Case Study 2 – Unknown Restrictions in Care

In the same ACLU report, Dr. Rebecca Cohen reports that a patient was harmed due to the care she received at a CHI:

⁹¹ Ibid., 19-20.

She had decided during her previous pregnancy that she wanted a tubal ligation and had informed the secular hospital where she was then receiving prenatal care. She signed the necessary consent forms well in advance of her delivery. When she went into labor, however, she had to rush to the nearest hospital—a Catholic hospital—because the fetus was in a breech position, her contractions were coming quickly, and she would not have been able to make it to the hospital where she had received her prenatal care. She presented the consent forms for the tubal ligation and had an emergency C-section. All went well, and she assumed that the tubal ligation had been completed as planned. The hospital certainly never told her otherwise.⁹²

This patient ended up seeking an abortion after she realized she was pregnant after not receiving a tubal ligation. Not only was this woman harmed due to her care, but as a result of the patient not being informed that a tubal ligation was not performed, a fetus was aborted. This case brings multiple issues to light. The first is that CHIs must be better trained in employing the ERDs in order to avoid situations like these, where unnecessary harm is done to a patient. The second is that employing the ERDs when their restrictions are not well known or expected by women may lead to hurtful and preventable consequences. Had this woman known that her tubal ligation was not performed, or had it been possible that this woman could have chosen another institution for her emergency care, the abortion could have been prevented. Knowing that situations like this occur, CHIs and the USCCB should act to prevent the conditions that lead to these cases.

Case Study 3 – Changing Enforcement

Surely, it is confusing when hospitals and systems transition in and out of the purview of the ERDs and the accompanying restrictions in care, but enforcement can also vary within the same institutions that have always given care according to the

⁹² Ibid., 21.

ERDs. Reports suggest that care seems to vary based on changes in local bishops' interpretations of the ERDs, but even changes in the papacy can also be felt on a local level according to one physician:

“...there were times when we've had patients that ... should never get pregnant, because if they did, it would be risking a life. And if we recommended that a tubal be done at the time of c-section or time of delivery, we would have to petition the hospital's Ethics Committee to see if they would allow us to do that. I think probably about ten years ago, the Ethics Committee was much more amenable to sitting down and listening to us and would grant us permission to do it in those special circumstances. Interestingly, I think over the last ten years, after the new pope [Benedict] came out, the rules of the Church started to be more heavily enforced. And so that option was taken off the table.”⁹³

It is reasonable to expect that any ministerial arm in the Church is going to hold varying positions on certain moral issues over time. It is problematic, however, when access to certain medical procedures change as frequently as the clergy changes. The fact that these changes are largely unwritten and enforced culturally, so to speak, also is problematic. This can create confusion that leads to compromised patient care. Those that seek care according to Catholic principles may feel misguided and those that want non-Catholic care will not know what restrictions they face until they are at the institution in need of care. Even those that frequent a particular institution could be caught off guard with blocked access to a particular service, as is demonstrated in this physician's report of access to tubal ligations at his institution. The potential for harm when facing unexpected restrictions in access to care were already demonstrated in Cases 1 and 2.

⁹³ Stulberg et al., "Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences," 426.

Conclusion

All of these cases demonstrate one essential conflict, which is the choice between cooperating with what the Church considers an unjustifiable evil or putting women in harm's way. The opportunity for harm originates in using a religious standard of care to serve a pluralistic population; some women may choose to seek care according to Catholic principles at a CHI while others are forced to obtain care that is Catholic. If a woman chooses to seek Catholic care and is fully aware of what this entails, she is choosing to risk her life in a very limited number of circumstances. This woman would choose to carry a doomed pregnancy to its natural termination without intervention, regardless of the risk to her own life. In this scenario, the CHI would not be harming the woman; she is choosing to assume the health risks associated with her choices and might deem these risks as less harmful than cooperating with unjustifiable evil. Conversely, in the scenarios presented in this chapter, women are being forced to assume unwanted and unnecessary risk due to CHI policies. If Catholic healthcare can be reformed in a way that avoids harming non-Catholics and still remains faithful to Catholic principles, then this should be pursued.

CHAPTER 5 – OBSTACLES TO THE CATHOLIC HEALTHCARE MINISTRY

When Catholic Healthcare Institutions (CHIs) are discussed in popular discourse, the conversation often revolves around the restrictions in care that are established by the United States Conference of Catholic Bishops (USCCB) through the Ethical and Religious Directives (ERDs). Certain segments of the public, particularly those advocating for widespread availability of abortion and contraceptives, are not particularly concerned with the success of Catholic healthcare as a system. These concerns, the validity of which is explored in the previous chapter, are only one particular subset of concerns. The distinctness of the Catholic healthcare system and its future in the US is another concern that must be discussed.

Evidence of the homogenization of health care was discussed in Chapter 2. If the only truly distinctive feature of Catholic healthcare system is the restrictions on care set by the ERDs, then CHIs do not provide any of the unique benefits to the public that is claimed they provide. In this case, it is harder to defend the place of CHIs in the American healthcare system. Non-Catholic institutions can provide the same level of care to the public using the same amount of public funding without impeding access to certain services. Alternatively, evidence of homogenization is also used to argue for more protections for CHIs in the US. Those that support the availability of Catholic healthcare argue that the Catholic health system must become more distinct from its secular counterpart, otherwise the goal of providing care in the healing tradition that Jesus exemplified will go unfulfilled.

Homogenization, more specifically the reduction of the Catholic healthcare tradition to restricted access to certain services, may be detrimental to the Church and her interests. The pressures that drive hospital homogenization prevent CHIs from

pursuing their mission in a complete sense; the tensions that CHIs experience as a result of their peculiar private-public hybrid position impede their mission. These obstacles can be divided into three categories: the use of Church resources to accomplish what it regards as unjustifiable evil acts, the loss of integrity of the Church's position as a countercultural option in healthcare, and the imperfect relationship between the Catholic Social Tradition and the ERDs. Obstacles in these categories are due to inconsistencies between core beliefs of the Church and those of CHI management, health care providers, or on a broader scale, local and federal governments.

Use of Church Resources to Accomplish Unjustifiable Evil Acts

In the growing body of literature on restrictions in care at CHIs, the studies most often focus on harm being done to women or other conflicts of personal and religious liberties. A recurring theme in this literature is that physicians, management, and institutions find a way to act contrary to the ERDs as a way to resolve the tension between core beliefs that differ between the Church, individual, or institution. These actions are largely framed in a positive light, whether they are framed as such by the physicians giving care, the patients receiving care, or by the authors of the literature. The results are certainly not reported to shine light on how the Church's healthcare mission is being subverted.

On the surface, it may seem that the Church should not be held morally responsible for any actions taken by its employees that contradict the ERDs. Physicians that work for CHIs are required by the Church to obey the ERDs.¹ If a CHI hires someone that promises to obey the ERDs and the employee disobeys, a CHI is not

¹ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services".

morally responsible, especially if the CHI is unaware of the employee's actions.

Although the CHI facilitated the interaction between provider and patient and provided the possibility for the unjustifiable evil act to occur, steps were taken to prevent evil acts, sufficiently removing the CHI from the evil act. Despite the steps taken, the literature indicates that these steps are not sufficient for preventing employees and CHIs from perpetrating what it considers to be unjustifiable evil. In other words, translating a Catholic healthcare mission to actual Catholic health care is still a challenge.

Furthermore, there is evidence to suggest that institutions are inconsistent in applying the ERDs, creating the danger of scandal. In some cases, employees indicated that certain services might be procured at a particular CHI, despite the clear prohibition by the USCCB in the ERDs. Access to these services may or may not be justified based on individual judgments, loopholes, or "creative solutions."² This creates the danger of implying that the Church approves of these services as morally licit treatment options, which the Church considers to be harmful.

The Church in a broad sense is generally not morally responsible for most of the evil being perpetrated, as per the explanation above. This does not mean, however, that the Church should not work towards preventing these evils if at all possible. Preventing these unjustifiable evils, as the Church sees them, not only can remove women from potentially harmful situations, but also has the added benefit of allowing for a more faithful expression of the Catholic healthcare mission. These occurrences must be brought to light and discussed in order for a prevention plan to be made. The following demonstrates evidence that Church resources are being used to perpetrate what Catholics believe to be unjustifiable evil in the context of the current healthcare system.

² See page 20.

For the remainder of this discussion, I will use the word evil to mean what the Church considers to be an unjustifiable evil, or an action that is never permissible and always wrong no matter the consequences.

Providers and ERD compliance

One particularly significant way evil acts occur at CHIs is when health care providers intentionally perform actions prohibited by the ERDs. The following case studies demonstrate various opportunities that providers have to perform prohibited acts, in some cases going so far as to hide the act from ethics committees and management.

Case Study 1 – Providing Referrals for Prohibited Services

The permissibility of providing referrals to patients for prohibited services varies by diocese and by the treatment or procedure in question. Certain circumstances can mitigate the moral permissibility of providing a referral for a prohibited service, which is why the rules regarding referrals vary among CHIs. When referrals are prohibited, however, it is quite easy for physicians to ignore this prohibition as is explained in one study on referral practices in Catholic hospitals:

Another physician explained that he was unsure if the administration knew about the contraceptive referrals made in his Catholic residency program: “We would tell [patients] just pretty directly that we could not provide contraception at that facility and usually would refer them to Planned Parenthood or to the health department. I’m not sure [the hospital administration] knew.”³

³ Stulberg, Jackson, and Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities," 114.

In this instance, not only is the CHI employee providing a referral for a prohibited service, but the employee is providing the referral for an institution that largely contradicts the ethos of the Catholic Church. The employee is in effect providing free advertising for Planned Parenthood, which openly advocates for easily accessible abortions, among other services deemed as evil by the Church.⁴ The institutional policy on referrals in this case is unclear, but what is clear is that if employees are internally motivated contrary to the ERDs, it is very easy to provide a prohibited referral.

Case Study 2a – Covert Counseling

Another recurring theme in the literature is that physicians are able to provide counseling on prohibited services without making management or fellow employees aware. Whether it is due to conscientious beliefs, a concern for patient welfare, or some other internal motivation, physicians have navigated CHI restrictions on counseling with covert actions. One physician reports that she and others repeatedly counsel patients, even when explicitly prohibited:

The hospital does not keep methotrexate in house, and Dr. Y suspects that this is because the hospital does not want physicians using it. To navigate these barriers, Dr. Y often takes patients aside and reviews all of their treatment options, even though this level of disclosure is not permitted in the hospital. She knows of a few other physicians who offer referrals and information “under the radar.” Dr. Y worries that the restrictions on treatment options impact the health and welfare of women. In cases of ectopic pregnancy, she feels that the policies at her hospital increase the risk of tubal rupture because ectopic pregnancies are often not diagnosed in a timely manner.⁵

⁴ Planned Parenthood, "Mission," Planned Parenthood Federation of America Inc., <https://www.plannedparenthood.org/about-us/who-we-are/mission>.

⁵ Foster, Dennis, and Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," 106.

The Church considers methotrexate treatment for ectopic pregnancies as morally equivalent to elective abortions, as both intend the direct destruction of the fetus.⁶ Although the physician in question certainly does not agree, the Church considers this a referral for a service that will end a person's life. Further, she admits that she is not the only physician that provides counseling on methotrexate and that she counsels in such a manner often. It is hard to discover and ameliorate isolated incidents of ERD violation at CHIs. If there are recurrent violations that occur with relative ease, steps should be taken to prevent these acts.

Case Study 2b – Covert Counseling

Sometimes, physicians use creative charting practices to justify the provision of prohibited counseling. This physician recounts at least one time she has used this practice:

One obstetrician-gynecologist explained that physicians had to manage contraceptive counseling and charting discreetly: "We couldn't provide abortion services there, and we also couldn't provide contraception. Although when the door was closed to the exam room, we did talk about contraception.... And I think the nurses knew that this was going on. I mean, it wasn't that they were policing us.... The given was that they wouldn't get us in trouble for talking about it, but the documentation that went in the chart would be sparse around the contraceptive counseling. You know, there were little euphemisms that went in there about menstrual regulation and things like that."⁷

Beyond the intentionally inaccurate charting practices, this physician alludes to a silent agreement with the nurses in order to provide prohibited counseling. This not only demonstrates that provision of prohibited counseling is more substantial than a few

⁶ See page 82.

⁷ Stulberg, Jackson, and Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities," 114.

isolated events, there might actually be intentional collusion among CHI employees to evade the ERDs and associated hospital policies.

Case Study 3a – Covert Treatment

Taking matters a step further, physicians sometimes go so far as to provide prohibited treatments to patients or perform other illicit acts so that treatment can be provided. As will be shown in the following five cases, there are a multitude of ways that this can be accomplished. One physician, citing social justice concerns, admits to prescribing contraceptives in prohibited circumstances by incorrectly documenting the patient's health concerns.

Finally, financial barriers—especially for patients from lower socioeconomic groups—were reported as a reason that referrals were not always an adequate solution. A physician explained how, at one Catholic hospital with a large indigent population, providers would prescribe birth control under the guise of treating menstrual irregularity because there was no other way the patients could get contraception. Prescribing pills to treat menstrual irregularity, this physician commented, “was just the right thing to do.”⁸

This physician felt compelled to provide the prohibited service based on his or her own moral code, one that differs from the Church's ethical directives. This suggests the possibility that any time this physician encounters a situation in which their own beliefs do not match those of the Church, they might be compelled to act against the ERDs. Again, the documented evidence suggests that these violations of the ERDs are a chronic problem, not isolated incidents.

⁸ Ibid., 116.

Case Study 3b – Covert Treatment

It is easy for a physician to document certain conditions that might justify a prohibited treatment, even if those conditions are not present in reality. This simply requires writing a few words on a patient's chart and the employee can successfully evade the restrictions of the ERDs. It is not hard to imagine that this type of evasion occurs more often than others, since the treatment in question is physically available at the CHI and the only physical action necessary to provide the treatment is writing a few inaccurate words on a patient's chart. Sometimes, covert treatment can be more active than false documentation. Physicians have also reported acquiring the means to provide prohibited treatments from another non-Catholic institution.

Dr. Foster recalls one physician's report, saying "Dr. Y adds that she sometimes provides methotrexate to patients surreptitiously, 'I've gotten the drugs from my office and given them to the patients off the record because the diagnosis was unclear and I wasn't allowed to tell the patient [all of her treatment options].'"⁹ This particular physician, like many others that work at CHIs, has admitting privileges at another institution or another practice that is not Catholic. From the doctor's perspective, the only restriction on their ability to give care is essentially geographical. If the patient had come for treatment at the other office or hospital, the physician would be able to give the treatment in question. If the doctor believes this treatment option is a morally acceptable course to take and perceives increased risk for the patient if treatment is delayed, it is very easy for the physician to feel compelled to provide treatment covertly.

⁹ Foster, Dennis, and Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," 106.

Case Study 3c – Covert Treatment

As discussed in Chapter 3, the favored course of treatment for an ectopic pregnancy is the most surgically conservative option that will end the ectopic pregnancy. At CHIs, however, the most conservative option (methotrexate) is not morally acceptable because the fetus is directly attacked. The only morally permissible options for treating ectopic pregnancies are expectant management or removal of the fallopian tube (a salpingectomy).¹⁰ According to the literature, some surgeons will perform salpingectomies when another more surgically conservative option is available with the intention of impeding a woman's fertility. Dr. Foster explains one surgeon's experience:

Although salpingectomy was generally not a preferred mode of treatment by physicians (from all institution types), several physicians at Catholic facilities spoke about using an ectopic pregnancy as an opportunity to provide a patient with a tubal ligation, a procedure explicitly prohibited under the Directives. As Dr. Z explained, "In my population, many patients are dealing with unplanned pregnancies already. I talk to them before I take them to the OR to determine if future fertility is an issue. If it's not an issue I would tend to take out the tube.. The hospital has never said anything about it one way or another."¹¹

In the Catholic Social Tradition, a lot of care is taken to discern what is moral and immoral in situational contexts, taking means, ends, and intentions into account. The difficulty in applying these principles on a systemic level to health care decision making is that it is nearly impossible to assure that employees are intending to treat in a morally permissible way, especially when the resulting treatments do not differ based on whether the intentions are moral or immoral.

¹⁰ See page 82.

¹¹ Foster, Dennis, and Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," 107.

Case Study 3d – Covert Treatment

In order to ensure that treatments are morally aligned with the ERDs, physicians at CHIs must seek the permission of ethics boards before providing certain treatments. Inducing labor before fetal viability is one example of such a treatment. This requirement has practical challenges, which were explored in Chapter 4. Because of these challenges, some doctors can be tempted to manipulate a particular situation so that the delays associated with seeking permission from an ethics board can be avoided. One way this might be accomplished is by intentionally failing to perform certain checks, the results of which decide if there is a need to consult the ethics board. Dr. Freeman discusses such a case in her study:

Dr G also circumvented the ethics committee in her southern Catholic-owned hospital. She opted not to check fetal heart tones or seek ethics committee approval when caring for a miscarrying woman for fear that documentation of fetal heart tones would have caused unnecessary delays. This led to conflict with the nurse assisting her. “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.’ Because then that's the thing; it would have muddied the water in this case.”¹²

The doctor in this case failed to check to see if the fetus was still alive and proceeded with treatment as if the fetus had already died. The life of the fetus was certainly doomed at that point and delaying treatment would have put the mother's life at risk.

¹² Freedman, Landy, and Steinauer, "When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals," 1777.

Those two facts informed the doctor's decision to betray hospital policy, as she was not sympathetic to the Church's emphasis on the immorality of pursuing evil means to achieve good ends.

Case Study 3e – Covert Treatment

As seen in the last case, if a physician does not agree with the ethical underpinnings of the ERDs, it is not likely that the physician will act according to the ERDs when situations become critical. Emergency situations, especially ones where a pregnant woman's life is at risk, put physicians in a position where they must make a moral choice; should every action possible be taken to save the mother's life expediently or should care be delayed to ensure that actions are considered moral by the Catholic Church? There is little reason for a physician to choose the latter if he or she is not sympathetic with the Catholic moral tradition, especially considering that all doctors are trained to preserve life and avoid illness as a primary goal of medicine. Dr. Freedman documented the experience of one physician that was put to this test, who went so far as to manually end the life of a fetus in order to expedite treatment:

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] 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."¹³

¹³ Ibid.

It is unclear in this case whether or not the ERDs were being employed properly. As demonstrated by Chapter 4, it is not rare for CHI ethics boards and employees to treat conservatively in fear of violating the ERDs. If the ERDs were employed correctly, and there were no practical delays in seeking approval for treatment, it is possible the patient would have never been in such a life-threatening state. Regardless of this possibility, manually snapping the umbilical cord and ending the life of a fetus is an egregious violation of the ERDs and is considered to be the murder of an innocent person by the Church. It is quite clear in the physician's language that the doctor was not sympathetic to the notion of attempting to save the fetus' life. If current practices allow such a physician to be employed at a CHI, and these practices remain unchanged, then such events will continue to happen at Church institutions.

Inconsistency and Scandal

It is clear that if physicians are not sympathetic with Catholic social teachings, there is very little to prevent them from acting contrary to the ERDs. This is one substantial way evil actions continue to occur within Church institutions. On the other hand, even those that hold authoritative positions within the Catholic healthcare ministry can inadvertently become an obstacle to the Catholic healthcare mission. CHI management teams, comprised of both laymen and clergy, are responsible for education and enforcement of the ERDs. The literature suggests that when these responsibilities are not carried out properly, there is opportunity for the mission to be impeded at Catholic institutions. These opportunities most commonly fall under three themes: creating the danger of scandal, financially motivated compromises, and contradicting authorities.

Case Study 1 – The Danger of Scandal

Scandal, as defined by the catechism of the Catholic Church is “an attitude or behavior which leads another to do evil.”¹⁴ The primary opportunity for scandal in the Catholic health care system is through cooperation with evil. There are various degrees of cooperation with evil; when an action satisfies certain criteria, it may be considered to be morally licit even if it does in some way contribute to evil being done. Even if an action is considered to have a moral degree of cooperation with evil, it may still be considered immoral because of the danger of scandal.¹⁵ This can happen when a CHI exhibits a certain degree of cooperation with other persons or institutions that regularly carry out treatments considered to be evil by the Church. Unfortunately, the unique position of CHIs in American healthcare create ample opportunity for scandal. This is demonstrated in one case reported by Dr. Stulberg:

One respondent explained how a clergyman, who was described as a consultant of the Catholic Church, came from a major metropolitan area to a small Southern town to talk to physicians at the respondent’s hospital. The clergyman instructed obstetrician-gynecologists to refer patients out for tubal ligations and other prohibited services, which surprised the respondent: “He came in and spoke to us about the Catholic ethic....And one of the things he recommended was that if we have a situation where a patient needs something that can’t be provided by the Catholic institution, that we should refer them to...the place where they could get things taken care of...as quickly as possible.... I was really surprised. He was like...‘If...somebody wants a tubal, you know, refer them to a doctor that can do a tubal at another hospital.’ I thought that was interesting ’cause usually you would think they would say, ‘Well, we don’t want them to have a tubal. That’s not the right thing to do.’”¹⁶

¹⁴ *Catechism of the Catholic Church*, 2nd. ed., 2284, accessed May 1, 2017, http://www.vatican.va/archive/ENG0015/_P80.HTM.

¹⁵ *Catechism of the Catholic Church*, 2nd. ed., 1753, accessed February 1, 2017, http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a4.htm

¹⁶ Stulberg, Jackson, and Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities," 113-14.

Based on the clergyman's emphasis on the need to provide referrals for a prohibited service at the patient's request, the respondent perceived a strange willingness to facilitate access to a treatment that is deemed immoral. While expedient transfer of care between providers and institutions is an expected part of the profession, a referral that ensures access to a prohibited service is considered to be moral cooperation in some circumstances. There is a moral distinction between simply allowing a patient to visit another provider and in sending a patient to someone who will ensure the provision of the evil act. The clergyman in this instance makes no distinction and the resulting confusion calls the immorality of tubal ligations into question. This is dangerous for the clergyman himself in a moral sense, but also for the institution as a whole. If the Church is to remain a countercultural option in healthcare in the US, it should work to invalidate the perception that these institutions offer more than referrals for services it prefers not to perform. Should cases like this continue to happen, it would be reasonable to ask why CHIs prohibit the procedures in question if their employees are willing to assist patients in procuring the procedures anyway.

Case Study 2 – Financially Motivated Compromises

Financial viability is a concern for any hospital in the US, but CHIs face unique financial challenges. The procedures that are prohibited by the ERDs provide a source of revenue for other hospitals. CHIs must be able to balance their budgets without this revenue. Because this can prove to be a difficult task, physicians have noted in the literature that they have observed compromises being made for the sake of finances.

One doctor explains what she observed at her CHI:

Noting that no one at her Catholic facility was allowed to provide fertility services, one respondent explained: "Now, they're getting a little

crafty with how they get around it, and they go off-campus [to provide such services]. So we actually do now have...an infertility specialist, who is starting up an in vitro fertilization clinic off-campus.... We had somewhere to send them anyway before—it was just out of the system—but now the system wants the business.”¹⁷

The system described demonstrates a problematic level of financial cooperation between two facilities in the same system, one of which is providing a Church-prohibited service. The pressure for CHIs to compete financially in a profit driven system encourages these morally dubious compromises. This compromise touches on the same problem as Case Study 1; if this particular healthcare system is going to profit from prohibited services and the CHI in question is financially dependent on that system, what is the moral distinction between this profit and providing the actual services?

Case Study 3 – Contradicting Authorities

Authority figures at CHIs are comprised of management, which is usually a committee of lay people, and the local Bishop and other clergy that have pastoral responsibilities at that institution.¹⁸ The Bishops are tasked with the role of interpreting and guiding the implementation of the ERDs via the hospital ethics committee (ERDs).¹⁹ The management’s role is to run the hospital in every other aspect of the healthcare system, especially regarding financial survival. While it is certainly true that the ethics board can have concerns for financial survival of the institution and that management may not always be made up of only laypeople or non-Catholics, these two

¹⁷ Ibid., 115.

¹⁸ Although the Bishop has a pastoral duty to a local Catholic hospital, CHIs are now largely run by lay people. See Dunne, "Challenges Ahead for Catholic Health Care, Keehan Says."

¹⁹ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services".

rolls can come into conflict if the people filling the roles are not in agreement on an institution's priorities. Some doctors report evidence of this in the literature:

Similarly, one perinatologist explained that her Catholic hospital objected when she suggested that she stop accepting obstetric patient transfers during the pre-viable period because she could not provide a full range of care to those patients. This respondent had cared for a pregnant patient whose fetus had a severe heart defect, and the patient's membranes had ruptured at 19 weeks. The respondent had approved an induction of labor, and had then been accused by her Catholic ethics committee of performing an illicit abortion. The respondent recounted her response and subsequent interaction with the ethics committee: "[I asked the committee,] 'So am I to understand that if I receive a patient in transfer, who's 20 weeks and has a number of other complicating factors, that, you know, I can't offer [labor induction]? Because if that's the case, then I am going to turn away all patients between 18 and 24 weeks, because we can't manage them in what I believe to be, and what I'm quite certain is, standard of care.'"

After the meeting, the respondent noted that once the opposition had left the room, "several people came up to me and said, 'No, no, no, don't stop accepting those patients.' [The] nurse vice president, the chairman of the ethics committee, kind of quietly afterwards...[came] up to me and [said], 'You know, we don't disagree with what you did, and we don't want you to not accept those referrals... because we're a referral hospital, and you start losing referrals for one thing, and you'll lose referrals for all kinds of things.'"²⁰

Here, the doctor explained that she was receiving two very different messages, one from the ethics committee and one from hospital management. Management directly contradicted the ethics committee, citing financial concerns. This scenario, while exhibiting a combination of the problems explained in both Case Studies 1 and 2, demonstrates unique obstacles to the Catholic healthcare ministry. First, if CHI employees are being told different things by management and by the ethics board, the proper course of action becomes questionable. Second, having a lay management that is willing to vocally contradict the Catholic ethics boards undermines the authority of the

²⁰ Stulberg, Jackson, and Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities," 115.

Church and the implementation of the ERDs.

Theoretical Issues with the ERDs

There is a third obstacle to the Catholic healthcare ministry which is rooted in the ERDs; even when the ERDs are applied to specific situations correctly, it seems that they might not necessarily lead healthcare providers to make the morally right decision, or the decision that is most faithful to the Catholic Social Tradition (CST). This is reflected in the ongoing debates about specific points of Catholic medical ethics, usually brought about by a case with a poor outcome that becomes publicized. Situations like these can become obstacles in two different ways. First, it deters providers following the ERDs from providing care that they might think is morally right, but are discouraged from providing in fear of violating the ERDs. Second, it provides cause for concern over the compatibility of Catholic healthcare institutions within the larger American healthcare system.

One such debate erupted within the Catholic academic community after the Phoenix abortion case discussed on pages 108-111. The ERDs prohibit any direct abortions, or those that directly aim at the death of the fetus. There is a dilemma, however, when the pregnancy itself causes life-threatening symptoms, and the only way to save the life of the mother is to terminate the pregnancy. Even if life-saving therapeutic direct abortions are rare, this remains a pressing issue for CHIs. Platitudes, like “an unborn child can never be pathological,” belittle the existence of this conflict. Multiple Catholic ethicists, including M. Therese Lysaught, have presented different ways to look at the life-saving abortions in these limited instances and argue that it is a

morally licit course of action.²¹ While the content of the debate itself is quite interesting from an academic perspective, it is not what is relevant to the discussion at hand. What is relevant, however, is that this issue and others need clarification and revision if Catholic healthcare is going to succeed in the face of increasing homogenization and legal opposition. Clarifying and revising the relevant Directives would not only prevent the individual tragedies that might result from these tricky scenarios, but would better enable the Catholic healthcare ministry to go forward with less opposition.

The Root of the Problem

In summary, the following are obstacles to the Catholic healthcare ministry that have been found in the current body of literature:

1. Intentional and covert provision of prohibited counseling and treatments by physicians working at CHIs
2. Utilization of Church resources to carry out acts deemed as immoral
3. The danger of scandal from incomplete counseling, improper advising, or compromising institutional relationships
4. Financial motivations that encourage scandalous or otherwise immoral institutional relationships
5. Competing priorities between ethics board and institution management
6. Correct applications of the ERDs that lead to problematic outcomes

All of these obstacles are interrelated and stem from the unique position that CHIs occupy in American healthcare, as was discussed in Chapter 2. CHIs have to carefully

²¹ M. Therese Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital," in *Origins* (Catholic News Service, 2011).

navigate the conflict between their positions as arms of the Church and as distributors of a public service subject to secular laws and professional norms and each of these issues is an extension of that conflict.

Catholic hospitals hire physicians from a diverse pool of applicants that have endured a standardized education process. Even if a physician was educated at one of only five Catholic medical schools in the country, students are still taught a standardized curriculum on a particular canon of topics and are required to pass a national board exam. As medical students are taught throughout their education and inculcated with medicine's "hidden curriculum," they learn norms that are established within the medical community.²² When a CHI hires a doctor, there is a demand that this physician turns those norms on their heads and behaves according to a countercultural ethical standard. Although hiring practices vary across CHIs, it seems that current hiring practices are broadly ineffective at identifying physicians that are truly sympathetic with the ERDs, regardless of their religious affiliation. This is unsurprising, given the countercultural nature of what a physician is asked to do when asked to abide by the ERDs. A doctor who abides by the ERDs must be comfortable with watching a patient suffer because the Church deems a treatment to be immoral, even though society has given him or her the authority to help the patient.

Hiring practices at CHIs must be reformed in order to improve the current state of affairs. It is evident that simply asking physicians to abide by a certain set of restrictions upon hiring is not sufficient for carrying out the Catholic healthcare ministry. A process needs to be introduced through which physicians can come to a

²² FW Hafferty and R. Franks, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education " *Acad Med* 69, no. 11 (1994).

deeper understanding of what it means to abide by the ERDs. This reformed process would greatly improve the illicit utilization of CHI resources for prohibited services and treatments, since physicians are by and large the proverbial gatekeepers of those resources.

Bishops and management teams are often asked to make difficult decisions that balance adherence to Church principles and financial survival. Despite the Catholic origins of healthcare in the US, the current system does not allow for full pursuit of the Catholic healthcare mission. In the age of the dominance of corporate hospital models, Catholic institutions are not only required to be profitable, but are also required to defend their position in healthcare on a financial basis. Catholic hospitals are not gaining a proportion of patient beds in the US because there is necessarily an increasing demand for Catholic healthcare, but because of the necessity to make economically vital mergers. As long as the Church is required to secure their position in the American healthcare system in financial terms, there will always be the necessity to forge morally dubious relationships for economic reasons. This, due to the danger of scandal, is potentially harmful to the Church. At the very least, this ultimately impedes the Catholic healthcare ministry. Conflicting messages from lay management and clergy to CHI employees is evidence of this obstacle to the ministry.

CHAPTER 6: AN ALTERNATIVE SOLUTION FOR REFORM

It is increasingly difficult for Catholic healthcare institutions (CHIs) in the US to pursue their mission in a distinctive way that honors the fullness of the Catholic Social Tradition in medicine. As explained in Chapters 1 and 2, this is due to the awkward position of CHIs in the US, one filled with significant tension. Catholic hospitals have been forced to occupy a position that straddles a private religious practice and a public service. Because of this, CHIs are subject to two competing sets of norms and regulations that must be navigated. One of these is Catholic Social Tradition, articulated specifically for medicine in the Ethical and Religious Directives (ERDs) published by the United States Conference of Catholic Bishops (USCCB).

The ERDs are a rich expression of Catholic healthcare ministry, but translating this expression into practice remains challenging. In very specific instances, the ERDs clash with certain American federal and state laws. In other instances, the ERDs contradict standards of practice both explicitly stated by the American Medical Association (AMA) and legally enforced in medical practice. I explored these tensions in Chapter 3. In Chapter 4, I surveyed the current literature to explore the impact of the ERDs on women's health, especially concerning suffering and autonomy. In Chapter 5, I explored how the configuration of the current healthcare system and other factors impede the Catholic healthcare mission.

Based on the evidence presented thus far, it appears that the current healthcare system favors a corporate hospital model that is not ideal for the Catholic healthcare ministry. Attempting to retain this model within Catholic healthcare gives rise to the tensions listed above. Reform is necessary in order to resolve these tensions. First, I am going to provide a brief summary and discussion of these tensions. Second, I will use

Chris Durante's "pragmatic perspectivism" to form the foundation of a reform proposal. Lastly, I will outline the proposal, followed by discussions of the benefits and costs of carrying out the reform.

Summary of the Problem

I have already discussed the relevant ethical tensions at length throughout this thesis. Here, I will summarize the current state of the problem, taking care to highlight precisely where and why reform is needed. The subsequent reform proposal will address these points specifically.

Impact on Women

The evidence presented in Chapter 4 suggests that there are two primary ways CHIs interfere with women's lives; the first way is the prevention of patient education on available treatment options, which in turn limits the possibility of obtaining truly informed consent for treatment. The second point of impact is the requirement of women to endure heroic suffering in order to refrain from participating in an evil action.

Informed consent

The American Medical Association (AMA), which sets medical practice standards for physicians in the US, describes informed consent as a physician's obligation "to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice."¹ The AMA emphasizes the importance of

¹ "The AMA Code of Medical Ethics' Opinions on Informing Patients," *AMA Journal of Ethics - Virtual Mentor* 14, no. 7 (2012).

complete medical counseling, stating that “the patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice.”² This issue is so vital to ethical medical care that the AMA follows this definition with a description of what qualifies as withholding information from patients. The AMA decries “therapeutic privilege,” defined as “the practice of withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated.”³

Although therapeutic privilege is not always associated with religiously motivated restrictions in care, it is certainly related. In Catholic healthcare, restrictions in counseling are not imposed for the purpose of impinging on personal liberties. The ethos that underpins these restrictions is that certain treatments aim at impeding natural, non-pathological functions that speak to the divine design of the human, and these are unethical.⁴ Treatments aimed at alleviating disease might also alter natural cycles of the human body and this is generally acceptable provided there is no better alternative. What is problematic for Catholics, however, is treating a healthy, normally functioning process as something pathological that must be addressed within the realm of good medical practice. Along with the duty to refrain from participating in evil acts, these restrictions are justified by the duty not to harm patients in a Catholic health care setting. This justification, in the therapeutic sense, is not satisfactory according to the AMA and may not be used as a reason for withholding information from patients.

There is one particular scenario in which the AMA deems it is morally permissible to withhold information from patients, which is when the patient indicates

² Ibid.

³ Ibid.

⁴ Paul VI, "Humanae Vitae".

that they do not want to be informed of certain information before it is conveyed.⁵ This is a key component of the discussion on informed consent in Catholic institutions; if a patient indicates that she wishes to only be informed of options that are morally consistent with the beliefs of the Catholic Church, this would allow CHI physicians to withhold prohibited information and remain ethically consistent with the AMA. Unfortunately, some patients are admitted to CHIs without a choice in the matter, regardless of their religious beliefs. Even those that do make a true choice to seek care at a CHI might not know how Catholic healthcare differs from other types of healthcare. CHIs remain between a rock and a hard place; they must choose whether to tell employees to assist patients in evil acts or in contradicting the requirements of the AMA. The choice has been and still is to not fulfill the AMA's requirements completely; the fact that this remains the status quo does not mean that this conflict should remain unaddressed.

Beyond conflicting with the AMA, some interest groups are trying to pass legislation that requires physicians to divulge all legal and relevant treatment options to patients, specifically aimed at religious restrictions in counseling patients.⁶ If the legislation passes, this will become yet another legal battle that Catholic health care must endure. Instead of waiting to respond to these legal battles from a defensive position, the Church might opt to re-envision the future of Catholic healthcare so that they can better pre-empt these issues surrounding informed consent. Pre-empting these

⁵ "The AMA Code of Medical Ethics' Opinions on Informing Patients."

⁶ American Atheists, "Atheists' 'Right to Know Act' Is Introduced in AZ Legislature," <https://www.atheists.org/2016/02/atheists-right-to-know-act-is-introduced-in-az-legislature/>.

legal battles would not only allow CHIs to avoid wasting resources on legal defenses, but it would prevent the ethical issues that come with restricting information to patients.

Heroic Suffering

Catholic beliefs about the purpose of suffering were discussed in Chapter 4, specifically in relevance to the perceived suffering of women receiving Catholic health care. As previously discussed, the ERDs may cause women to suffer when they would not choose to endure this suffering based on their own personal beliefs. This issue is not given enough attention, perhaps because of a perceived lack of alternative options for Catholic providers and institutions. For Catholics, it is not morally significant if another person suffers because they refrain from participating in unjustifiable evil. They cannot perform an unjustifiable evil action in order to achieve a good end, so they are not morally culpable for allowing that person to suffer by refraining from intervening via unjustifiable, evil means. Because it appears that the only options available are to either participate in evil and alleviate suffering or to refrain from participating and allow suffering, the conversation ends prematurely. What is not discussed in full is how the current healthcare system leads to these situations. When women are stripped of their choice in seeking Catholic or non-Catholic care, they are also stripped of their choice of whether to endure suffering for the sake of remaining faithful to Catholic beliefs or to alleviate their suffering.

This choice is not insignificant; the suffering that women are sometimes asked to endure is heroic. Examples of this suffering were recounted in Chapter 4, which included significant injury, pain, stress, and potential loss of life. This suffering can be monumental and is recognized by the Church as such. John Paul II canonized St. Gianna Beretta Molla in 2004, a doctor who sacrificed her own life to save the life of

her unborn child.⁷ It was discovered that St. Gianna had a fibroma on her uterus during the second month of her fourth pregnancy. The doctors offered three options: a hysterectomy, which would constitute an indirect termination, or removal of the fibroma.⁸ Although a direct abortion would never have been a morally licit option, a hysterectomy would have been considered moral by the Church, since the death of the fetus would have been a foreseen but unintended consequence of the hysterectomy. St. Gianna heroically decided to preserve the life of her child, opting for fibroma removal. After she gave birth to her child, she died of sepsis as a complication from her original condition.⁹ After her death, two miracles were cited as justification for St. Gianna's beatification and canonization. Two women, one in the late 1970s and the other some twenty years later, had troublesome pregnancies in which they almost lost their lives.¹⁰ After prayers for intercession to St. Gianna, both women experienced miraculous survivals that allowed their children to live.¹¹

The language used to describe these events, like miraculous and heroic, paint a picture of how much suffering these women endured in order to stay true to their religious beliefs. These women chose their own path that is considered noble within their own religious tradition. What about the women that are forced to take such a path and endure great suffering? Surely, if a Catholic woman feels called to exhibit saintly fortitude and risk her own life for her child's, she should be allowed to act according to

⁷ The Society of Saint Gianna Beretta Molla, "Path to Canonization," <http://saintgianna.org/stgiannascannonization.htm>.

⁸ Gretchen Filz, "St. Gianna Beretta Molla: A Modern Mother's Heroism," <https://www.catholiccompany.com/getfed/the-feast-of-st-gianna-beretta-molla-a-modern-mothers-heroism/>.

⁹ Ibid.

¹⁰ The Society of Saint Gianna Beretta Molla, "Path to Canonization".

¹¹ Ibid.

her beliefs. Why must a woman, who makes an equally difficult decision to preserve her own life so that her other children can be fed, be forced to endure suffering and not live according to her own beliefs?

In Chapter 4, there were many cases in which the unborn child was doomed to die regardless of the action taken. One action consisting of what the Church considers unjustifiable evil means would have spared the woman of complications and injury, the other consisting of licit means put the woman at risk. No innocent life was being saved because of the Church's teaching in these situations. These cases are not strictly matters of protecting the vulnerable; rather, they are matters of choosing to act according to two different moral codes. If the current healthcare system goes unreformed, women will continue to be forced to seek care according to a moral code they do not agree with and will be forced to endure risk that they do not want to assume. Catholics should not have to commit what they believe to be unjustifiable evil acts to alleviate the suffering of others and women should not be asked to assume unnecessary risk for a cause they do not believe in. The current system is configured so that in some cases, these are the only two options that exist; both women and the Church are failed by this system. If the proper reforms are made, these situations can be avoided, so that the Church may act according to its own professed beliefs and so that woman regain the autonomy to decide how much risk and suffering she is willing to endure for the sake of her child.

Interference with the Church's Healthcare Ministry

As previously mentioned, the current system fails both women and the Church. In Chapter 5, I presented various ways that the Church's healthcare ministry is being impeded, mainly caused by perpetuating the Catholic healthcare ministry within a corporate hospital model. These points of tension are discussed below, where I identify

specific issues that need reform.

Evil Acts and Church Resources

It is clear from the evidence presented in Chapter 5 that it is quite easy for physicians to subvert the ERDs using CHI resources to perform or prescribe prohibited treatments. Even though the prevalence of these incidents is not known, reports by physicians admitting that they regularly skirt the ERDs are abundant. This is problematic for the Church's healthcare ministry; if the goal is to ensure that medicine is being done in a way that is consistent with the Catholic Social Tradition and employees are regularly working against the provision of Catholic health care, the goal cannot be accomplished. The Church is not necessarily morally culpable for the covert use of Church resources to accomplish illicit acts by its employees. After all, employees of CHIs are asked to declare in one form or another that they will uphold the ERDs in practice. It is not necessarily the fault of the Church if its employees lie or commit evil acts. And yet, CHIs seem to fail to foster an environment in which their employees feel compelled to adhere to the ERDs. For the sake of the Catholic healthcare ministry, CHIs must become environments where the ERDs are encouraged as good medical practice, both in writing and in institutional culture.

This type of reform would require a two-pronged approach. First, if the system is reformed so that women are not forced to seek services at a Catholic institution and they only seek care willingly, then it is more likely that physicians would not be in a scenario where they must choose between the patient's perceived well-being and the Church's social teachings. Both Chapters 4 and 5 list situations in which the physician cited concerns about protecting the patient's agency or well-being as justifications for acting against the ERDs. Removing the need to make this choice would necessarily improve

adherence to the ERDs. Second, hiring practices need to be improved to better identify health care professionals that are genuinely sympathetic with the ERDs. While employees do not necessarily have to be practicing Catholics to be sympathetic with the ERDs, it is unlikely that a physician that regularly performs abortions at another facility is going to be sympathetic with the Catholic Social Tradition in practice. In fairness, determining where the line must be drawn in this sense is a gray area that must be carefully navigated. Potential employees may lie if they desperately need a job and even faithful Catholics may not agree with every Directive. The important point here, however, is to determine if the potential employee would be willing to provide care consistent with the Church if that is truly what the patient is seeking. In an ideally reformed system where one must “opt-in” to Catholic healthcare, this would theoretically mean that the employee would be compelled to provide care consistent with the Church in all scenarios.

Reform in hiring practices would be no easy feat given the structure of the current healthcare system. Because CHIs must remain competitive with other non-Catholic institutions to stay operational, they do not have much control over hiring practices. If, for example, CHIs required doctors to be practicing Catholics that were living in full accordance with the ERDs, there may not be enough physicians to fill all the positions at the many Catholic hospitals that operate in the US. The need to fill a minimum number of positions in the wide array of specialties that make up any one institution complicates the issue. If the system persists as is, CHIs will continue to have a difficult time finding employees that are truly sympathetic with the ERDs.

Lack of Distinctiveness

In Chapter 2, I discussed the homogenization of hospitals in the US and the lack of distinctiveness of Catholic healthcare. While the level of integrity varies by institution, Catholic healthcare is trending towards being reduced to secular care with religious restrictions. Many academics featured in Chapter 2 decry this homogenization and call for increased efforts in striving toward a fuller realization of the Catholic healing ministry. Unfortunately, the increasing number of political and legal battles for CHIs does not bode well for the realization of a more Catholic mission in practice. If CHIs cannot seem to achieve this fuller realization of the ministry, in other words if they cannot offer more in practice than restricted care and the sacraments, is it worth investing Church resources in this costly ministry?

If CHIs lack distinction, there are few compelling reasons for those institutions to remain Catholic. Sacraments can be sought at local Churches and there are health ministry teams that will visit the sick in hospitals if requested. The restrictions set by the ERDs have a dual purpose; one is so that Catholics and CHI employees have a clear sense of what is morally acceptable and that there is a duty to refrain from morally unacceptable actions and the second is to solidify the position of Catholic healthcare as a countercultural force. The first purpose does not hinge on the existence of CHIs, as Catholic health care providers can act according to their religious beliefs in any institution if they follow AMA and hospital guidelines on conscientious objections. The second purpose goes unfulfilled if CHIs have become as homogenized as the evidence suggests. The evidence suggests that it is easy for physicians to perform illicit treatments and procedures at CHIs as seen in Chapter 5. When this happens, the Church's position as a countercultural healthcare option is undermined. Patients deal

directly with health care providers. When providers subvert the ERDs, one of two things can happen. Either a patient is unaware of a restriction and remains unaware after the patient-physician interaction, or the patient is aware and learns that she or he can obtain that treatment despite the restrictions. Both work to undermine the Church's position on issues in healthcare.

Unfortunately, "branding issues" compound the apparent lack of distinctiveness in Catholic health care. Most women do not know that their health care options are restricted when they seek care at a CHI, even if they are aware that the institution is indeed Catholic.¹² This demonstrates two problems; one is that many are unaware of what Catholic healthcare entails and the second is that some hospitals are harder to identify by a patient as Catholic. This is problematic for many reasons. First, patient satisfaction is thought to depend on patient expectations.¹³ If a patient expects to get birth control without any issues or expects to have all legal options available during an emergency, they will most likely be disappointed with an institution that prevents those treatments, no matter how good or justified the reason is for the restriction. Second, if a devout Catholic or otherwise Catholic-sympathetic person wanted to seek care at a facility with a mission that aligns with their own beliefs, they may have difficulty identifying such an institution. Furthermore, they may have variable success in finding a CHI that incorporates a spiritual component in healing on a physician-patient basis. Ultimately, "branding issues" and homogenized institutions make seeking care

¹² Guiahi, Sheeder, and Teal, "Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care."

¹³ Andrew G. H. Thompson and Rosa Suñol, "Expectations as Determinants of Patient Satisfaction: Concepts, Theory and Evidence," *International Journal for Quality Health Care* 7, no. 2 (1995).

challenging for people that want to avoid or to seek Catholic care.

Interpretation of the First Amendment

At the time of this writing, the Church has defended against some legal battles by invoking the first amendment. When Trinity Health corporation was sued by the American Civil Liberties Union (ACLU), the health system's legal team made the argument that the First Amendment protections extend to CHI operations.¹⁴ In the motion to dismiss the case, the legal team states that "the First Amendment is intended to give religious organizations 'independence from secular control or manipulation, in short, power to decide for themselves, free from state interference, matters of church government as well as those of faith and doctrine.'"¹⁵ The legal team also states that the ERDs are "a statement of the Roman Catholic Church's moral and religious postures as it relates to health care issues," and that this qualifies the ERDs are a statement of Catholic theology.¹⁶ Because of legal precedents that interpret the First Amendment as a prohibition for the courts to debate the reasonableness of religious beliefs, Trinity's team correctly argues that the courts cannot decide for the Church how the ERDs should be interpreted or applied to specific cases.¹⁷ This prevents a potential plaintiff from arguing that the activity of a CHI is related to medical care and not to the "inner workings of the Church," because it is a theological statement that governs the actions taken at CHIs.¹⁸

¹⁴ "American Civil Liberties Union V. Trinity Health Corporation ", in *Case No. 15-cv-12611* (Detroit: United States District Court for the Eastern District of Michigan Southern Division).

¹⁵ *Ibid.*, 20.

¹⁶ *Ibid.*, 21.

¹⁷ *Ibid.*, 20-21.

¹⁸ *Ibid.*, 21.

This argument is based on only one part of the First Amendment. There are two relevant portions of the First Amendment; the Free Exercise Clause and the Establishment Clause.¹⁹ The first protects an individual's right to religious exercise, which is the basis for Trinity Health's motion to dismiss. The second maintains the separation of church and state.²⁰ Even if everything Trinity's team says is correct according to the appropriate legal precedents, this application of the First Amendment is significant in that it forces a non-believer citizen to be subject to the religious beliefs of a religious institution to obtain a public and sometimes necessary service. This is a significantly different application of the First Amendment, moving from protections of the personal and self-governing to protections of activities that actively impact non-believers. Again, this reflects the peculiar place of CHIs in American healthcare as a strange hybrid of private religious institution and place of public service. This is a point of vulnerability for CHIs; if the courts decide that ubiquitous access to most forms of reproductive healthcare is a compelling government interest, they would legally be able to order CHIs to provide prohibited services.²¹

If Catholic healthcare systems are going to defend themselves as religious institutions with all of the accompanying protections, they could avoid this vulnerable point by transitioning from a public-private hybrid role to a fully private role. This would require that non-believers are no longer forced to obtain Catholic healthcare services in emergency situations; in other words, the system would have to become a fully privatized, opt-in system analogous to the Catholic school system. This would in

¹⁹ Jason M Kellhofer, "Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers between Catholic and Non-Catholic Healthcare Systems," *Journal of Law and Health* 16 (2001): 119.

²⁰ *Ibid.*, 127.

²¹ *Ibid.*, 120-21.

essence strengthen the boundary between state and religion in a way that is reflected across other ministerial arms of the church. For example, the Catholic school system functions as a fully private “opt-in” system, where they are allowed to instruct students in religious formation. Catholic groups run many charities that serve the vulnerable, but never force a recipient to partake. Why then should it be acceptable for CHIs to have religious protections if citizens do not always have a choice in seeking Catholic care over non-Catholic care? As has been demonstrated thus far, the answer is not as simple as it may appear, but moving the Catholic health ministry from its hybrid role into a fully private sphere would resolve most of the ethical issues at hand.

The Root of the Problem

The root of every conflict described thus far is the unsatisfactory public-private hybrid position of CHIs in the US. These problems exist because of the tension between the dual roles of CHIs in the US. If CHIs could be fully committed to their roles as ministerial arms of the Church and were removed from the semi-public portion of their functions, the Church would be able to more fully realize the goals of the Catholic healthcare ministry while leaving the option to pursue Catholic care in the hands of women. If women could choose whether to seek care at a CHI, consent could always be fully informed. Women seeking care at non-Catholic institutions would be fully informed of all legal treatment options as per AMA guidelines and women seeking care at Catholic institutions would only be seeking treatment consistent with the Church’s guidelines, effectively opting to have illicit options withheld. With this choice, along with the freedom to transfer between Catholic and non-Catholic institutions, a woman would never be forced to endure heroic suffering at the expense of her own health. Furthermore, fully moving Catholic care into the truly private realm would allow for

stricter hiring practices and a more faithful integration of mission into practice. This transition would require a reformation of the current healthcare system. I will take the next section to detail my proposal based on the pragmatic perspectivist methodology, which outlines what this reform would look like. Subsequently, I will draw comparisons between my proposal and examples of similar systems that can be found both within and outside of American medicine.

Pragmatic Perspectivism

The immediate cause of the role strain that CHIs experience is a fundamental conflict between two conceptions of medical ethics that strive toward different ultimate goals. The current healthcare system makes it increasingly difficult for the two conceptions to coexist, as has been explained at length in this thesis. In order to move forward and find a way that both systems might coexist, we must identify either shared principles between the two perspectives or ways that both systems might express contradictory views without interfering with the other. This is not a problem unique to Catholic medical ethics in the context of a larger, secular-dominated healthcare environment, but is relevant to many different issues in bioethics. Chris Durante, drawing on the work of important philosophers before him, developed a methodology to address issues like these precisely.

At the 2016 International Association of Bioethics World Congress of Bioethics meeting in Edinburgh, Scotland, Durante addressed the need for his methodology:

In that the questions raised by bioethical dilemmas are often literally questions concerning life and death itself they are arguably some of the most important questions regarding human reality. Persons ought to feel as though the solutions they arrive at, the decisions they make, and the actions they take (or are allowed to take) as a result are in accord with their unique conceptions of the good. It hardly seems possible to show someone that they are being respected as a person while simultaneously

telling her that her outlook on life is, or her religio-cultural tradition's beliefs and norms are, entirely misconceived because they do not fit a particular portrait of human nature and the moral standards some claim to be universal.²²

This need is reflected in both the current literature and popular discourse; much of the discussion around Catholic healthcare is polarized, with one party accusing the other of either being anti-woman or anti-life. In reality, positions are much more complex than these simple binaries. Both parties would say that they value the lives of women and value safe and ethical healthcare, and yet these values manifest in different ways by being looked at through different moral lenses. Mutual respect requires the equal consideration of the parties involved and this can be attempted through pragmatic perspectivism.

Durante also addresses the increased tendency toward secular thought and language in bioethics, which can marginalize religious perspectives. Durante describes this trend as a “push towards professionalization and desire to be a quasi-scientific secular discipline.”²³ Durante pushes back against this common theme of the marginalization of religious bioethical perspectives, arguing that “if bioethics is really going to be a domain for public intellectual activity we must allow the varied types of perspectives found in the civil and public arenas to actually engage in the conversations that help enact the norms that govern their lives.”²⁴ This way of thinking is what is sorely needed in order to move conversations past the binaries that they are trapped by; if both parties feel that their perspectives are considered and valued equally, even if they

²² Chris Durante, "Dialogue Despite Diversity: Sharing Norms When Our Moralities Differ," in *International Association of Bioethics World Congress of Bioethics* (Edinburgh, Scotland: UNESCO Biochair, 2016), 2.

²³ *Ibid.*, 3.

²⁴ *Ibid.*

are not held as true by the other, a compromise can come to fruition. If conversation proceeded in this way, neither party could accuse the other of being anti-woman or anti-life, but would come to realize that the other party holds certain value judgments to be true based on their own epistemological contexts. Even if one party still disagrees with the other, perhaps alternative expressions of what it means to be “pro-woman” or “pro-life” could be explored, making the binary irrelevant and assisting in the formation of a compromise.

The final reason that makes pragmatic perspectivism an ideal methodology for this work is the ability to use a common morality approach without subscribing to moral relativism, while simultaneously overcoming the weaknesses of existing common morality approaches in medical ethics. Other common morality approaches, like Beauchamp and Childress’ principlism, fail according to Durante because they do not consider the many distinct moral traditions of those that are expected to abide by them.²⁵ Durante explains this phenomenon by stating that “this is, at least in part, the result of a failure to recognize different moral perspectives as possessing valid insights on bioethical matters and as being equally worthy of representation in the processes that will eventually lead to mutually binding norms, guidelines and policies.”²⁶ If we can formulate an approach that all parties are invested in and can abide by, then the ethical issues at hand will be resolved. After describing the methodology, I will give a brief explanation on how pragmatic perspectivism is able to incorporate multiple moral perspectives while not succumbing to moral relativism. I will also explain how this methodology should be suitable for Catholic and secular medical ethical traditions.

²⁵ Ibid., 3-4.

²⁶ Ibid.

Methodology

Durante, in describing his methodology, starts by discussing the mind set that must be used for a productive conversation between parties. This mind set is prerequisite for using the methodology, which might arguably be the biggest hurdle to a successful conversation between parties. Durante asks that the parties in conversation realize the possibility that the other party might be justified in holding their views, even if they do not agree that those views are true.²⁷ Here, Durante draws on the work of Jeffrey Stout, who draws a distinction between justification and truth. Stout claims that although truth is an absolute property of a proposition, justification is different in that it is relative.²⁸ Justification is relative to epistemic circumstances, which include beliefs, culture, and information that is available at any given time.²⁹ Durante, echoing Stout, concludes that “therefore, if the relationship between the proposition, the individual, and one’s epistemic circumstances exists in the proper way, the assertion that this proposition is true can be justified despite the falsity of the proposition, or even unjustified despite its truthfulness.”³⁰

Considering this distinction between justification and truth, Durante suggests that the parties in conversations should not be “seeking agreement on universal metaphysical truths, endorsing contractual agreements that will potentially require interlocutors to compromise core beliefs, or appealing to a shared mode of moral reasoning.”³¹ Rather,

²⁷ *Ibid.*, 5., "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity", 41.

²⁸ "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity", 41., Stout, *Ethics after Babel; the Languages of Morals and Their Discontents*, 30.

²⁹ Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity", 41.

³⁰ *Ibid.*

³¹ "Dialogue Despite Diversity: Sharing Norms When Our Moralities Differ," 5.

the productive goal should be to discover moral propositions that may be shared, despite arriving at the propositions using different methods of moral reasoning.³² These propositions must be mutually justified for a policy to be legitimate; if this is not the case, the situation slides backwards into what is already present in bioethics today, which is a “universalist principlist” set of guidelines that everyone is expected to abide by, although only a select group has contributed to those guidelines.³³

These are practical agreements that help manage ethical conflict; this is to say that ethical disagreements might still exist, but the actual conflict created by these disagreements can be managed.³⁴ It is vital that these guidelines do not require “deeper onto-metaphysical commitments,” as the only requirement should be practical points of moral agreement.³⁵ This can help avoid mistrust and skepticism, which Durante claims can kill conversation and negotiation before it starts.³⁶ Additionally, consensus should be considered to be a dynamic process. According to Durante, agreements must be “tentative and provisional.”³⁷ Considering another person’s epistemic context can be new and challenging for many; if an agreement is made, but certain aspects of the conflict were not considered properly, the agreement should be open to revision and further deliberation.

In order to increase the chance that a policy is successful, Durante recommends including a “guideline of hermeneutical diversity or interpretive limits,” especially when one can foresee that the same policy can be interpreted in varied ways that might

³² Ibid.

³³ Ibid.

³⁴ Ibid., 7-8.

³⁵ Ibid., 5.

³⁶ Ibid., 7-8.

³⁷ Ibid.

be unacceptable to either party.³⁸ Another common obstacle to conversation is foreseen disagreements or misinterpretations; indeed, purposeful misinterpretations of ethical guidelines were evident in Chapter 5. Instead of letting these obstruct a path to consensus, preparing for these can increase the chances that a particular policy is successful.

For ease, here is a succinct summary of the methodology:

- Arriving at points of moral agreement on a specific issue;
- Acknowledging that we might endorse similar claims for different reasons;
- Arriving at a second tier of consensus by creating a range of acceptable interpretations of a given norm and accepting diversity when it comes to putting our shared norms into practice; &
- Arriving at a tertiary agreement on the general parameters of what we collectively consider permissible and setting boundaries to what we can tolerate when it comes to our differences.³⁹

It is helpful here to include a concrete example provided by Durante of how pragmatic perspectivism might be used. In this example, Durante engages beliefs about whole brain death from two different moral traditions.⁴⁰ He compares the beliefs of a Theravada Buddhist and of a Thomist Catholic about the relationship of the brain with personhood. From the Theravada Buddhist perspective, brainstem death means loss of the body's ability to "coordinate the organic functioning of the body," which interferes with a person's organic wholeness.⁴¹ In this tradition, a human is "constituted" by this organic wholeness. Once this is lost, a person can be considered dead. From the Thomist Catholic perspective, brain death causes "integrative unity" to be lost, and the

³⁸ Ibid., 12-13.

³⁹ Ibid., 18.

⁴⁰ Chris Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity," *Med Health Care and Philos* 12 (2009): 42-43.

⁴¹ Ibid., 42., D. Keown, *Buddhism and Bioethics* (New York, NY: Palgrave Publishing, 2001), 155.

body loses the capacity for rational ensoulment.⁴² Loss of both the “rationally-correlated and biologically-integrative functioning” of the brain indicated the departure of the rational soul, and the person can be considered dead.⁴³

In this example, both the Theravada Buddhist and the Thomistic Catholic agree that whole brain death can be considered a criterion for death of a person. This exemplifies how one might identify a mutually agreeable proposition based on drastically differing epistemic contexts without conceding core beliefs. Durante explains this as an important key to his methodology:

Therefore, although two epistemic contexts may differ to the extent that they are able to justify conflicting propositions, it does not necessarily follow that the two epistemic contexts will never be able to justify the same proposition. In this way members of a given religio-moral tradition who maintain a belief in the existence of absolute truth—even going so far as asserting the universal truth of their own propositions and the universality of their own paradigms of belief—may be able to simultaneously acknowledge the justifiability of particular propositions across epistemic contexts.⁴⁴

This distinction between justifiability and truthfulness is key to navigating the pitfalls of the other methodologies that have failed to be satisfactory. This methodology cannot be properly understood as moral relativism, since interlocutors are not asked to abandon the concept of absolute truths, but are only asked to interact with another moral tradition to identify shared principles. In the example just mentioned, the Theravada Buddhist can enter into cooperative conversation with the Thomist Catholic about using whole brain death as a criterion for death of a person, while still holding his conception of the

⁴² Ibid., J.T. Eberl, "A Thomistic Understanding of Human Death," *Bioethics* 19, no. 1 (2005): 42-43.

⁴³ Ibid.

⁴⁴ Ibid., 43.

understanding of a person as an organic wholeness as an absolute truth.

Additionally, this pragmatism does not refer to the philosophical tradition of arriving at truths via the acceptance or rejection of practical consequences. More simply, it refers to the practical method of forging consensus, working not to impose any demands to necessarily modify epistemic contexts or core beliefs.⁴⁵ In this way, one can employ this methodology to give equal priority to the moral traditions of all interlocutors involved, even those that adhere to a religious moral tradition.

Using Pragmatic Perspectivism to Move Forward

I will use this space to apply the process of consensus building to the issue at hand. This methodology is intended to facilitate consensus between two interlocutors or parties, which is not what I will be physically doing. Despite this, I intend to use Durante's principles to outline what such a consensus might be between parties invested in Catholic or secular healthcare, such as the USCCB and the AMA. This is intended to help facilitate conversation between the two parties, providing the foundation for my proposal for reform. I will identify points of moral agreement between the two parties using the wealth of published resources on medical ethics from both systems of beliefs. I start from these points and expand on them through the consensus building process. In this process, I play the role of a theoretical mediator that attempts to hold both parties' belief systems on equal footing.

The issue in need of consensus is the accessibility of reproductive health care in the US. Catholic healthcare, as one theoretical party, holds multiple beliefs that prevent them from administering certain forms of reproductive health care, like abortions,

⁴⁵ Ibid., 46.

sterilization, and contraception. Secular healthcare, as another theoretical party, holds that patients should have access to these prohibited services so that they can make their own decisions informed by their own moral traditions. These positions are more complex than stated here, which has been the subject of this thesis until this point. The USCCB can be used as a theoretical representative of Catholic healthcare and the AMA can be used as a theoretical representative of secular healthcare.

One point of moral agreement between both the AMA and the USCCB is that patients and physicians must discuss treatment options and create a plan together, considering various holistic factors. Although this principle is applied in very different ways and restricted in certain circumstances, it is still a shared point of agreement. Both the AMA and the USCCB describe the patient-physician interaction as a relationship that requires trust and confidentiality.⁴⁶ Both recognize that within this relationship, there is an exchange of information and decision making. Both also recognize the necessity of free and informed consent for patients and access to “moral and medical information and counseling.”⁴⁷

Although these claims are similar, we must now acknowledge that both claims are supported by both parties for different reasons. For the USCCB, these principles about the patient-provider relationship stem from the beliefs about human dignity; every human has been made in God’s image and commands commensurate respect. For the AMA, these principles about the patient-provider relationship have arisen from the primacy of patient autonomy, given broad priority in Western medical culture.

⁴⁶ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services"., The American Medical Association, "Chapter 1: Opinions on Patient-Physician Relationships".

⁴⁷ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services" Directives 27-28.

Acknowledging that this common moral agreement stems from different epistemological contexts, we must now determine the acceptable interpretations of this relationship of trust, including free and informed consent and a right to information. For the USCCB, the right to free and informed consent and the right to information only exist in the paradigm of morally permissible care. Their current interpretation of the ideal patient-physician relationship excludes counseling and information on abortion, certain forms of miscarriage management, sterilization, and most forms of contraceptives.⁴⁸ For the AMA, the proper patient-physician relationship requires physicians in most situations to disclose information about these procedures if medically indicated. The only exception to this requirement is if the patient requests upfront that certain information be withheld.⁴⁹

Now that these interpretive differences have been expressed, it is critical that both sides understand the other's points in terms of their epistemological contexts. What may help is to consider that both parties are simply providing free and informed consent and relevant counseling as restricted by their own ethical codes and under their own conception of good health care. For example, consider the Catholic belief that any human life, even that from conception, should be accorded the full rights due to a human person. Even if the AMA does not express this position, it is possible for the AMA to thoughtfully consider what this means for Catholics. Participating in any kind of termination, morally permissible or not, means that a human person's rights will have been violated at the deepest level according to Catholic beliefs. Thus, the AMA can recognize what is at stake for Catholics when they refuse to counsel on abortion, even if

⁴⁸ Ibid.

⁴⁹ The American Medical Association, "Chapter 1: Opinions on Patient-Physician Relationships".

they do not agree with the beliefs that inform the prohibition. The AMA can also agree that it is not desirable to force any party to commit what they believe is the moral equivalent of murder. Conversely, the USCCB can consider the possible negative impacts of prohibiting these services, especially if one holds the belief that life does not start at conception. While they may not agree with the AMA on this, they can recognize that their concerns are valid in the context of the AMA's belief system. It is also a possibility that the USCCB might recognize that the negative impacts on women are undesirable, even if refraining from participating in an unjustifiable evil act justifies the impacts.

These contrasting interpretations of the point of moral agreement conflict under the current healthcare system. If these differences due to contrasting epistemological contexts are acknowledged upfront, we can come to a practical agreement within which they can coexist. In this situation, we can exploit the AMA's exception to a patient's right to information to come to a consensus. Again, if a patient asks for certain information to be withheld ahead of time, it is acceptable to withhold that information. So, if a patient asks a physician to withhold information about any treatment options that are immoral in the Catholic tradition, then this would be considered a proper patient-physician interaction by the AMA. In this scenario, the USCCB would also be satisfied, since they are relieved of any pressure to cooperate with evil, even in the remote sense of providing information about a prohibited service.

An explicit patient request like this is not feasible for most patients under the current healthcare system. If, however, the current system was reformed to make this feasible, these ethical issues could be resolved. For this to be possible, the reform would have to contain the following features:

1. Patients would have to be proactively informed about the type of care prohibited or provided at a CHI. “Branding” would have to be much clearer, so that a patient would know what to expect when choosing to seek care at a CHI.
2. Proactive consent to be treated at a CHI should be obtained. Patients should make an explicit agreement to receive care under Catholic principles before receiving any kind of care.
3. Unconscious patients, or any other patient where proactive consent could not be obtained, should never be brought to a CHI.
4. A CHI could not act as a sole community provider, since this would not allow the proactive consent to be free of coercion. Under this system, patients must make a true choice to seek Catholic health care.

If these features are able to be incorporated into the American healthcare system, the ethical issues presented thus far would be resolved. If CHIs could operate within these principles, they would occupy a position that is much more accurately described as a private, ministerial arm of the Church. The traditional legal and political arguments protecting the free exercise of religion would once again become relevant, solidifying the protections that favor the Catholic healthcare ministry. This ministry would be able to move forward without looming legal and social opposition. It would also become possible to continue to serve the vulnerable without compromising Catholic ideals.

These features would act as a conceptual bridge, connecting two sometimes conflicting moral systems in a justified level of cooperation for patients’ benefit. If the following reforms are implemented, then the cooperation between the two systems will be limited to simple transfers of care upon patient request rather than morally dubious referrals for prohibited services initiated by care providers. Under ideal implementation,

the two systems would be distinct, but would cooperate in a manner that is morally acceptable to both parties and that would not be harmful to patients.

An Alternative Solution for Reform

In order for these features to be incorporated, the current healthcare system would need to change significantly. Luckily, there is a model of medicine that already exists that we can look to as an example for this reform. In the following section, I will describe how this particular model, alternative medicine, is relevant to the discussion at hand. I will proceed to draw lessons from the history of the development of alternative medicine and apply them to my proposal for Catholic healthcare reform. This will lead to a formal description of my reform proposal.

Alternative medicine is a catchall term in the US, used colloquially to describe any medicine that falls outside of the realm of conventional Western medicine.⁵⁰ More accurately, there are two different categories of non-mainstream care: complementary and alternative medicine (CAM). Complementary care is used in cooperation with conventional medicine, and alternative care is used instead of conventional medicine.⁵¹ The term “integrative care” is used to describe the movement to incorporate complementary care with traditional medicine.⁵²

Mainstream medicine is a fluid canon of medicine, which makes defining CAM a difficult task. In a report compiled by The Institute of Medicine on CAM in the US,

⁵⁰ "Complementary, Alternative, or Integrative Health: What's in a Name?," National Center for Complementary and Integrative Health, <https://nccih.nih.gov/health/integrative-health>.

⁵¹ Ibid.

⁵² Ibid.

there is a thorough survey of the various definitions of CAM found in the literature.⁵³

The Institute describes the different ways that various descriptive, normative, and stipulative definitions of CAM fail, proving how difficult it is to say precisely what CAM encompasses.⁵⁴ The most widely used definition is one created in 2000 by the National Center for Complementary and Alternative Health (NCCAM), which has since been renamed to the National Center for Complementary and Integrative Health (NCCIH). The “definition” divides various types of CAM into five categories:

1. Alternative medical systems,
2. Mind-body interventions,
3. Biologically based treatments,
4. Manipulative and body-based methods, and
5. Energy therapies.

The NCCIH’s current definition reclassifies CAM into three categories:

1. Natural products
2. Mind and body practices
3. Other⁵⁵

The new category 2 combines the old categories of mind-body interventions, manipulative and body-based methods, and energy therapies into one category. Natural products become the new name for biologically based treatments, and alternative medical systems fall into the category “other.”⁵⁶ This last category encompasses anything that does not fall “neatly” into either of the other two categories. The NCCIH

⁵³ Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public, *Complementary and Alternative Medicine in the United States* (Washington DC: National Academies Press, 2005).

⁵⁴ Ibid.

⁵⁵ "Complementary, Alternative, or Integrative Health: What’s in a Name?".

⁵⁶ Ibid.

provides examples of CAM that falls into Category 3, including practices like Ayurvedic medicine, traditional Chinese medicine, homeopathy, and naturopathy.⁵⁷

Attempting to get to the substance of the differentiation between mainstream medicine and CAM, Dr. Sandra Grace explores biomedical evidence as the commonly cited benchmark for mainstream medicine.⁵⁸ After she correctly demonstrates that this benchmark is not necessarily accurate, she discusses the obstacles to performing appropriate scientific research on modalities of CAM:

Fundamental differences between the underlying philosophies of Western medicine and natural medicine are cited by many as the main barrier to high quality scientific research in natural medicine. These differences include the traditional reductionist, mechanistic approach of biomedicine as opposed to the biocultural approach of natural medicine; Western medicine's focus on eliminating the disease-producing agent as opposed to natural medicine's focus on encouraging the innate ability of the human body to restore itself to health; and Western medicine's focus on illness as opposed to natural medicine's focus on wellness.⁵⁹

In highlighting the difficulties of carrying out research about CAM, Dr. Grace touches on the overarching philosophical theme of CAM. This philosophical theme is constantly alluded to in the literature, elsewhere described as “holistic care, which focuses on treating a human being as a whole person.”⁶⁰

This difference in philosophy is the crux of the true differentiation between mainstream medicine and CAM. “Evidence-based medicine” is not particularly helpful in making the distinction between CAM and mainstream therapies; there are many treatments in mainstream medicine that are widely used that do not have a copious

⁵⁷ Ibid.

⁵⁸ Sandra Grace, "The Evidence Debate," *Journal of the Australian Traditional-Medicine Society* 22, no. 3 (2016).

⁵⁹ Ibid.

⁶⁰ Syed Amin Tabish, "Complementary and Alternative Healthcare: Is It Evidence-Based?," *Int J Health Sci* 2, no. 1 (2008).

amount of supporting evidence, while there are practices that are relegated to the realm of CAM that have substantial evidence for improving health outcomes.⁶¹ CAM modalities reside on an evidence-based spectrum. Some practices like Reiki have little to no evidence supporting improved health outcomes. On the other hand, chiropractic medicine is increasingly evidence-based, both in education and in practice.⁶² Although there is a limited quantity of evidence, some studies have found chiropractic care to be as effective as physical therapy and other methods of mainstream medicine for treating lower back pain.⁶³ This is reflected in the increasing health care coverage for chiropractic medicine in the US.⁶⁴

The frequency with which hospitals offer CAM services is on a steady increase as the result of efforts to integrate CAM and mainstream practices. As of 2011, a survey by the American Hospital Association found that 42 percent of hospitals in the US offer at least 1 CAM therapy.⁶⁵ The survey also asked respondents to indicate why they offered CAM treatments. The survey found that “85 percent of responding hospitals indicated patient demand as the primary rationale in offering CAM services and 70 percent of survey respondents stated clinical effectiveness as their top reason.”⁶⁶ The fact that so many hospitals believe so strongly in the effectiveness of CAM only blurs the evidence-based lines between mainstream medicine and CAM. Additionally, a press

⁶¹ Grace, "The Evidence Debate."

⁶² Tabish, "Complementary and Alternative Healthcare: Is It Evidence-Based?."

⁶³ Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public, *Complementary and Alternative Medicine in the United States*.

⁶⁴ Tabish, "Complementary and Alternative Healthcare: Is It Evidence-Based?."

⁶⁵ American Hospital Association and Samueli Institute, "More Hospitals Offering Complementary and Alternative Medicine Services,"

<http://www.aha.org/presscenter/pressrel/2011/110907-pr-camsurvey.pdf>.

⁶⁶ Ibid.

release about the survey spoke to hospitals' less clinical motivations for offering CAM, citing hospitals' "desire to treat the whole person—body, mind and spirit."⁶⁷

Catholic Care – An Alternative

Although not readily apparent at first, what most Americans colloquially call alternative medicine provides a framework through which an ideal Catholic healthcare ministry can be understood. Although CHIs do not offer the full gamut of legally available services, the services they do offer follow the same evidence-based rigors as any other hospital. It would certainly not be accurate to relegate Catholic healthcare outside the realm of evidence-based medicine. What differentiates CHIs in an ideal scenario is their "philosophy", or more accurately, their mission. As discussed in Chapter 2, the mission of Catholic healthcare is holistic in nature, with a lot of language in common with the philosophy of CAM. For the purposes of this discussion, it is useful to present the "Expression of Shared Identity" from the Catholic Healthcare Association (CHA) once again:

We are the people of Catholic health care, a ministry of the church continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen — bringing together people of diverse faiths and backgrounds — our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit. We work to bring alive the Gospel vision of justice and peace. We answer God's call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable. By our service, we strive to transform hurt into hope.

As the Church's Ministry of Health Care, we commit to:

- Promote and Defend Human Dignity
- Attend to the Whole Person
- Care for Poor and Vulnerable Persons
- Promote the Common Good

⁶⁷ Ibid.

- Act on Behalf of Justice
- Steward Resources
- Act in Communion with the Church ⁶⁸

First, “attend to the whole person” is an explicit commitment in this expression of shared identity. This makes Catholic healthcare holistic by definition. Second, Catholic healthcare is called a ministry, which is very different from mainstream medicine on a philosophical level. Surely, physicians can feel compelled to enter the field of medicine out of a noble desire to help the sick, vulnerable, and poor, but this is not equivalent to a ministry. According to the John Paul II Center, a lay ministry is carried out when the faithful are “called to participate in the mission of the church, to proclaim the good news of Jesus Christ by their actions and words, and to work toward the transformation of the world.”⁶⁹ The Catholic healthcare ministry if carried out correctly cannot be reduced to secular, evidence-based care with a few religious restrictions. Catholic medicine is informed by principles that are not necessarily common to secular medicine.

Furthermore, the ultimate goal of Catholic medicine is fundamentally different from that of secular medicine. While Catholic and secular institutions might share more immediate goals such as justice, wellness, and healthy communities, a CHI’s ultimate purpose is to propagate Jesus’ healing ministry by “bring[ing] alive the Gospel vision of justice and peace.”⁷⁰ Catholic care is ideally provided under a different philosophy and this underpins the restrictions stipulated by the ERDs. For Catholics, a person’s fertility reflects the proper nature of that person and what it means to be human.⁷¹ Impeding that nature with sterilization or contraceptives is seen as bad medical care, since there is

⁶⁸ Catholic Health Association of the United States, "A Shared Statement of Identity".

⁶⁹ "Lay Ministry," John Paul II Center, <http://www.johnpaul2center.org/Lay-Formation/Lay-Ministry.htm>.

⁷⁰ "A Shared Statement of Identity".

⁷¹ Paul VI, "Humanae Vitae".

nothing pathological being treated. Similarly, a chiropractor would not give an anti-inflammatory injection to a person presenting with lower back pain. The aim of chiropractic medicine is to treat maladies through manual manipulation and a shot of cortisone does not fit into that philosophical framework of care, as helpful as it might be to the patient.

The fundamental difference in the ultimate goals of Catholic and secular care is so wide, that it is not surprising that the “one system fits all” approach is causing conflict. Healthcare in the US started as a partially religious endeavor and has evolved into a system that allows secular institutions to thrive at the expense of religious ministries. Using the CAM model, Catholic healthcare can reclaim a space within the American healthcare system that allows for a full realization of its mission. In order to do this, Catholic healthcare would have to be drastically restructured. I will use the rest of this chapter to detail a plan for restructuring Catholic healthcare, and will show how this plan can solve many of the ethical issues that face CHIs today.

Catholic Healthcare as CAM

As already explored, the Catholic healthcare ministry has a unique mission that is oriented towards continuing Jesus’ healing ministry, an end that is not shared by secular institutions. The ultimate goal is not necessarily to alleviate pain or remove all suffering, but to carry out a religious ministry in a specific arena within a unique tradition. It is already clear that this type of care can fit into the landscape of American healthcare more broadly, even if it is accompanied by many ethical conflicts. These facts suggest that Catholic healthcare would fit most naturally into the category of complementary medicine. In essence, Catholic healthcare currently looks at evidence based medicine through the lens of Catholic theology. This lens dictates which

evidence-based therapies and treatments are consistent with the nature of the human body as designed by God. In addition, pastoral care is a vital component of holistic care in the Catholic tradition. Evidence-based medicine is still used, but it is used in conjunction with Catholic theology to provide a particular vision of holistic health. In this model of understanding, CHIs are using evidence-based medicine while incorporating Catholic theology as complementary medicine.

Structure

If this model is adopted, the structure of the Catholic healthcare system would have to change drastically. Instead of being pervasive and increasingly homogenized, Catholic care would be scaled back to a size where pursuing the mission of Catholic healthcare in its fullness would be achievable. This would require transitioning from whole Catholic hospitals within the mainstream medical system to a combination of Catholic care centers and Catholic medicine consultation specialists. This is required for a few reasons. First, complementary medicine must be sought by patients and a plan to incorporate complementary medicine into a patient's treatment is decided by doctor and patient as a team. This would mean that entire acute care hospitals that abide by Catholic theology, at least in the sense that they exist now, could not exist. The fact that some patients do not have a choice to seek non-Catholic healthcare under the current healthcare system would not be acceptable.⁷² This is because a CAM modality cannot be imposed on patients, and this would be impossible to avoid within the current model

⁷² There are objections from the Catholic academic community to withdrawing from society in face of social or legal opposition that emphasize the role of the Church as a countercultural witness of Catholic ideals before society. I will address this and other potential objections to the plan later in the Chapter, however, I would like to detail the entire plan before doing so.

of Catholic hospitals. Instead, Catholic care centers would offer the opportunity to seek care that integrates Catholic theology into treatment. Some of these institutions already exist, like natural family planning and palliative care centers. In addition, a program could be developed so that local dioceses could train Catholic healthcare consultation specialists. Alternatively, this education could happen on a national level under the guidance of the USCCB, which would address some of the standardization issues previously mentioned. This would allow patients to access Catholic healthcare as a complementary approach in every healthcare institution, not just those that are Catholic.

The second reason that a transition out of the mainstream, corporate hospital model is necessary is financial. If this type of reform is enacted, financial viability will be a concern for Catholic care centers. It would be exceedingly difficult for CHIs to withdraw from the corporate hospital model and maintain a general array of services while remaining financially viable. Instead, Catholic care centers would be targeted to provide care in the areas deemed most important by the USCCB. This prioritization of services could be determined by a perceived need for countercultural witness, a perceived material need for a particular segment of the population, or some other mitigating factor. Instead of providing many areas of care, some of which would be provided in the same exact manner as in non-Catholic hospitals, the goal would be to provide care under a more fully realized Catholic ministry in specific, targeted areas. This would also allow Catholic care centers to disengage from most forms of financial competition with other non-Catholic hospitals. Instead, these centers would be run much more closely resembling a ministry rather than a large corporation, using funds from the Church and donors to offer services at a financially sustainable level. This would alleviate institutional pressure to bend Catholic ideals in order to stay competitive with

other local hospitals, since the type of care offered would be radically different than a local hospital's services. This does not necessarily preclude the acceptance of Medicaid or Medicare funds, but it is possible that accepting these funds would not be a central mechanism of survival for these institutions.

Branding and Advertising

Increased transparency is necessary for this type of system to function; giving patients a true choice to opt for Catholic health care over other types of care requires that patients be clearly informed about Catholic health care. There would be little use in reforming the current structure of Catholic healthcare if patients remained unable to make an informed decision about their health care. In order to accomplish this, these hypothetical Catholic care centers and existing CHIs must begin to clearly advertise what Catholic healthcare is. Although a Catholic identity in medicine can be hard to pin down precisely in a way that is manageable for explaining to patients, it is feasible to require that a bare minimum of information is given to patients so that they can make a choice to opt for Catholic health care or not. I recommend that patients are informed of the following:

1. the Catholic nature of the mission of the center or institution,
2. a brief statement of the mission and primary goals of the center/institution,
3. a brief summary of what services are routinely offered that are not offered at other institutions,
 - a. A hypothetical example of this would be proactively offering pastoral care as part of a health care plan, since this normally might not be offered at a mainstream institution unless explicitly requested by the patient.

4. a brief summary of what services are not offered that are offered at other institutions,
 - a. This would include most contraceptives, sterilizations, and abortions.
5. a statement indicating that Catholic center/institution employees will not offer information or counseling to patients about any services that conflict with the Catholic Social Tradition,
6. and an encouragement to ask a healthcare provider if there is any confusion about any of the information conveyed in items 1-5.

There are multiple theoretical points in time and space to disseminate this information to patients. First, there should be increased efforts to make points 1 and 2 widely accessible in connection with the center. This means that the information would be on any website, pamphlet, commercial, or other advertising or informational material. Patients would ideally know very quickly if a health care center is Catholic. Although perhaps not as urgent, it would also be prudent to include information concerning points 3 and 4 in the same places depending on the materials and circumstances; advertising what makes Catholic health care distinct can help patients to choose care more consistent with their beliefs and put providers in less morally compromising situations. Points 5 and 6 need to be conveyed to patients at some point before any treatment is administered in order to ensure informed consent.

Proactive Consent

In order to ensure that all 6 points of information are disseminated to patients, my reform plan requires a new form of proactive informed consent. This would require a written consent form to be administered before any treatment is provided to a patient; the form would include all 6 previously mentioned points. This part of the reform would

be necessary to maintain cooperation between Catholic care centers and secular hospitals and institutions, since it allows for all patients seeking care to be considered fully informed and to give consent under secular legal standards. If patients certify and agree that they are aware that the care they receive will only be within the Catholic Social Tradition and that certain treatments will not be offered or discussed, this can be equivalent to voluntarily asking for that specific information to be withheld from patient-provider discussions. For this to be true, the wording on the “proactive” informed consent form must be intentional and unequivocal. The specifics of the wording might be determined by legal and medical professionals that can ensure the clarity of the form. The important principle though, is that patients become aware of what it means to seek Catholic healthcare and that they are voluntarily seeking this type of care.

Benefits

The benefits of this type of system are vast. Catholic care centers would be free to pursue the Catholic healthcare ministry in a more holistic sense. From a Catholic perspective, a true healthcare ministry cannot be reduced to alleviating suffering and disease. This view is reflected in the CHA’s “Expression of Shared Identity,” where these goods are put in perspective in relation to the whole ministry.⁷³ Leaving the realm of mainstream corporate model healthcare institutions would mean that care centers would be freed from increasing societal and legal pressure to pare back the Catholic healthcare ministry. This is because patients would have to actively seek care at a CHI and would be actively choosing to pursue care through a Catholic theological lens. If

⁷³ Catholic Health Association of the United States, "A Shared Statement of Identity".

ideally employed, no one patient would be stripped of the choice to seek non-Catholic care, which is a major ethical conflict between Catholic and non-Catholic medical groups. These patients might also be better able to incorporate pastoral care into their healing journeys at these centers, since it would be plausible to offer pastoral care as a routine service instead of one simply available upon patient request. Importantly, making this transition would drastically adjust patient expectations, as health-related pastoral counseling might be expected at such an institution. Bringing explicitly spiritual therapies into a patient's treatment plan would be viewed as acceptable and expected instead of potentially inappropriate.

The Church would be able to redirect resources in a more targeted and efficient manner, providing much more control over the outcomes of the Catholic healthcare mission. As the system currently operates, the Catholic Church provides a significant amount of resources for all types of care for a large segment of the American population. This is a public good and many Americans rely on these resources to get necessary health care. Despite this, if the current healthcare system could be reorganized in the manner described, Catholic resources could be allocated in a way that allows for a greater fulfillment of ministry. Providing Catholic resources for Americans in need of healthcare is a public good, but serving as a permanent crutch for an increasingly homogenized healthcare system may inhibit the long-term goals of the Catholic mission. Yes, caring for the poor and vulnerable is part of that mission, but doing it in a way that is insignificantly different from comparable secular institutions does not necessarily carry forward the Catholic healthcare ministry. There is more to the rich Catholic medical tradition than secular charity, and resources might be put to better use if the structure of the system is reorganized.

In practical terms, this would mean a transition away from homogenized, all-encompassing Catholic hospitals to axial Catholic care centers that could offer care where it is needed most as determined by the USCCB. Pre-natal services, natural family planning clinics, medical charities for the vulnerable, and palliative care centers are just a few examples of the areas in which the Church could increase its presence on a national level. Additionally, funds could be diverted to a national training program for physicians, nurses, pharmacists, and other experts committed to serving patients in the Catholic tradition. That way, there would be a Catholic presence in many institutions for patients that request Catholic care in a more standardized way.

An additional financial benefit of scaling back the Catholic health care system is the removal of mission-compromising forms of competition. This system would not have Catholic hospitals competing with secular hospitals for economic survival, but would be offering a truly unique service that occupies its own niche of the healthcare system. This would remove some of the temptation to act in way that contradicts the Catholic moral tradition for the sake of economic survival. Scaling back the Catholic health care system to a more targeted and financially manageable size would also make it easier to hire employees that are truly sympathetic with the ERDs and Catholic health care, since fewer employees would be required to make this system functional. Physicians working in mainstream hospitals could also opt in to education in complementary Catholic care and that particular portion of the medical workforce would be self-selecting for those sympathetic with the Church's views.

Changing the framework of how Catholic medicine is understood would mean better compliance with AMA ethical guidelines, some of which currently restrict the ability of CHIs to act according to the ERDs. The main point of conflict between the

AMA's code of ethics and the ERDs is informed consent, as mentioned earlier. Both state the importance of giving patients the autonomy to choose their own treatment path, however, the differing moral assessment of certain procedures has practical consequences for informed consent. In Catholic healthcare, advising a patient about a legal but morally unacceptable treatment or procedure can be considered cooperation with evil.⁷⁴ The mission of providing health care is not separated from what the Church considers good and evil, and good health care in this sense means only providing morally licit care that reflects Catholic beliefs about the nature and dignity of the human body. The secular physician abides by a different code of ethics that relies on an agreed set of principles that do not necessarily adhere to a specific religious tradition.⁷⁵ Because of this, the physician is required to advise a patient of all legal and relevant treatment options, not only the ones they consider to be morally licit based on personal religious beliefs. Even if the physician does not agree that the patient is choosing treatment in a moral manner, if it is considered ethical according to the principles of secular medicine, the physician is practicing good medicine in letting the patient make an autonomous, informed decision. The origins of these differences can be traced back to the disparity in the ultimate goals of secular and Catholic healthcare.

This problem is ameliorated in a system where a patient chooses to seek Catholic healthcare. This would simply require a revamped informed consent process unique to Catholic complementary care. A Catholic care center could easily make patients aware that they will not offer or counsel on any procedures that the Catholic

⁷⁴ United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services".

⁷⁵ The American Medical Association, "Chapter 1: Opinions on Patient-Physician Relationships".

Church does not endorse. If a patient is made aware of this and still chooses to pursue Catholic care, they are making an implicit statement that they consent to only being informed on Catholic-endorsed treatment options. This is a drastically different ethical scenario from a patient that is admitted to a CHI without a choice and is not informed of all legally available treatment options, especially when one of those options significantly curtails the risk to her own life.

It is especially important to note that while this type of framework for understanding Catholic healthcare is a new concept, the call for Catholic healthcare to develop alternative models of health care is not a new concept. In fact, in 1981, the USCCB published a paper on Catholic health care, in which it details that a component of the Church's prophetic role in health care is the development of these alternative models:

For example, community clinics, "satellite" clinics and other new models of health care delivery that meet the needs of the indigent, the underserved and the poor should be supported and developed. Hospices, which offer humane, personal care for the terminally ill, are also a welcome development in recent years. These services exemplify the all important integration of the spiritual, physical, psychological and social dimensions of health care.⁷⁶

There are also calls for Catholic institutions to transition away from the mainstream corporate hospital model in academia. Although Clarke Cochran argues that some Catholic hospitals should remain operational, he states that there are perhaps other healthcare models better suited to the ministry:

Although some Catholic hospitals should continue to exist, it may be time for the Church to focus on other forms of healthcare that better model the sacramental encounter. These might be neighborhood clinics for abused children and battered wives, hospices for the dying, AIDS ministry, inner city clinics for those without health insurance, clinics in

⁷⁶ United States Catholic Conference, "Health and Health Care: A Pastoral Letter of the American Catholic Bishops," (Washington, DC 1981).

immigrant labor camps, rehabilitation centers, addiction treatment facilities, and outpatient mental health centers.⁷⁷

He laments the reduction of the Catholic healthcare ministry to restrictions in care that is otherwise secular, like many other scholars mentioned in the same chapter.

According to Kenneth R. White, some CHIs have already gone in the direction that Cochran has suggested. In a recent article, White describes the competing forces on CHIs and potential adaptation strategies using institutional theory.⁷⁸ Out of the four possible adaptation strategies he describes, two of them provide an opportunity for maintaining a strong Catholic institutional identity. The first is to remain an acute care hospital, although White concedes that it will only become harder to maintain this structure while retaining a distinctly Catholic character, which earlier in the article he presents as problematic for the existence of these institutions.⁷⁹ The second is to transition to a sponsored social ministry, maintaining a high level of fidelity to Catholic social teaching while surrendering the pressures to remain competitive as an acute care hospital.⁸⁰ He argues that some CHIs have already made use of both of these adaptation strategies, although it may be too difficult for CHIs to use the first as time moves forward.⁸¹ Although this thesis posits another alternative for adaptation not discussed in his article, White's assessment of the difficulty in maintaining

⁷⁷ Cochran, "Institutional Identity; Sacramental Potential: Catholic Healthcare at Century's End," 30., I give a more detailed discussion of this statement on pages 46-47.

⁷⁸ Kenneth R. White, "When Institutions Collide: The Competing Forces of Hospitals Sponsored by the Roman Catholic Church," *Religions* 4 (2013).

⁷⁹ *Ibid.*, 22.

⁸⁰ *Ibid.*, 23.

⁸¹ *Ibid.*, 24-25.

Catholic acute care hospitals echoes what I have presented thus far.

In summary, the Church must be prepared for change and how this change might affect its ministries, just as it has done throughout history. By proactively recognizing that the corporate hospital model may no longer allow for sufficient realization of the Catholic healthcare ministry, the Church might be able to maintain its protected position within American healthcare by radically changing its structure, freeing itself from pressure towards homogenization through cooperation and conversation with American healthcare at large. This can be accomplished by carving out a niche in American healthcare using existing philosophical frameworks as described.

Potential Vulnerabilities

Although my proposal addresses many ethical issues that exist as a result of the Church's public-private hybrid role in healthcare, there are some vulnerabilities that one can reasonably predict in this reformed system. First, it is prudent to be concerned about the position of the Church as a countercultural witness in American society on social issues. If the Church withdraws from the mainstream hospital system, it may give the impression that the Church is caving into secularizing pressures and surrendering part of its prominent social position. This is a problem of optics, considering that the plan is meant to strengthen the Church's countercultural position in the country by allowing for a fuller realization of the Church's healthcare ministry. The poor optics can be avoided, however, depending on how the plan is implemented.

I do not recommend that the end goal of this reform plan would be enacted immediately and bluntly for several reasons, most of which are logistical. Later, I will address how the plan should be implemented that will minimize any negative effects of the plan. Part of this involves a slow, natural transition away from the corporate hospital

model to minimize negative economic impacts and to minimize lapses in access to healthcare for Americans. If this slow transition to Catholic care centers takes place, it will be easier for the American population to recognize that the Church is not surrendering its position in healthcare, but rather moving into a new position that allows it to be a stronger countercultural force. If the optics of the reform can be managed in this way, this potentially negative effect of the plan can be avoided.

On this note, it must be made clear that this reform does not represent a “withdrawal from the mainstream” in the colloquial sense of the phrase, but only in the sense of categorization of philosophies of medical care. In other words, this transition would not indicate a larger seclusion from society or an overarching theme of the incompatibility of Catholic life with American life. On the contrary, cooperating to ensure access to information about the differences between Catholic and secular care before ethical issues arise would demonstrate the Church’s commitment to be truly integrated into American society, being sympathetic to the culture of autonomy while remaining unapologetically steadfast in Catholic beliefs.

Further, transitioning from corporate hospital models of care to smaller charitable clinics and Catholic care centers would not necessarily diminish the position of the Church in American healthcare. The US relies on clinics and care centers to provide a large proportion of healthcare to its citizens.⁸² Increasing access to education and expertise on Catholic medical ethical principles and the Catholic Social Tradition could increase Catholic influence over American healthcare without further monetary investments in actual physical institutions of healthcare.

⁸² The National Association of Free & Charitable Clinics, "Getting to Know America's Free & Charitable Clinics," <http://www.nafcclinics.org/content/clinics>.

Second, withdrawing from mainstream medicine in the philosophical sense might also be concerning to the Church, considering the historically negative connotations that are associated with complementary and alternative medicine. These connotations are becoming outdated, with increased integration of CAM therapies into conventional medicine and increased insurance coverage of CAM therapies.⁸³ In 2007, a survey found that 38 percent of American adults were using a CAM therapy at that point in time.⁸⁴ Between increased acceptance by medical professionals and increased patient utilization, the influence of CAM in American medicine is only increasing. Furthermore, as mentioned earlier, evidence-based medicine no longer serves as the same barrier that has divided CAM and mainstream medicine in the past. For example, the whole of chiropractic medicine is transitioning to evidence-based medicine, as school curricula and research practices are reformed.⁸⁵ As the divisions between mainstream medicine and CAM become more philosophical than practical, the Church should recognize these changes in the landscape of American medicine. This would enable the Church to take advantage of this philosophical framework that already exists, so that the Church can make its healthcare ministry distinct in a way that is faithful to its principles while remaining integrated in American healthcare.

Third, as I have already previously alluded to, the economic stability of the current healthcare system would be threatened with a massive withdrawal of Church

⁸³ Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public, *Complementary and Alternative Medicine in the United States* (Washington DC: National Academies Press, 2005), Chapter 7.

⁸⁴ National Center for Complementary and Integrative Health, "The Use of Complementary and Alternative Medicine in the United States," National Institutes of Health, https://nccih.nih.gov/research/statistics/2007/camsurvey_fs1.htm.

⁸⁵ Ron LeFebvre, David Peterson, and Mitchell Haas, "Evidence-Based Practice and Chiropractic Care," *J Evid Based Complementary Altern Med* 18, no. 1 (2012).

funds from American healthcare. That being said, I am not recommending one blunt withdrawal of the Church from the realm of mainstream medicine. What I am recommending is a change in the framework with which we consider Catholic medicine, with consequences for the future direction of Catholic medicine. In other words, my proposal is meant to guide future decisions on Catholic health care institutions and not to be enacted immediately and absolutely. It is certainly financially feasible to transition Catholic acute care hospitals to non-Catholic hospitals on an individual basis, as this happens regularly in mergers where a Catholic identity is surrendered.⁸⁶ This seems to occur without financial penalty to the American healthcare system; as long as there are other systems willing to take over corporate model hospital institutions, then there is some form of financial stability in the broader healthcare system. A full transition out of the corporate hospital model may take a long time in this manner, but it is necessary to ensure that the larger healthcare system remains stable so that Americans can continue to access health care.

Fourth, there is a concern for both demand and viability of Catholic healthcare in a more holistically realized form. How many people would actually seek healthcare that is unmistakably Catholic? Would these centers generate enough revenue to continue operations all while maintaining a strongly Catholic identity? Although nothing like the proposal exists on a large, philosophically unified scale, current indications seem to suggest that these types of centers would be successful. There are already 156 indigent care clinics within the Catholic healthcare system, and the 1200 free and charitable clinics in the U.S. served 1.8 million patients in 2016 alone.⁸⁷ These clinics are able to

⁸⁶ See page 21 from Chapter 1.

⁸⁷ The National Association of Free & Charitable Clinics, "Getting to Know America's Free & Charitable Clinics," <http://www.nafcclinics.org/content/clinics.>, Catholic Health

generate revenue to support operations through donations, state and other local funding, and through volunteer healthcare staff. They are not federally funded.⁸⁸

If caring for indigent populations remains a strong priority for Catholic healthcare, it seems that there is a persistent need for these services and this will be well received. Other types of centers, like palliative care centers and Women's health clinics, also already exist and survive in America's healthcare system. There is no reason to suggest that Catholic Care centers would be any less important to the American healthcare system, especially as access to affordable healthcare remains a systemic problem. Further, the Church and its dioceses often advertise the centers and clinics that are run in the Catholic Social Tradition.⁸⁹ Having a strong, well-advertised Catholic identity may draw a population of patients that wish to find Catholic providers with ease, considering that many current CHI employees are not practicing Catholics.

Finally, this reform alone may not completely solve all ethical issues regarding access to women's reproductive health care in the U.S. Although introducing measures that make it possible for a woman to choose Catholic or non-Catholic reproductive care addresses most of the associated ethical challenges, there still remains the possibility that some women may be financially coerced to seek healthcare at a Catholic care center. There are multiple safety nets that would theoretically prevent such a situation, like Medicaid eligibility, the availability of other non-Catholic charity services, and charity care at hospitals. Additionally, emergency rooms are often inappropriately used

Association of the United States, "Facts - Statistics,"
<https://www.chausa.org/about/about/facts-statistics>.

⁸⁸ The National Association of Free & Charitable Clinics, "Issues,"
<http://www.nafcclinics.org/advocacy/issues>.

⁸⁹ United States Conference of Catholic Bishops, "Find an NFP Class,"
<http://www.usccb.org/issues-and-action/marriage-and-family/natural-family-planning/find-an-nfp-class.cfm>.

for non-emergency care for patients that cannot afford healthcare. If Catholic healthcare transitions away from the corporate hospital model, emergency rooms would theoretically ensure access to Catholic-prohibited services for those not able to pay. Still, the working poor may not be eligible for these services for a variety of theoretical reasons and may still not be able to afford healthcare through any of these methods.

In these very limited circumstances, a woman may only have Catholic charity care as her singular option for reproductive services. In areas of the country that may be prone to this type of scenario, the onus would not be on the Catholic care center to provide prohibited services. In this instance, the Catholic care center is acting more accurately as a charity service instead of an institution functioning in a public-private hybrid role. Charity services are much more safely within the realm of protected religious exercise; it is a donation of time, money, or services that may be donated according to the donors' wishes and not a public service that is meant to form a network of access that meets a certain secular criterion. If there is a perceived gap in public health care services so large that situations like this are possible, then the onus would be on the local or federal government to fill that gap, if accessible healthcare is deemed a deeply held government interest by whatever administration is in power.

Learning from the Past

Considering how little literature exists on philosophical and structural reform as a method for navigating ethical conflicts between Catholic and secular healthcare, I will opt to draw analogies between the Catholic healthcare ministry and other movements that have shared similar struggles. I will briefly detail two closely related examples below and identify points of consideration for the reform proposal.

Lessons from the Osteopathic Medicine Movement

The osteopathic medicine movement in the U.S. serves as a particularly fruitful point of historical comparison to the identity struggle of American Catholic healthcare. Osteopathy originated by departing from mainstream medicine and has also struggled with identity issues throughout its history, so the lessons that might be learned from the history of osteopathic medicine can help inform the future of Catholic healthcare. I will use the following section to draw out these lessons and show how they are relevant to the reform I have proposed, demonstrating the necessity for such reform.

Osteopathic medicine originated in 1874 as a reaction to some of medicine's more objectionable practices.⁹⁰ Andrew Taylor Still, the founder of osteopathy, objected to the heavy reliance on drugs and invasive, painful treatments to manage diseases.⁹¹ Still's vision for osteopathy was a holistic school of medicine, relying on the therapeutic use of manipulative treatment.⁹² In addition to an objection to drugs, Still also objected to treatments like bloodletting and shock therapy.⁹³ Although Still would eventually be proven right about the inefficacy of many mainstream treatment methods of the time and even though he cured some patients' ailments that mainstream physicians failed to treat, Still's osteopathy was initially considered with great skepticism.⁹⁴

Despite this skepticism that continued throughout osteopathy's history, osteopathic medicine still exists today, albeit in a greatly modified form. Ever since the

⁹⁰ Katherine Miller, "The Evolution of Professional Identity: The Case of Osteopathic Medicine," *Social Science & Medicine* 47, no. 11 (1998): 1740.

⁹¹ *Ibid.*, 1740-42.

⁹² *Ibid.*, 1742.

⁹³ *Ibid.*, 1741-42.

⁹⁴ Patrick Wu and Jonathan Siu, "A Brief Guide to Osteopathic Medicine: For Students, by Students," American Association of Colleges of Osteopathic Medicine, <http://www.aacom.org/docs/default-source/cib/bgom.pdf>.

death of A. T. Still, osteopathy struggled to establish a distinctive but competitive identity, one that would allow osteopathic medicine to thrive in American medicine and yet remain faithful to Still's principles. This theme can be found throughout history in primary resources from authority figures within osteopathic medicine and historical commentary. Beginning in the 1920's, legal pressures in the form of professional certification encouraged the incorporation of pharmacology into osteopathic practice and education.⁹⁵ Although learning about drug therapies was directly contradictory to Still's principles, the field of medicine had developed since Still's departure from the mainstream. Some medicines had proven unequivocally effective, with decreased side effects and clear benefits for the patient. Osteopathy had to adapt to survive through these developments, taking Still's aversion to drug therapies and transitioning to a "know the enemy' and 'some drugs are okay'" policy on pharmacology.⁹⁶

As further changes were made to the identity of osteopathic medicine, there was a reinterpretation of Still's philosophies. Katherine Miller comments on this reinterpretation, saying "indeed, contradictions between current practice and founding vision could be clearly justified if Still was seen as someone who merely glimpsed the possibilities of osteopathy rather than someone who developed core tenets of the profession."⁹⁷ This changed and broadened Still's influence from distinct principles that defined osteopathy to a philosophical framework that allowed for adaptation as time and medicine progressed. The new goal of the 1920s became to progress in both breadth and distinctiveness.⁹⁸ Some also recognized, however, that there were risks to this strategy

⁹⁵ Miller, "The Evolution of Professional Identity: The Case of Osteopathic Medicine," 1743.

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ Ibid., 1744.

for survival. R.B. Gilmour prophetically remarks in his address as the president of the American Osteopathic Association in 1927 that “[we are] well within the danger mark of an attempt to absorb the distinctive theory of osteopathy by the dominant school, just as has been the case in other instances that were first scorned by that autocratic body.”⁹⁹

The 1950’s through the 1970’s saw a period of increased professional cooperation with allopathic physicians and other healthcare providers, a call to be more moderate in rhetoric, and a general erosion in the distinctive nature of the movement.

Miller explains this change in identity:

Though osteopathy did not totally abandon appeals toward distinctiveness, leaders argued that the mature profession of osteopathy could best serve the public with approaches that were not radical (Heatherington, 1969, p. 13): “The challenge for new leadership, then, is the challenge for a new and moderate voice, a voice that foregoes rhetoric and political slogans and replaces them with wisdom, common sense, and understanding. We, the members of the osteopathic profession, can supply that voice.”¹⁰⁰

Not coincidentally, this time also saw the passage of legislation in many states, giving osteopathic physicians the same practicing rights as allopathic physicians.¹⁰¹

Today, there is little functional distinction between osteopathic and allopathic medicine. Both types of medical schools teach to the same standard that allows accreditation.¹⁰² If any differences remain, it is the taught but only sometimes utilized

⁹⁹ Ibid., R. B. Gilmour, "Presidential Address," *Journal of the American Osteopathic Association* 27, no. 1 (1927)., Here the dominant school refers to allopathic, mainstream medicine.

¹⁰⁰ Miller, "The Evolution of Professional Identity: The Case of Osteopathic Medicine," 1745., J. S. Heatherington, "Presidential Acceptance Speech," *Journal of the American Osteopathic Association* 69 (1969).

¹⁰¹ Norman Gevitz, *The Do's: Osteopathic Medicine in America* (Baltimore, Maryland: Johns Hopkins University Press, 2004).

¹⁰² Miller, "The Evolution of Professional Identity: The Case of Osteopathic Medicine," 1746.

practice of osteopathic manipulation therapy.¹⁰³ Drugs and surgical therapies are now widely utilized by osteopathic physicians.¹⁰⁴ Some within the field lament this homogenization with allopathic medicine, while others claim that osteopathic medicine's days are numbered.¹⁰⁵

There are multiple themes that emerge from a cursory glance at the history of the evolution of osteopathic medicine:

1. Legal pressures, including the leveraging of important items like accreditation and certification, challenged the professions distinction.
2. The evolving nature of medicine made it difficult to maintain distinction and credibility without greatly altering the original vision of osteopathic medicine.
3. Moving away from well-defined and distinct principles and moving towards a generalized philosophical tradition made it difficult to maintain distinction.
4. Although osteopathic medicine demonstrates a movement that was successful at withdrawing from mainstream medicine, it seems that doing this without a clearly defined niche in American healthcare can be detrimental to maintaining distinction.
5. Awareness of the broader healthcare environment is necessary for survival, although other factors can mitigate what this survival looks like.

¹⁰³ Wu and Siu, "A Brief Guide to Osteopathic Medicine: For Students, by Students".

¹⁰⁴ Miller, "The Evolution of Professional Identity: The Case of Osteopathic Medicine," 1747.

¹⁰⁵ *Ibid.*, 1746.

From these themes, one can draw a few lessons to inform the future direction of Catholic healthcare. First, well-defined principles informed by a distinct philosophical or moral tradition is necessary to maintain a distinct identity in American healthcare. The Catholic Church certainly provides these, although application is becoming increasingly challenging. Second, legal pressures to conform to the mainstream provide a point of vulnerability, so it is important to address these vulnerabilities proactively instead of retroactively. Third, operating within an existing framework in American healthcare may provide an avenue for survival while maintaining distinction. Finally, forecasting the direction of American healthcare to assess future obstacles is vital to survival for Catholic healthcare.

These lessons from osteopathic medicine support my proposal for reform. In order to address the first lesson, a successful proposal should make it easier for Catholic healthcare to function according to its well-defined principles of ethical healthcare. By using Durante's methodology to find common points of moral agreement and by transitioning Catholic healthcare into a fully private role, it will be much harder to challenge Catholic healthcare in the modes it is being challenged today. These reforms will also address the second lesson, which is the threat of legal pressures to distinction. The transition to a fully private role in American healthcare from a public-private hybrid role increases the applicability of current protections for religious practices. The call to consider Catholic healthcare in terms of CAM provides an avenue for American healthcare to understand Catholic healthcare in a way that both conveys its importance and increases its protection, simultaneously providing avenues for increased modes of cooperation that are moral between Catholic and non-Catholic providers. Both the second and fifth lessons speak to the necessity of such reform.

Miller comments on how these challenges were not overcome by osteopathic medicine, and how this resulted in the perhaps irrevocable loss of a distinctive identity:

The osteopathic struggle for survival and success has required the profession to craft an identity that bears little resemblance to their founding identity and bears a striking resemblance to the profession they originally were revolting against. It may be impossible for osteopathy to craft an identity that justifies a distinctive and separate profession in the coming century.¹⁰⁶

Luckily, these obstacles might still be overcome in the Catholic healthcare ministry before true distinction is totally lost.

Lessons from the Catholic School System

The origins of the parochial school system in the US are based on the maintenance and strengthening of a countercultural identity. These schools, which teach children in the Catholic tradition, can be one of three types. The first type is the parochial school, which is supported by a local parish. The second is the diocesan school, which is supported by the local diocese. The third is a private order school, which is run by a specific group within the Church, like the Jesuits.¹⁰⁷ These were established starting in the mid-1800s by orders of sister-teachers, so that Catholic immigrants could maintain their identities in the face of pressure to homogenize by then Protestant-dominated America.¹⁰⁸

Timothy Walch, an authority on the history of Catholic education in the US, describes the beliefs that underpin the system; “At the heart of the Catholic parochial

¹⁰⁶ *Ibid.*, 1747.

¹⁰⁷ National Center for Education Statistics, "Catholic-Parochial Schools," <https://nces.ed.gov/pubs/ps/97459ch2.asp>.

¹⁰⁸ Timothy Walch, *Parish School: American Catholic Parochial Education from Colonial Times to the Present*, 1st ed. (National Catholic Education Association, 2003), 151., Timothy Michael Dolan, "The Catholic Schools We Need," <https://www.americamagazine.org/issue/747/article/catholic-schools-we-need>.

school movement is the unwavering belief that the education of children is a primary responsibility of the family and the church, not the government.”¹⁰⁹ This belief is countercultural in contemporary America, but used to be a “prevailing view” among Americans prior to the nineteenth century according to Walch.¹¹⁰ From a Catholic view, the proper education of children is not reduced to mathematics, grammar, or other subjects commonly taught in public schools, but also includes education on matters of faith. The goal of Catholic education is the formation of young adults that are able to contribute to society while living out the tenets of the Catholic faith. The USCCB describes navigating this balance in its discussion of Catholic education:

Catholic schools provide young people with sound Church teaching through a broad-based curriculum, where faith and culture are intertwined in all areas of a school's life. By equipping our young people with a sound education, rooted in the Gospel message, the Person of Jesus Christ, and rich in the cherished traditions and liturgical practices of our faith, we ensure that they have the foundation to live morally and uprightly in our complex modern world.¹¹¹

The theme of remaining a steadfast countercultural option is pervasive in both the USCCB’s language and in Walch’s account of the history of parochial education. Ensuring the presence of such an option was a way of addressing the struggle to maintain both Catholic practices and integration into American society. This theme is also very readily found in the literature on Catholic healthcare in the US. Much of the body of literature on the topic is dedicated to the struggle of CHIs to function in an

¹⁰⁹ Walch, *Parish School: American Catholic Parochial Education from Colonial Times to the Present*, 1.

¹¹⁰ *Ibid.*

¹¹¹ United States Conference of Catholic Bishops, "K through 12," <http://www.usccb.org/beliefs-and-teachings/how-we-teach/catholic-education/k-12/index.cfm>.

increasingly secular environment while remaining true to Catholic principles.¹¹² This provides a fruitful point for comparison between the success of the Catholic school system in the US in the face of struggles similar to those experienced by the Catholic healthcare ministry.

The Church encourages its members to be countercultural with great frequency. Pope Francis has called young Catholics to “be revolutionaries, I ask you to swim against the tide” in reference to embracing the vocation of marriage in a time when marriage rates are the lowest they have ever been.¹¹³ Catholics are called to “prophetic witness,” which Pope John Paul II describes as “an urgent and essential service not just to the Catholic community but to the whole human family.”¹¹⁴ Part of this witness is shaping public policy, both by individuals and by CHIs. In a paper published in 1981, the USCCB describes the prophetic role of CHIs in the context of American health care policy:

We believe and hope that American society will move toward the establishment of a national policy that guarantees adequate health care for all while maintaining a pluralistic approach. As this develops, the role of Catholic institutions in the health field will change. They will take an even greater responsibility in fulfilling the prophetic role of promoting basic Christian values, championing the cause of the poor and neglected in society, and finding new ways to blend personal care and technological skills in health care service.¹¹⁵

Some see the increasing share of Catholic hospital beds and a supposed decrease in the

¹¹² See Chapter 2, page 39.

¹¹³ Pope Francis, "Meeting with the Volunteers of the Xxviii Wyd - Address of Pope Francis,"

https://w2.vatican.va/content/francesco/en/speeches/2013/july/documents/papa-francesco_20130728_gmg-rio-volontari.html.

¹¹⁴ United States Conference of Catholic Bishops, "Living the Gospel Life: A Challenge to American Catholics," <http://www.usccb.org/issues-and-action/human-life-and-dignity/abortion/living-the-gospel-of-life.cfm>.

¹¹⁵ United States Catholic Conference, "Health and Health Care: A Pastoral Letter of the American Catholic Bishops."

availability of procedures deemed to be unjustified evils as a form of this prophetic witness to Gospel values. This view is reflected in the controversy that ensues when a Catholic hospital goes up for sale.¹¹⁶ Even if a Catholic hospital is sold to a non-Catholic entity, most times, there is a stipulation in the agreement that the hospital will continue to abide by the ERDs, if only for a period of a few years. In other scenarios, Bishops have decried selling or transferring of CHIs to non-Catholic entities as material cooperation with evil, that is if the new entity does not abide by the ERDs.¹¹⁷

Selling a CHI to another institution that provides abortions would mean profiting in a way that increases access to prohibited services, however, matters are not that simple. In Chapter 4, we have already seen that many of the ERD's restrictions prevent evils but do not necessarily prevent loss of vulnerable life in a practical sense. Further, the prevention of evil may not be truly prevention, but rather postponement, since patients are not being proselytized to change their ways, but are simply told they must go elsewhere to seek the unjustifiable, evil acts. All of this considered, the moral equation changes when there is an attempt to provide more holistically Catholic care than is possible in the current system. Is it still truly material cooperation with evil to transfer a Catholic hospital to non-Catholic hands with the intention of opening an axial care center that is better prepared to serve patients in a countercultural, prophetic way?

The intention is not to increase access to abortions or contraceptives, but to

¹¹⁶ See the following for one example: Jim Doyle, "Vatican Steps into Fray on Hospital Sale," *St. Louis Post-Dispatch*, Nov 17 2012.
http://www.stltoday.com/business/local/vatican-steps-into-fray-on-hospital-sale/article_23e94c6f-25cb-5ec4-9a47-b26d3fcd5c79.html.

¹¹⁷ Melinda Henneberger, "Lose-Lose on Abortion: Obama's Threat to Catholic Hospitals and Their Very Serious Counterthreat,"
http://www.slate.com/articles/double_x/xxfactor_xxtra/2008/11/loselose_on_abortion.html.

reconfigure resources in a way that better allows health care professionals to practice truly Catholic care. Considering the frequency with which providers at CHIs skirt the ERDs, or simply refer patients to their own off-campus offices to obtain illicit procedures, there may be an over-estimation of the countercultural value of CHIs as they exist today and an underestimation of the potential of CHIs as they could exist in an axial, complementary system. Indeed, looking back at the Catholic education system, the formation of the parochial model is what is partly credited with the preservation of the Catholic faith in the US during years of anti-Catholic sentiment. Today, the Catholic educational system also faces issues in identity and declining enrollment due to other mitigating factors.¹¹⁸ This does not change, however, that the Catholic school system has demonstrated the utility in creating a separate, countercultural system in the face of homogenization and assimilation.

Summary of the Proposal

Here, I will provide a summary of the entire reform plan, which constitutes the long-term recommendations I make for addressing the ethical conflicts experienced when women attempt to access prohibited procedures in CHIs.

- Catholic healthcare will become a new category of complementary and alternative care. Catholic healthcare will continue to be provided using evidence-based medicine, viewed through a Catholic theological lens.
- CHIs will make a graduated transition away from corporate hospital models to alternative, charitable institutions. These institutions will be scaled to a size that allows them to be freed from the pressure of compromising the

¹¹⁸ Dolan, "The Catholic Schools We Need".

Catholic Social Tradition for the sake of financial survival.

- A novel, proactive consent practice will be enacted at CHIs. The aim of this practice is to make patients aware of what Catholic healthcare entails, both in terms of mission and philosophy and also in terms of practical limitations and expectations.
- A centralized and standardized Catholic medical ethics education program will be initiated. Guidelines will be set by the USCCB in conjunction with leading canon and medical scholars to assist. This program will be offered to all CHI employees, and will also be available to any Catholic providers that are not employed at CHIs.
- A group of Catholic medical ethicists will be trained extensively to offer consults to medical professionals across all health care institutions. This consult service will be available by phone to all health care professionals, and will publish materials to help inform patients about making health care decisions in the Catholic Social Tradition.

Short-term Recommendations

Changing an entire framework of thought for a sizable segment of the American healthcare system and the accompanying structural changes would be a monumental undertaking. Even if this system was agreed upon by all parties involved immediately, the actual time it would take to transition into a new arena of Catholic healthcare could take years. In this section, I will offer short term recommendations that will serve to lessen the negative impacts of the ethical issues discussed. None of these strategies will completely circumvent the ethical challenges presented, but can at least help women

and healthcare professionals cope with the current system in the transition period.

While Catholic hospitals still utilize a corporate hospital model system and maintain their public-private hybrid role in American healthcare, there might be opportunities to give women some control over receiving Catholic or non-Catholic care without major structural changes. For example, if there is more than one hospital in any given location, protocols can be put in place that ensure that miscarrying patients or victims of sexual assault are brought to the non-Catholic hospital by default. This may or may not have financial or logistical consequences for the hospitals involved, so this would require hospital and community cooperation.

Additionally, there are certain aspects of the proposed reform that could be enacted without the accompanying structural changes. Again, they will not be as effective for preventing these ethical issues, but it may help ameliorate any negative impacts currently being experienced by patients. First, a modified, proactive consent can be obtained for anyone seeking care at a Catholic hospital. It would most likely not be in the same full form as described earlier in this chapter, but simply making patients aware of what will not be offered at a particular institution and ensuring that they understand those limitations would solve some of the problems discussed. For example, before a pregnant patient is seen by her doctor in the hospital setting, she will be aware of the fact that a surgical sterilization will not be a possibility, perhaps giving her time to make other arrangements without facilitation from the Catholic institution.

Second, enacting a type of “Catholic consultant” program does not require any structural changes to the existing healthcare system. By centralizing and standardizing education on the Catholic Social Tradition in medicine, it may be easier to achieve ethical consistency across both CHIs and non-Catholic institutions that employ Catholic

healthcare providers or serve Catholic patients. This is one of the most feasible and attainable aspects of the proposed reform. The program would require some educational and organizational resources from the Church, advertising costs to make American hospitals aware of the service, and would require willingness of healthcare providers to participate, all of which can be accommodated relatively easily within the current system. This would make healthcare consistent with the Church's social tradition available to virtually any American, although, this is not the same as making Catholic healthcare widely available in all hospitals, since Catholic healthcare cannot be reduced to care that is at least consistent with its principles. Further, this relatively small change might help to avoid the harm that women might experience when the Catholic Social Tradition is variably interpreted.

Conclusion

Ultimately, radical cooperation and mutual understanding will be necessary to resolve ethical conflicts between Catholic and secular medical ethics on access to reproductive healthcare. These conflicts, although immediately caused by incompatibility on certain ethical principles, are exacerbated by the structure of the current healthcare system. In order for a resolution to be effective, it will need to address the structural causes that give rise to these conflicts.

Using Durante's pragmatic perspectivism, I have identified a key conceptual bridge between Catholic and secular medical ethics on reproductive healthcare, which is the importance of autonomous decision making and availability of accurate medical information. I then used this bridge as the basis for my proposal for reform. This reform addresses all of the contributing factors to this ethical conflict by recommending both philosophical and structural changes in the Catholic healthcare ministry that allows both

parties to respect the other's view on autonomous decision making and informed consent practices. This reform plan draws on lessons from the past, incorporating the wisdom of history to lend the greatest chance for success.

CHAPTER 7: CONCLUSION

Research Overview

The structure of the current Catholic healthcare system is becoming increasingly ill-suited for the Catholic healthcare ministry. Catholic healthcare institutions (CHIs) and employees are being pressured both legally and financially to betray or dilute the Catholic healthcare mission, while women are being made to suffer due to ethical conflicts between Catholic and non-Catholic moral traditions in medicine. This environment has led me to ask the research question that is the focus of this thesis: is it possible to reduce harm experienced by American women while simultaneously preserving the Catholic Social Tradition in medicine?

I posited in Chapter 1 that yes, it is possible to preserve the Catholic Social Tradition in medicine and reduce harm to women, although reform is necessary to accomplish this. By the end of Chapter 6, I supported my hypothesis, giving a novel proposal for Catholic healthcare reform that would accomplish the goal of reducing harm to women while preserving the Catholic healthcare tradition. Here, I will give a brief summary of what I have accomplished in Chapters 1 through 6, and how this relates to the confirmation of my hypothesis.

In Chapter 1, after giving a brief introduction of the problem in question, I introduced the relatively recent and small body of literature on the topic. I demonstrated that no satisfactory resolutions to these ethical issues have been proposed. The coping mechanisms that have been proposed in the past have been costly in terms of time and resources and have not been proven to be sustainable.

In Chapter 2, I explored the public-private hybrid role that Catholic hospitals occupy in the United States and discuss how this hybrid role gives rise to the ethical conflicts in question. Occupying this role subjects CHIs to increasing economic and legal pressures, both of which have led to increased homogenization with non-Catholic institutions. This has resulted in a sort of identity crisis for the Catholic healthcare ministry, which contributes to the difficulty in preserving the Catholic Social Tradition in medicine.

In Chapter 3, I discussed the Ethical and Religious Directives (ERDs), their enforcement, and their practical and theoretical consequences for women and healthcare providers. I presented the directives in tandem with the relevant clinical information, comparing and contrasting the legal standard of care in secular medicine with the proscriptions of the ERDs. I also introduced the idea that the ERDs are inconsistently applied and enforced, which gives rise to a unique set of problems for both women and healthcare providers.

In Chapter 4, I presented primary and secondary sources describing cases of patients that have been harmed either directly or indirectly by CHI policies based on the ERDs. I showed that although the ERDs were crafted to protect the dignity and lives of both women and pre-natal humans, women are sometimes harmed by their application in the clinical setting. Although incorrect application of the ERDs is responsible for many of these cases, there are other cases where the ERDs were perfectly employed and women were still harmed. This harm does not necessarily lead to the judgment that the ERDs are morally flawed according to the Catholic Social Tradition; indeed, even in secular medicine, following ethical practices means that healthcare providers are sometimes prohibited from preventing all harm and injuries. Recognizing the presence

of this harm and its connections to the ERDs, however, does mean that something should be done to reduce the harm if at all possible.

In Chapter 5, I outlined the obstacles that face the Catholic healthcare ministry, stemming from the structure of the Catholic healthcare system. The first category of threats to the ministry that I name is covert or non-compliant actions by CHI employees that directly contradict the ministry. The second category of threats are those of inconsistencies and scandal perpetrated by hospital leadership and clergy. The last category are external threats, namely the economic and legal pressures that encourage CHIs to provide care that is contradictory to the ERDs.

In Chapter 6, I proposed a reform plan that aims to reduce harm experienced by women I described in Chapter 4 and to free the Catholic healthcare ministry from the obstacles I described in Chapter 5. The reform would change the structure of the Catholic healthcare system so that CHIs transition away from the public-private hybrid role I outlined in Chapter 2. The plan would also address the challenges in applying the ERDs in a clinical setting as described in Chapter 3, since education on the ERDs would become more standardized. The addition of a novel, proactive informed consent procedure in combination with the move to a mostly charitable function address the legal issues I raise in Chapters 2 and 3. I described within Chapter 6 how my plan for reform addresses all of the points that give rise to the ethical conflicts, how it addresses the conflicts themselves, and how lessons from history support my proposal. Here is a brief summary of the proposal:

- Catholic healthcare will become a new category of complementary and alternative care. Catholic healthcare will continue to be provided using evidence-based medicine, viewed through a Catholic theological lens.

- CHIs will make a graduated transition away from corporate hospital models to alternative, charitable institutions. These institutions will be scaled to a size that allows them to be freed from the pressure of compromising the Catholic Social Tradition for the sake of financial survival.
- A novel, proactive consent practice will be enacted at CHIs. The aim of this practice is to make patients aware of what Catholic healthcare entails, both in terms of mission and philosophy and also in terms of practical limitations and expectations.
- A centralized and standardized Catholic medical ethics education program will be initiated. Guidelines will be set by the USCCB in conjunction with leading canon and medical scholars to assist. This program will be offered to all CHI employees, and will also be available to any Catholic providers that are not employed at CHIs.
- A group of Catholic medical ethicists will be trained extensively to offer consults to medical professionals across all health care institutions. This consult service will be available by phone to all health care professionals, and will publish materials to help inform patients about making health care decisions in the Catholic Social Tradition.

Purpose

The ability to find a resolution to these ethical conflicts that I have described has broad implications for American society. The US is an incredibly diverse population, especially in terms of religious and other non-religious moral traditions. It is imperative that American society does its best to protect personal religious (and moral) exercise;

not only is this a core principal of American governance, woven into the foundations of the country, but it also speaks to our collective ability to show mutual respect and a good faith effort in achieving goals that require cooperation. This in a general sense requires us to move away from unhelpful and inaccurate binaries in discourse and to move towards mutual understanding and cooperation, even if total agreement is never achieved. This motivation requires us to resolve large, structural problems that create conflicts between one or more moral traditions. This is especially true when people's health and lives are at stake, as they are in this particular conflict.

There are also more immediate reasons to find a satisfactory resolution to this conflict. Speaking to the interests of the Church and its healthcare ministry, it is prudent to be proactive about foreseen challenges to the ministry. These conflicts only serve to impede the goals of the ministry. Although there is no doubt that the Catholic Church has a large presence in the US with an accompanying influence over legislation and policy, it is certainly possible the legal developments and future court cases might make Catholic healthcare as it is known today illegal. The Church has an interest to prevent this from happening. Working to prevent women from being harmed where possible while still remaining faithful to Catholic principles might also help decrease scepticism and hostility towards the Church, something that would work towards more productive cooperation between the Church and non-Catholic healthcare entities.

Contribution to the Field

In this thesis, I present a novel proposal for reform in order to address the ethical conflicts in accessing reproductive healthcare. Although many academics have written about the identity crisis of Catholic healthcare and about the ethics of restricting access to reproductive healthcare, there have not been any satisfactory methods proposed to

address these issues. Several adaptation strategies were discussed in Chapter 1. These strategies proved costly and inconsistent, resulting in the formation of unstable relationships. My proposed reform differs from these strategies by addressing the underlying structural issues that lead to the conflicts instead of enacting surface level accommodations that are tenuous.

Additionally, my research shows how Chris Durante's pragmatic perspectivism might be used successfully for large scale cooperation and change between religious and secular parties.¹ My research demonstrates that there are bioethical methodologies better suited for ethical challenges arising from the conflict of religious and secular ethics in medicine than what is currently widely used, which are the four universal principles of bioethics.² Unless moral traditions within medicine are given equal consideration, it will be difficult to have a productive conversation that leads to compromise.

Limitations

Primarily, I am limited in this project by only being trained in the biological sciences and medical ethics, when the goal of this project requires multidisciplinary work. The proposal I recommend is largely based on principles that I argue are necessary from an ethical standpoint for the reform to be successful. It is not, however, a piece of policy that is ready for implementation. Writing a functional policy would require the help of healthcare administrators, economists, clergy, physicians, and government officials. Although what I have provided is the ethical basis for the reform,

¹ Durante, "Bioethics in a Pluralistic Society; Bioethical Methodology in Lieu of Moral Diversity"., "Dialogue Despite Diversity: Sharing Norms When Our Moralities Differ.",

² Beauchamp and Childress, *Principles of Biomedical Ethics*.

provisions must be made so that the American healthcare system remains financially stable and so that there would be no lapses in healthcare access.

The proposal itself has the limitation of needing substantial levels of cooperation between the Church and secular governing bodies of healthcare policy to be enacted. While this is absolutely theoretically possible, existing skepticism and mistrust between the two parties might make the reform practically challenging. Much of the research that underpins the reform is demonstrative, done through case studies to exemplify the existence of certain issues. While we know these problems exist, we do not know how often or how badly these conflicts impact women seeking medical care. Even if the current evidence suggests that these numbers are likely underreported rather than over-reported, knowing this information would show exactly how vital reforming the healthcare system is. Considering the cost of this type of reform, it might be necessary to discover this information before parties agree that the reform is worthwhile.

Implications

In arguing for the adoption of a CAM-based framework for understanding Catholic healthcare, I presented the fundamental difference in the ultimate goals of Catholic and secular medicine. Understanding this difference is vital to understanding *why* both parties have different conceptions of what can be considered good and moral healthcare. This difference in philosophy and theology on healthcare allowed for the application of the CAM-based framework. Although I applied this framework to the Catholic healthcare ministry, these principles can be applied to any movement or tradition within healthcare that is based on a unique philosophical or theological approach not shared by mainstream medicine. This might not be necessary for

movements or traditions that are otherwise compatible with mainstream medicine, but for those that face conflicts like the Catholic healthcare ministry, this framework could prove to be useful.

Although this project was limited in scope to ethical conflicts in restricting access to reproductive healthcare, the conclusions drawn are also applicable to other points of conflict between Catholic and non-Catholic medical moral traditions. For example, these reforms would also solve similar ethical conflicts encountered when the ERDs prohibit certain aspects of a patient's advance directives from being fulfilled, or other aspects of end-of-life care.

Areas for Further Research

In the course of carrying out this research, I identified multiple gaps in the literature. First, as already previously mentioned, much of the research presented in Chapters 4 and 5 was organized as case studies. This allowed me to demonstrate the existence of certain ethical issues, even though it is still unknown how often or how badly these issues impact both women and CHIs across the US. It is essential to determine in quantitative terms how large an impact these ethical conflicts are making. Having this information would provide the impetus for cooperation and reform.

Considering how limits the possibility of obtaining many of the legal battles against Catholic healthcare are quite recent, the body of literature on these ethical conflicts is small and new. Therefore, there is little to refute or support my proposal and the associated conclusions. Once this research is published, academic and Church response will be vital determining the feasibility of the reform proposal. These responses will

help me to incorporate any future modifications to the proposal. This will be my next avenue of research.

It may be worthwhile to study methods of improving hiring practices so that employees are more likely to remain faithful to an institutional mission. Even if it is a long time before the healthcare system can be reformed in the manner I have proposed, simply improving employee education and fidelity might help reduce some of the confusion and misapplication of the ERDs.

Finally, it would be useful for academics on Catholic healthcare to work together with the USCCB to produce a centralized educational platform that serves to standardize knowledge on Catholic identity in medicine, as well as proper applications of the ERDs. Although my proposal makes this recommendation, it purposely leaves the methods for doing so vague. It would be an interesting line of inquiry to determine how this might be done best, finding the method that best increases the understanding of the ministry.

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