

*Doctors, Dioceses, and Decisions: Examining the Impact of the
Catholic Hospital System and Federal Conscience Clauses on
Medical Education*

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ABSTRACT

In a time when health care reform and the limits on First Amendment freedom of religion are persistent subjects of debate, Catholic restrictions on health care have made it to the forefront of public concern. Catholic providers prohibit a variety of medical procedures traditionally viewed by the Church as contrary to the tenet of respect for human life and dignity. Many Americans view this as an unconstitutional restriction on care. As a result, the growing presence of Catholic providers, namely hospitals, has become a major point of contention in many communities. The potential barrier to medical services raises concern not only for potential patients, but also for medical students whose chosen specialty may include a prohibited service. This article identifies some difficulties that may emerge for current and prospective medical students and advocates that both groups should be required to contemplate (1) their personal beliefs as they pertain to religiously-restricted care, and (2) the effects those beliefs will have on their medical education and training. This article also gives a comprehensive background of the history of the Catholic hospital system in America and analyzes the federal "conscience clauses" and their implications for the instruction and practice of medicine. Finally, this article concludes that a mandatory bioethics curriculum is absolutely crucial to ensure adequate ethics training for medical students.

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I. INTRODUCTION

Imagine you are an obstetrician/gynecologist who has spent the better part of the past decade working diligently to achieve that title. You have finally landed a job at the premier Catholic hospital in your town and are preparing to deliver your first baby, a forty-year-old mother's fifth child. Delivery goes well, and the mother requests a tubal ligation (a sterilization procedure). You are prepared to proceed when the hospital administrator tells you to stop; you are forbidden from performing this procedure. "Why?" you ask. "Because," she replies, "Pope Benedict says so."

Catholic providers dominate the American non-profit health care industry,¹ basing the provision of services upon the tenet of respect for human life and dignity.² It is upon this ground that Catholic providers prohibit a variety of medical procedures, such as sterilization, abortion, termination of life support, and the provision of contraceptives.³ Due to the Catholic sector's restriction of what it deems to be religiously-repugnant procedures, its growing presence among American health care providers has proven to be a significant and often controversial barrier to the availability of medical

¹ See CATHOLIC HEALTH ASS'N OF THE U.S., CATHOLIC HEALTH CARE IN THE UNITED STATES 2 (2011), <http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147489259> [hereinafter CATHOLIC HEALTH CARE].

² See UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 4 (5th ed. 2009), available at <http://www.usccb.org/index.html> (Then Search: Ethical and Religious Directives for Catholic Health Care Services) [hereinafter ETHICAL AND RELIGIOUS DIRECTIVES].

³ See generally *id.*

services in some communities.⁴ This barrier raises several concerns not only for patients, but also for medical students whose chosen specialty may include a prohibited service.

This article advocates that current and prospective medical school students must actively contemplate their personal beliefs on the topic of religiously-prohibited medical services; those students must also assess the effect their religious attitudes will have on their medical education and training. This process should take place in two contexts: (1) an undergraduate advising session, and (2) a mandatory bioethics course at the graduate level.

By focusing on the Catholic hospital industry, this article will examine current trends in the provision of religiously-prohibited services and discuss some issues that medical students will face. First, Section II will discuss the history and development of the United States hospital industry. Section III will explore the dominance of Catholic providers and the effect it has on the provision of care. Section IV then analyzes several federal "conscience clauses" and their implications for the instruction and practice of medicine. Finally, Section V proposes that medical students develop a professional plan to guide them through the bioethical issues of religiously restricted health care.

II. THE AMERICAN HOSPITAL INDUSTRY

On February 11, 1753,⁵ the nation's first hospital opened its doors to the "sick-poor, and insane" of Philadelphia, Pennsylvania.⁶ The facility, aptly named Pennsylvania Hospital, was opened by Dr. Thomas Bond and

⁴ See Heather L. Carlson, Comment, *Freedom at Risk: The Implications of City of Boerne v. Flores on the Merger of Catholic and Non-Catholic Hospitals*, 17 ST. LOUIS. U. PUB. L. REV. 157, 162–63 (1997).

⁵ *The Creation of the Nation's First Hospital*, PENN MED., <http://www.uphs.upenn.edu/paharc/features/creation.html> (last visited Mar. 16, 2012).

⁶ *Id.*

Founding Father Benjamin Franklin.⁷ It adopted the Good Samaritan as its seal and a verse from the gospel of Luke as its mission: "Take Care of Him and I Will Repay Thee."⁸ The first generation of American hospitals was born.

The country's early facilities were not defined, as hospitals are today, by the availability of specialized technical resources or comfortable care.⁹ Rather, nineteenth century hospitals were associated with need and dependency; often they were regarded as the "last resort for the city's most helpless and deprived."¹⁰ They frequently served as tools of Christian stewardship, a means of providing for the common good.¹¹ In later years, as the hospital industry began to flourish, the number of religious hospitals multiplied.¹²

Christian hospital policy traditionally favored the moral imperatives of Christian stewardship over physicians' medical values.¹³ Competition between the two value systems resulted predictably in conflict between hospital administrators—appointed for their moral and religious virtues—and

⁷ *Id.*

⁸ *Id.* The gospel of Luke states, "And on the morrow when he departed, he took out two pence, and gave them to the host, and said unto him, **Take care of him, and** whatsoever thou spendest more, when I come again **I will repay thee.**" *Luke* 10:35 (King James) (emphasis added).

⁹ CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* 5 (1987).

¹⁰ *Id.* at 5, 15.

¹¹ *Id.* at 105.

¹² *Id.* at 109. The different religious affiliations of those hospitals reflected the cities' diverse populations. For example, New York saw a rapid increase in religious hospitals over the course of two decades with St. Vincent Hospital (Catholic) in 1849, St. Luke's (Episcopal) in 1850, Mt. Sinai Hospital (Jewish) in 1852, and Presbyterian Hospital in 1868. *Id.*

¹³ *Id.* at 48.

physicians—hired for their medical expertise.¹⁴ Often, medical needs clashed with the administration's opinions as to what constituted appropriate stewardship.¹⁵ For example, hospitals often objected to the use of alcohol—despite its proven benefits—as a stimulant and tonic on grounds of immorality.¹⁶ These internal conflicts led to a national aversion to institutional health care, stunting the growth of the early hospital industry.¹⁷ The nation's first hospital survey, conducted in 1873, revealed a paltry 178 hospitals, including mental institutions.¹⁸ Together, these institutions housed a combined total of fewer than fifty thousand beds.¹⁹

Less than forty years later, however, hospitals had become firmly entrenched in the American community.²⁰ The 1909 census identified more than four thousand hospitals having more than 421,000 beds.²¹ By the mid-twentieth century, the nation had begun to view hospitals as institutional providers of medical care and training.²² Hospitals now attracted middle and upper class citizens who were willing to pay for their medical care as opposed to being the last stop for the destitute.²³ By 1930, the number of hospitals had increased by a staggering 2,500 percent.²⁴

¹⁴ *Id.* at 52.

¹⁵ *Id.* at 53.

¹⁶ *Id.* at 54.

¹⁷ *See id.* at 5.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ GUENTER B. RISSE, *MENDING BODIES, SAVING SOULS: A HISTORY OF HOSPITALS* 467 (1999).

²¹ ROSENBERG, *supra* note 9, at 5.

²² *Id.*

²³ RISSE, *supra* note 20, at 467–68.

²⁴ *Id.* at 471.

The hospital industry continued to improve in size and reputation, eventually emerging as the primary institution for the seriously ill and dying.²⁵ Today, Americans regard hospitals as a crucial component of the medical education experience as well as the "primary workshops" for medical careers;²⁶ they are the epicenters of medical practice in its most sophisticated form.²⁷ Driven by scientific and technological advances, the industry's focus has shifted in large part from caretaking to active treatment, and from religious responsibility to medical excellence and economic productivity.²⁸

III. CATHOLIC DOMINANCE OF THE AMERICAN HOSPITAL INDUSTRY

*One in six patients is cared for by Catholic hospitals.*²⁹

A. THE CATHOLIC HOSPITAL SYSTEM: THE MUSTARD SEED

The dignity of the human person is the foundation of all permanent principles of the social doctrine of the Catholic Church (the "Church").³⁰ Flowing from this main precept is the principle of the "common good."³¹ The Church places heavy emphasis on every person's responsibility for the

²⁵ ROSENBERG, *supra* note 9, at 10.

²⁶ *Id.*; RISSE, *supra* note 20, at 472.

²⁷ See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 146 (1982).

²⁸ *Id.* at 146, 148; RISSE, *supra* note 20, at 467–68.

²⁹ CATHOLIC HEALTH CARE, *supra* note 1, at 2.

³⁰ See PONTIFICATION COUNCIL FOR JUSTICE AND PEACE, COMPENDIUM OF THE SOCIAL DOCTRINE OF THE CHURCH (USCCB Publishing 2004) (referring to principles that are the foundations of Church's social teachings and part of a broad social doctrine developed by the United States Council of Catholic Bishops to address modern social, economic, and political issues, and the Church's stance on those issues).

³¹ *Id.* at 71–72 ("common good" defined as "the sum of total social contributions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily").

common good and demands a commitment to the "provision of essential services to all."³² "Essential services" includes access to basic health care. It is the Church's view of health care as a universal human right that sparked the ministry of the non-profit Catholic hospital system.³³

In 1828, seventy-five years after Franklin and Bond opened Pennsylvania Hospital, Irish-American millionaire John Mullanphy founded the nation's first Catholic hospital.³⁴ Located in St. Louis, Missouri, Mullanphy Hospital was staffed by the Sisters of Charity of St. Joseph and provided medical services to the indigent.³⁵ Today the facility operates under the name DePaul Health Center and is the "oldest continuing existing business in St. Louis."³⁶ Its mission is to "reveal the healing presence of God" through outstanding services³⁷ and, like many of the early Catholic hospitals, it prides itself on serving both the patient's spiritual and social needs.³⁸

³² *Id.* at 72.

³³ Thomas Nairn, *Catholics Understand Health Care as a Right*, HEALTH PROGRESS 58 (2010), available at <http://www.chausa.org/workarea/DownloadAsset.aspx?id=7261>; see ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2, at 7 (explaining that "In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying").

³⁴ *St. Louis Hospital (Mullanphy Hospital)*, CATHOLIC HISTORY.NET, <http://www.catholichistory.net/Places/StLouisHospital.htm> (last visited Mar. 20, 2011).

³⁵ *Id.*; "Saint Elizabeth Ann Seton founded the Sisters of Charity of St. Joseph's in 1809. This was the first native-sisterhood of religious women to be established in the United States." THE DAUGHTERS OF CHARITY EMITTSBURG PROVINCE, FACTS & FIRSTS, available at http://www.the-daughtersofcharity.org/userfiles/File/Master--Facts_Firsts_2.pdf.

³⁶ *About Us*, SSM DEPAUL HEALTH CTR., http://www.ssmhealth.com/depaul/about_us/Pages/aboutus.aspx (last visited Mar. 3, 2012).

³⁷ *Our Mission*, SSM DEPAUL HEALTH CTR., http://www.ssmhealth.com/depaul/about_us/pages/ourmission.aspx (last visited Mar. 3, 2012).

³⁸ RISSE, *supra* note 20, at 514.

By 1885, more than 154 Catholic hospitals were providing regular care in the United States.³⁹ Subsequent decades were marked by continued proliferation of the Catholic hospital system and the communities in which those hospitals were erected. Waves of new immigrants were received into communities that encouraged them to protect their cultural identities.⁴⁰ In particular, many communities established Catholic hospitals to accommodate Irish immigrants.⁴¹ By 1910, more than four hundred Catholic hospitals populated the hospital sector.⁴² Non-Catholic hospitals' admissions suffered as a result.⁴³ Today, Catholic hospitals operate in forty-five states, pledging to faithfully and without discrimination, serve patients of all faiths.⁴⁴

Representing the largest single group of non-profit hospitals, Catholic hospitals now constitute 12.7 percent of all community hospitals and 15.8 percent of all community hospital admissions.⁴⁵ They are [the] largest provider of religiously restricted health care in the United States, boasting 636 facilities,⁴⁶ approximately one-third of which are located in rural areas.⁴⁷

³⁹ ROSENBERG, *supra* note 9, at 111.

⁴⁰ RISSE, *supra* note 20, at 468.

⁴¹ ROSENBERG, *supra* note 9, at 111.

⁴² Catholics in Health Care, CATHOLIC HISTORY.NET, <http://www.catholichistory.net/Spotlights/SpotlightHealthcare.htm> (last viewed Mar. 14, 2012).

⁴³ See ROSENBERG, *supra* note 9, at 111.

⁴⁴ STARR, *supra* note 27, at 175. As of January 2011, no Catholic hospitals operated in Hawaii, North Carolina, Utah, Vermont, or Wyoming. CATHOLIC HEALTH CARE, *supra* note 1, at 2.

⁴⁵ CATHOLIC HEALTH CARE, *supra* note 1, at 2. For this purpose, community hospitals include "all nonfederal, short-term, general and other specific hospitals." They include academic medical centers and other non-federal, short-term teaching hospitals. They do not include hospitals which are not accessible by the public, e.g. prison hospitals or college infirmaries. *Id.*

⁴⁶ Written Complaint from Judy Waxman, Vice President Health and Reproductive Rights, and Jill Morrison, Senior Counsel, Nat'l Women's Law

In five states, Catholic hospitals account for 30 percent or more of all annual hospital admissions.⁴⁸ On any given day, approximately 532,000 people are employed full-time by Catholic hospitals and approximately 237,000 are employed part-time.⁴⁹

B. DIRECTIVES AND MERGERS: "MOVING FORWARD UNDER GOD"⁵⁰

As the Catholic hospital industry grew, so did the need for careful scrutiny of medical practices.⁵¹ The American Catholic Hospital Association ("CHA") responded in 1949 with a medical code of ethics, the "Ethical and Religious Directives for Catholic Hospitals."⁵² A revised version, entitled the "Ethical and Religious Directives for Catholic Health Care Services" ("Directives"), was promulgated in 1971 by the National Conference of Catholic Bishops ("NCCB") and distributed by the CHA.⁵³ The current Directives set forth a number of faith-based principles which are applied by health care providers within the various dioceses.⁵⁴ The purpose of the

Ctr. to Ctr. for Medicare and Medicaid Serv. (Jan. 20, 2011) (on file at http://www.nwlc.org/sites/default/files/pdfs/nwlc_cms_complaint_jan_2011.pdf).

⁴⁷ CATHOLIC HEALTH CARE, *supra* note 1, at 2.

⁴⁸ *Id.* Those five states are Alaska, Missouri, South Dakota, Iowa, and Montana. *Id.*

⁴⁹ *Id.*

⁵⁰ RISSE, *supra* note 20, at 553.

⁵¹ *Id.* at 523.

⁵² *Id.*; see generally ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2.

⁵³ RISSE, *supra* note 20, at 545. This document is to be subjected to further revisions whenever research concerning advancing medical and moral knowledge justifies such modifications.

⁵⁴ Jean Deblois & Kevin D. O'Rourke, *Introducing the Revised Directives: What Do They Mean for Catholic Healthcare?*, 76 HEALTH PROGRESS 3, 20 (1995), available at <http://www.chausa.org/workarea/>

Directives is two-fold: "(1) to reaffirm the ethical standards of behavior that flow from the Church's teaching about dignity of all human persons (born and unborn alike); and (2) provide authoritative guidance on certain moral issues that currently face Catholic health care."⁵⁵ The document is divided into six parts, the central tenet of all six being that the end result of a medical procedure *never* justifies immoral means.⁵⁶ Consequently, the Directives prohibit Catholic hospitals from performing certain religiously immoral procedures.⁵⁷ That prohibition includes the provision of abortion, sterilization, contraception and the morning-after pill, HIV counseling that advocates condom use, in vitro fertilization, euthanasia, and termination of life support except where treatment is an "extraordinary or disproportionate means of preserving life."⁵⁸ The "[d]irectives are drawn from the Church's theological

DownloadAsset.aspx?id=5055; *see generally* ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2.

⁵⁵ ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2, at 3–4.

⁵⁶ *See* ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2 (The six parts of the Directives are: (1) The Social responsibility of Catholic Health Care Services; (2) The Pastoral and Spiritual Responsibility of Catholic Health Care; (3) The Professional-Patient Relationship; (4) Issues in Care for the Beginning of Life; (5) Issues in Care for the Seriously Ill and Dying; and (6) Forming New Partnerships with Health Care Organizations and Providers.).

⁵⁷ *See id.*

⁵⁸ *See generally* ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2. There has been some recent debate concerning the Church's advocacy of use of condoms to prevent AIDS. "In the book-length interview, 'Light of the World,' published in November, Pope [Benedict XVI] said that while condoms were not the answer to the AIDS epidemic, the use of condoms may be a sign of moral responsibility in some specific situations when the intention is to reduce the risk of infection." The Vatican planned to host international scientists at a conference on AIDS in late May, 2011, to help clarify the pope's recent comments on condom use in AIDS prevention. John Thavis, *Vatican Plans Conference, Pastoral Guidelines on AIDS Care*, CATHOLIC NEWS SERV. (Feb. 3, 2011), <http://www.catholicnews.com/data/stories/cns/1100446.htm>. *See generally* ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2. In March 2004, Pope John Paul II issued an

and moral teachings on various aspects of health care delivery" and form a basis for hospital policy.⁵⁹ The NCCB readily acknowledges that many trustees, administrators, and other health care professionals in the Catholic hospital system are not practicing Catholics, yet it nonetheless requires them to administer care in compliance with the Directives.⁶⁰ The Church views this as a necessary measure to defend the respect and dignity of human life.⁶¹

A Catholic hospital that fails to adhere to the Directives risks being stripped of its Catholic affiliation.⁶² For example, in 2009, St. Joseph's Hospital and Medical Center in Phoenix, Arizona had its Catholic affiliation revoked after it permitted a prohibited procedure to take place.⁶³ In that case, a mother of four developed pulmonary hypertension in her eleventh week of pregnancy and was told by her doctors that death was inevitable without a

Address restricting the exception for termination of life support and holding it inapplicable to patients in a "vegetative state." In September 2007, the Congregation for the Doctrine of the Faith issued a statement (approved by Pope Benedict XVI) clarifying the implications of that Address. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, Q&A FROM THE USCCB COMMITTEE ON DOCTRINE AND COMMITTEE ON PRO-LIFE ACTIVITIES REGARDING THE HOLY SEE'S RESPONSES ON NUTRITION AND HYDRATION FOR PATIENTS IN A "VEGETATIVE STATE" 1–2 (Sept. 2007).

⁵⁹ *Ethical and Religious Directive for Catholic Health Care Services*, CATHOLIC HEALTH ASS'N OF THE U.S., <http://www.chausa.org/Contenttwocolumn.aspx?pageid=5653&terms=directives> (last visited Mar. 4, 2012).

⁶⁰ Deblois & O'Rourke, *supra* note 54, at 21.

⁶¹ See PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, COMPENDIUM OF THE SOCIAL DOCTRINE OF THE CHURCH 426 (USCCB Publishing 2004) (stating that the Church is "truly and intimately linked with mankind and its history" and therefore claims the freedom to express moral judgment on human reality whenever it is required to defend a person's fundamental rights or the salvation of his/her soul).

⁶² Deblois & O'Rourke, *supra* note 54, at 21.

⁶³ Rob Stein, *Religious Hospital's Restrictions Sparking Conflicts*, *Scrutiny*, WASH. POST, Jan. 29, 2011.

particular surgery. However, the surgery would terminate the pregnancy.⁶⁴ The hospital agreed to the surgery, believing that because the purpose of the surgery was not to kill the baby—but rather to save the life of the mother—it would not violate the Catholic Directives.⁶⁵ Accordingly, Sister Mary McBride allowed the pregnancy's termination on hospital premises.⁶⁶ Bishop Thomas Olmsted reprimanded the hospital for its actions, eventually revoking the Church's endorsement of St. Joseph's.⁶⁷ Sister McBride was excommunicated, and in 2010, St. Joseph's Hospital was stripped of its affiliation.⁶⁸ In the wake of these events, St. Joseph's has stood adamantly by its decision. It stated in a press release that, "[c]onsistent with [its] values of dignity and justice, if [the hospital was] presented with a situation in which a pregnancy threatens a woman's life, [its] first priority is to save both patients. If that is not possible, [it] will always save the life [it] can save, and that is what [it] did"⁶⁹ St. Joseph's has continued operating under the same name, despite the loss of affiliation.⁷⁰

Another way Catholic hospitals can risk losing affiliation is by merging with a non-Catholic hospital.⁷¹ Beginning in the 1980s, a "merger mania" swept the hospital industry, a phenomenon characterized by the formation of

⁶⁴ *Id.*

⁶⁵ Michael Clancy, *Phoenix Diocese Strips St. Joseph's Hospital of Catholic Status*, THE ARIZ. REPUBLIC, Dec. 22, 2010, <http://www.azcentral.com/community/phoenix/articles/2010/12/21/20101221phoenix-diocese-strips-st-josephs-hospital-catholic-status.html>.

⁶⁶ Stein, *supra* note 63.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Media Statement, St. Joseph's Hosp. and Med. Ctr., St. Joseph's Resolved in Saving Mother's Life, Confident Following Bishop's Announcement (Dec. 21, 2010), *available at* <http://www.azcentral.com/ic/pdf/1221st-joseph-statement.pdf>.

⁷⁰ *See id.*

⁷¹ Stein, *supra* note 63.

numerous partnerships between Catholic hospitals and their non-Catholic counterparts.⁷² The movement gained momentum in the early 1990s in response to tough economic times and a presidential push for health care reform.⁷³ Many non-Catholic hospitals sought mergers in an attempt to: (1) decrease competition for managed care contracts; (2) increase economic security; and (3) minimize the cost of operation and care.⁷⁴ However beneficial these mergers may have been to the economic status of non-Catholic facilities, they came at a rather steep price.

Often, when Catholic hospitals merge with non-Catholic hospitals, the Directives are imposed on the newly-formed partnership.⁷⁵ In order to facilitate mergers and ensure that newly-formed partnerships adhere to Church doctrine, the 1994 NCCB revised the Directives to include instructions for "Forming New Partnerships with Health Care Organizations and Providers."⁷⁶ A common result of these mergers has been the elimination or restriction of some reproductive health services, the unavailability of which disproportionately affects women.⁷⁷ This especially impacts those

⁷² See Carlson, *supra* note 4, at 158–59.

⁷³ *Id.*

⁷⁴ *Id.*; see Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J.L. & ECON. 523, 528 (2009) ("Managed care penetration increased from less than 30 percent of private insurance in 1988 to nearly 95 percent by 1999." As a result, hospitals gained great motivation to consolidate during the 1990s. "Between 1989 and 1996, there were 190 hospital mergers, compared to 74 [in the previous five years].").

⁷⁵ Carlson, *supra* note 4, at 160.

⁷⁶ *Id.* at 159; ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2, at 34–37.

⁷⁷ Carlson, *supra* note 4; see also Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1102–04 (1996) (identifying concerns particular to rural areas); Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1446 (1995).

women who are poor and/or living in rural communities because they often have few choices among health care providers.⁷⁸ Rural communities are known to provide very few health care options,⁷⁹ while a lack of transportation creates additional barriers to access of non-Catholic health care providers.⁸⁰ In some instances, the potential for limitation of reproductive services for women has meant the end of merger negotiations.⁸¹

Meanwhile, numerous advocacy groups have taken a stance against religious restriction of care, particularly on the subject of women's reproductive rights.⁸² In a January 2011 report, the National Women's Law Center ("NWLC") stated that religious-based limitations on treatment of pregnancy complications contravene the core principles which underlie

⁷⁸ Carlson, *supra* note 4, at 162.

⁷⁹ *Id.* at 163.

⁸⁰ *Id.* A total elimination of these services is not always, however, a necessary result of a merger. Some partnerships have succeeded in implementing more creative measures such as forming legally separate corporations to provide Church-prohibited services or implementing referral systems. *Id.* at 164–65.

⁸¹ See, e.g., *id.* at 164; Bill Hess, *Hospital, Carondelet to Terminate Deal*, THE ARIZ. RANGE NEWS (Mar. 30, 2011 00:01), <http://www.willcox.rangenews.com/articles/2011/04/06/news/news24.txt> (Carondelet Health Network in Tucson, Arizona terminated its two year integrative network agreement with Sierra Vista Regional Health Center due to public opposition. The agreement allowed both parties to assess the mutual value of formalizing a long-term partnership. At issue was a prohibition on sterilization procedures that occurred at the Sierra Vista hospital as a result of the agreement).

⁸² See, e.g., CATHOLICS FOR CHOICE, <http://www.catholicsforchoice.org> (last viewed Mar. 4, 2012); *Health Care and Reproductive Rights*, NAT'L WOMEN'S LAW CTR., <http://www.NWLC.org/repro> (last viewed Mar. 4, 2012); THE MERGERWATCH PROJECT, www.mergerwatch.org (last viewed Mar. 4, 2012); PHYSICIANS FOR REPRODUCTIVE HEALTH, <http://www.prch.org> (last viewed Mar. 4, 2012).

federal and state law protection of patients.⁸³ In its report, the NWLC cites a study conducted by Ibis Reproductive Health which found that four serious lapses in care result from religious restrictions:

- (1) Doctors performed medically unnecessary tests, resulting in delays in care and additional medical complications for patients. These tests were done solely to address hospital administrators' concerns that the treatment complied with religious doctrine.
- (2) Doctors transferred patients with pregnancy complications because their hospitals' religious affiliation prohibited them from promptly providing the medically-indicated standard of care.
- (3) Hospital administrators interfered with doctors' ability to promptly provide patients with the standard of care.
- (4) Hospital administrators interfered with doctors' ability to provide patients with relevant information about their treatment options.⁸⁴

The Ibis study concluded that religious restrictions on reproductive care can unjustifiably place women's lives and health at risk, violating women's rights to receive the appropriate medical standard of care.⁸⁵ Concern also exists as to the legality of the Directives' informed consent requirements, which

⁸³ NAT'L WOMEN'S LAW CTR., BELOW THE RADAR: HEALTH CARE PROVIDERS' RELIGIOUS REFUSAL CAN ENDANGER PREGNANT WOMEN'S LIVES AND HEALTH 2 (2011), <http://www.nwlc.org/sites/default/files/pdfs/nwlcbelowtheradar2011.pdf>.

⁸⁴ *Id.* (Ibis Reproductive Health is a clinical and social science research organization).

⁸⁵ *Id.* at 14–15.

require physicians to provide the patient only with those care alternatives that are "reasonable and morally legitimate."⁸⁶

Controversy surrounding religiously restricted care has pervaded academia for at least the past decade, focusing predominantly on the conflict between patient autonomy, standard of care, and institutional religious autonomy. Many academics argue against Catholic restriction on care. The United States Congress and Supreme Court have also weighed in on the topic, consistently *supporting* the religious health care provider's right to refuse religiously-repugnant procedures.

IV. CONSCIENCE CLAUSES AND MEDICAL STUDENTS

A. THE "FEDERAL HEALTH CARE PROVIDER CONSCIENCE PROTECTION STATUTES"

America's legal institutions have traditionally upheld Catholic providers' right to practice medicine in conformity with religious mandates. The Church Amendments,⁸⁷ Section 245 of the Public Health Service Act,⁸⁸ and the Weldon Amendment,⁸⁹ collectively referred to as the "federal health care provider conscience protection statutes" ("federal conscience statutes"), prohibit certain entities from discriminating against health care providers who refuse to participate in religiously or morally objectionable medical practices.⁹⁰

⁸⁶ ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 2, at 20.

⁸⁷ 42 U.S.C. § 300a-7 (2006).

⁸⁸ 42 U.S.C. § 238n (2006).

⁸⁹ Consolidated Appropriations Act 2010, Pub. L. No. 111-117, § 508(d), 123 Stat. 3034, 3279–80.

⁹⁰ 45 C.F.R. § 88.1 (2011).

1. THE CHURCH AMENDMENTS

The Church Amendments, named after Senator Frank Church of Idaho,⁹¹ were enacted in 1973 in response to *Taylor v. St. Vincent's Hospital*.⁹² In that case, the plaintiffs brought an action to enjoin St. Vincent's Catholic hospital from refusing to perform a tubal ligation in combination with Mrs. Taylor's caesarian section delivery.⁹³ The Taylors obtained the injunction, and shortly thereafter Congress enacted the first federally mandated "conscience clause," the Church Amendments to the Health Programs Extension Act of 1973.⁹⁴ The Church Amendments allow health care providers—facilities and individuals alike—to refuse to perform religiously or morally objectionable services.⁹⁵ The Church Amendments function as a voluntary condition to the receipt of federal funding. Therefore, hospitals that do not receive federal money are not subject to its requirements.⁹⁶ Because Catholic hospitals regularly accept Medicare patients, they are subject to the conscience clause.⁹⁷

The Church Amendments' dual goals were to clarify the obligations of health care "facilities with regards to abortion, and create conditions for the receipt of government funding."⁹⁸ First, they prohibit public officials and authorities from requiring health care providers to perform, assist with, or provide facilities for abortion or sterilization procedures where it would be

⁹¹ Nicole Huberfeld, *Conditional Spending and Compulsory Maternity*, 2010 U. ILL. L. REV. 751, 777 n.181 (2010).

⁹² 369 F. Supp. 948 (D. Mont. 1973).

⁹³ *Id.* at 949.

⁹⁴ *See id.* at 951.

⁹⁵ 42 U.S.C. § 300a-7 (2006).

⁹⁶ *See id.*

⁹⁷ Ikemoto, *supra* note 77, at 1115.

⁹⁸ Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 145 (2003).

contrary to the provider's religious beliefs or moral convictions.⁹⁹ Second, they prohibit discrimination against employees who perform or assist with, or refuse to perform or assist with those procedures.¹⁰⁰ Many states have expanded the Church Amendments to also allow conscientious objection to contraception, sterilization, euthanasia, and artificial insemination.¹⁰¹

This conscience clause has several important implications for medical students and physicians. First and foremost, it forbids hospitals from discriminating against religious objectors.¹⁰² Second, religious hospitals may not discriminate against employees who perform religiously-prohibited procedures at separate facilities.¹⁰³ Finally, the Church Amendments deny a physician the right to perform religiously-prohibited procedures at a private religious institution when those procedures violate the hospital's policies.¹⁰⁴ The Church Amendments have been consistently upheld by the courts against both facial and constitutional challenges, and persist today as a valid act of congressional power.¹⁰⁵

2. SECTION 245 OF THE PUBLIC HEALTH SERVICE ACT

Section 245 of the Public Health Service Act ("Section 245") prohibits federal, state, and local recipients of federal funds from discriminating against health care entities on any of three bases:

- (1) The entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or

⁹⁹ 42 U.S.C. § 300a-7(b), (d) (2006).

¹⁰⁰ 42 U.S.C. § 300a-7(c), (e) (2006).

¹⁰¹ Carlson, *supra* note 4, at 165.

¹⁰² See 42 U.S.C. § 300a-7 (2006).

¹⁰³ See *id.*

¹⁰⁴ See *id.*

¹⁰⁵ *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308, 311 (9th Cir. 1974) (citing *Cary v. Curtis*, 44 U.S. 236 (1844)).

to provide referrals for such training or such abortions;

- (2) The entity refuses to make arrangements for such activities; or
- (3) The entity attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide, or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.¹⁰⁶

Like the Church Amendments, Section 245 defines the health care "entity" broadly to include individual physicians, postgraduate physician training programs, and participants in any type of medical training program.¹⁰⁷ The statute provides two main protections: (1) no medical program may have its accreditation revoked or denied because the institution refuses to offer abortion or sterilization training;¹⁰⁸ and (2) physicians and hospitals are free to refuse participation in abortion or abortion-related services for any reason, religious or otherwise.¹⁰⁹ Section 245 further clarifies that Title IX of the Education Amendments¹¹⁰ shall not be construed as prohibiting or requiring any individual or entity to provide or pay for abortion-related services.¹¹¹

¹⁰⁶ 42 U.S.C. § 238n(a) (2006).

¹⁰⁷ 42 U.S.C. § 238(c)(2) (2006).

¹⁰⁸ Huberfeld, *supra* note 91, at 777.

¹⁰⁹ *Id.*

¹¹⁰ 20 U.S.C. § 1681 *et seq.* (2006).

¹¹¹ JODY FEDER, CONG. RESEARCH SERV., RS 21428, THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS 2 (2005), *available at* <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>.

3. THE WELDON AMENDMENT

In 2005, the Hyde-Weldon Amendment ("Weldon Amendment") was passed as part of the Health and Human Services ("HHS") appropriation act and has been either readopted or incorporated by reference in all subsequent HHS appropriations acts.¹¹² This conscience statute requires federal funds to be disbursed only to those federal agencies that honor conscience clauses.¹¹³ Like its predecessor, the Weldon Amendment is intentionally broad, protecting moral as well as religious objections.¹¹⁴

4. MODERN MEASURES: THE BUSH AND OBAMA FINAL RULES AND PPACA

Another recent addition to the federal conscience statutes is the 2008 Bush Final Rule.¹¹⁵ In fall 2008, the Bush Administration proposed a rule to ensure that Department of Health and Human Services funds do not support coercive or discriminatory policies or practices in violation of federal law.¹¹⁶ The final rule, enacted that December, attempted to clarify the federal conscience statutes and provide for their enforcement. It designated the Office of Civil Rights ("OCR") as the handler of all related complaints.¹¹⁷

¹¹² U.S. DEP'T OF HEALTH & HUMAN SERVICES, OVERVIEW OF FEDERAL STATUTORY HEALTH CARE PROVIDER CONSCIENCE PROTECTIONS, HHS.GOV, <http://www.hhs.gov/ocr/civilrights/faq/providerconsciencefaq.html> (last visited Mar. 20, 2011) [hereinafter HHS OVERVIEW].

¹¹³ Consolidated Appropriations Act 2005, Pub. L. No. 108-447, § 508(d), 118 Stat. 2809.

¹¹⁴ *Id.*

¹¹⁵ Rob Stein, *Obama Administration Replaces Controversial 'Conscience' Regulation for Health-Care Workers*, WASH. POST, Feb. 19, 2011, at A3.

¹¹⁶ 73 Fed. Reg. 50274 (Aug. 26, 2008) (to be codified at 45 C.F.R. pt. 88).

¹¹⁷ 73 Fed. Reg. 78072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88); 76 Fed. Reg. 9968-02 (Feb. 23, 2011) (to be codified at 45 C.F.R. pt. 88).

The Bush Final Rule also required that all health care providers receiving federal funds "certify" their compliance with the terms of the federal conscience statutes.¹¹⁸ In effect, the Bush Final Rule over-broadened the scope of the federal conscience statutes and placed an undue burden on the health care community.¹¹⁹ The public outcry was immediate.

In response to public dissatisfaction, the Obama Administration rescinded in part and revised in part the Bush Final Rule.¹²⁰ These changes were implemented via the Obama Final Rule which went into effect March 25, 2011.¹²¹ It adopts the purpose of the Bush Rule—providing enforcement of the federal conscience statutes—and allows the OCR to retain its position as handler of complaints.¹²² The primary changes instituted by the Obama Final Rule are the rescission of the certification requirement and the stripping of the previous statute's expansive definitions.¹²³ As a result of these

88). Notably, until the Bush Final Rule, the government provided no private means of redress for victims of conscience clause violations. Robin Fretwell Wilson, *Empowering Private Protection of Conscience*, 9 AVE MARIA L. REV. 101, 103 (2010). The effectiveness of these "enforcement provisions" is another issue in and of itself. A number of scholars argue that HHS holds too much discretion in deciding whether or not to bring an action, leaving victims powerless in the face of inaction.

¹¹⁸ 73 Fed. Reg. 78072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).

¹¹⁹ 76 Fed. Reg. 9968 (Feb. 23, 2011) (to be codified at 45 C.F.R. pt. 88). Bush's Final Rule went into effect on January 20, 2009, except that its certification requirement never took effect, as it was subject to the information collection approval process of the Paperwork Reduction Act (never completed).

¹²⁰ 76 Fed. Reg. 9968-02 (Feb. 23, 2011) (to be codified at 45 C.F.R. pt. 88).

¹²¹ *Id.*

¹²² *See id.* at 9972.

¹²³ *Id.* at 9974–77.

changes, the federal conscience statutes are more likely to provide a slightly narrower range of protection in the future.¹²⁴

The most recent addition to federal conscience clause legislation belongs to the Patient Protection and Affordable Care Act ("PPACA").¹²⁵ The PPACA provides new health care provider conscience protections within the proposed health insurance exchange program.¹²⁶ Specifically, § 1303(b)(4) provides that "[n]o qualified health plan offered through an exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions."¹²⁷ A March 2010 Executive Order issued by President Obama affirmed that under PPACA the federal conscience statutes will remain intact and new protections will prohibit discrimination against health care facilities and health care providers in the area of abortion.¹²⁸

B. IMPLICATIONS FOR MEDICAL STUDENTS

The federal conscience statutes seek to ensure that no individual, medical program or hospital is discriminated against on the basis of availability of training in abortion procedures.¹²⁹ This affects medical students in two respects. First, the legislation affects how freely students may pursue

¹²⁴ Republican congressmen have already stated their dissatisfaction with Obama's changes to the Bush Final Rule. In fact, Representative Joe Pitts (R-Pa) has already sponsored the "Protect Life Act" which is intended to write more protections into the federal conscience statute legislation. Stein, *supra* note 115.

¹²⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Pub. L. No. 111-152).

¹²⁶ HHS OVERVIEW, *supra* note 112.

¹²⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303(b)(4), 124 Stat. 119, 899 (2010) (as amended by Pub. L. No. 111-152).

¹²⁸ Exec. Order No. 13535, 75 Fed. Reg. 15599 (Mar. 24, 2010).

¹²⁹ HHS OVERVIEW, *supra* note 112.

specialty practice after graduation. Second, it influences where medical students may realistically seek medical education and training. Medical school programs may refuse to provide certain abortion education while also refusing to provide arrangements for students who wish to receive such training on the premises.¹³⁰ The same is true for residency programs.¹³¹ As a result, students applying to medical and residency programs must educate themselves as to the range of training those prospective programs offer.

When selecting the ideal medical school, the average applicant must consider a number of variables. A student whose interests lie in one of the more religiously controversial specialty areas, e.g., obstetrics and gynecology ("OB/GYN") or family practice, often has even more criteria to consider. Before a medical school interview, the student should research the institution's religious affiliation, curriculum, and clinical opportunities. At the interview, the student should inquire as to restrictions in procedures and prescription-writing as well as the amount of time generally spent in lecture and clinic on religiously-restricted areas of interest.¹³²

These same inquiries should be made prior to applying for residency. The medical residency program is characterized as the post-graduate medical education a student pursues after receiving an M.D., and one of the most important stages in the formation of the student's medical knowledge.¹³³ During residency, the physician develops expertise in a medical specialty,

¹³⁰ 42 U.S.C. § 238(n) (2006).

¹³¹ *Id.*

¹³² See *OB/GYN or Family Practice*, MED. STUDENTS FOR CHOICE, <http://www.medicalstudentsforchoice.org/index.php?page=ob-gyn-or-family-practice> (last visited Mar. 20, 2011). In a survey conducted by Medical Students for Choice, most students surveyed who asked questions about abortion training reported that they did not encounter any overt anti-choice interviewers.

¹³³ *St. Agnes Hosp. v. Riddick*, 748 F. Supp. 319, 320–21 (D. Md. 1990).

such as family practice or obstetrics and gynecology.¹³⁴ Because the federal conscience statutes allow Catholic hospitals to forego training as to religiously-prohibited procedures, students who desire training in any restricted areas should either avoid Catholic residency programs altogether or prepare to arrange for supplemental training. Those students must also be aware that some *non*-Catholic institutions abstain from providing certain training.¹³⁵ According to Medical Students for Choice, a non-profit medical student advocacy group, only fifty-eight OB/GYN residency programs offer training in abortion and family planning.¹³⁶ In response to this statistic, the National Abortion Federation provides medical students with training at its member clinics.¹³⁷ Student advocacy groups have also pledged to provide funding for students seeking supplemental abortion training.¹³⁸

Accreditation is yet another facet of medical education influenced by the federal conscience statutes. Accreditation is the process through which the Accreditation Council for Graduate Medical Education ("ACGME") and its twenty-eight review committees assure "medical students, residents, specialty boards, and the public that residency programs meet established educational

¹³⁴ *Id.*

¹³⁵ A 1998 Study of abortion training in OB/GYN residency programs revealed that 9 percent of public program residents and 8 percent of private non-church program residents received no abortion training whatsoever. See Rene Almeling, Lauren Tews & Susan Dudley, *Abortion Training in U.S. Obstetrics and Gynecology Residency Programs, 1998*, 32 FAMILY PLANNING PERSPECTIVES 268, 270 (2000), available at <http://www.guttmacher.org/pubs/journals/3226800.pdf>.

¹³⁶ *Abortion Training: Residency Guides*, MED. STUDENTS FOR CHOICE, <http://www.medicalstudentsforchoice.org/index.php?page=residency-guides> (last visited Mar. 20, 2011).

¹³⁷ *Training Opportunities*, NAT'L ABORTION FED'N, http://www.prochoice.org/education/resources/medical_students.html (last visited Mar. 20, 2011).

¹³⁸ See, e.g., *Abortion Training*, MED. STUDENTS FOR CHOICE, <http://www.medicalstudentsforchoice.org/index.php?page=funding-program> (last visited Mar. 20, 2011).

standards for graduate programs in the various medical specialties."¹³⁹ In other words, accreditation constitutes the proverbial stamp of approval for medical and residency programs. In its standards for OB/GYN residency programs, the ACGME provides:

No program or resident with a religious or moral objection shall be required to provide training in or to perform induced abortions. Otherwise, access to experience with induced abortion must be part of residency education Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral, or legal restriction that prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive satisfactory education and experience in managing the complications of abortion¹⁴⁰

This language has substantial implications for OB/GYN residents who desire abortion training as well as those who do not. For students interested in abortion training, this guideline makes it clear that residency programs need not provide it on their premises.¹⁴¹ Furthermore, the requirement of supplemental training appears to apply only to training in complications of abortion, not inducement.¹⁴² For all OB/GYN residents, this standard presents the risk that a failure to adequately train in abortion complications, either on-

¹³⁹ *St. Agnes Hosp. v. Riddick*, 748 F. Supp. 319, 321 (D. Md. 1990); THE ACGME AT A GLANCE, ACGME.ORG, http://www.acgme.org/acWebsite/newsRoom/newsRm_acGlance.asp (last visited Mar. 20, 2011).

¹⁴⁰ ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., ACGME PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION IN OBSTETRICS AND GYNECOLOGY, [www.ACGME.org](http://www.acgme.org), 13 (Jan. 2008) http://www.acgme.org/acWebsite/downloads/RRC_progReq/220obstetricsandgynecology01012008.pdf.

¹⁴¹ *Id.*

¹⁴² *Id.*

site or otherwise, could result in a program's loss or denial of accreditation.¹⁴³ Consequently, OB/GYN residents who desire such training must take special care to ensure that the programs to which they apply either offer on-site training or adequate opportunities to receive that training elsewhere.¹⁴⁴

Illustrating this point is *St. Agnes Hospital v. Riddick*, a case in which a Catholic hospital's accreditation was revoked in part due to a prohibition on residents from obtaining abortion training either on-site or elsewhere.¹⁴⁵ Citing the federal conscience clause statutes, the hospital motioned the court for an injunction to have its accreditation reinstated.¹⁴⁶ The court denied the injunction on the grounds that the Catholic hospital could have complied without compromising its principles by allowing students to receive abortion training through a separate program. Thus, it was not burdened by the ACGME's requirements.¹⁴⁷ The court further upheld the ACGME standards upon finding that they establish medical standards and are not recriminatory in nature.¹⁴⁸ This decision prompts students to be wary of programs that do not offer the full range of training for their specialty, especially where programs resist its residents' efforts to receive that training elsewhere. Where students are not careful, they may risk receiving training from a non-accredited program.

In addition to their effect on education, training, and accreditation, the federal conscience statutes also greatly impact physicians' freedom to practice medicine. One common provision of the federal conscience statutes supports the Catholic hospital's right to restrict religiously-repugnant services without fear of legal recourse.¹⁴⁹ Catholic hospitals may also require physicians to

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ 748 F. Supp. 319, 320 (D. Md. 1990).

¹⁴⁶ *Id.* at 343.

¹⁴⁷ *Id.* at 328.

¹⁴⁸ *Id.* at 342.

¹⁴⁹ See HHS OVERVIEW, *supra* note 112.

sign, as a pre-requisite to privileges or employment, a statement obligating them to abide by the Directives while on hospital premises.¹⁵⁰ These contracts are binding under the federal conscience statutes.¹⁵¹ For example, in *Watkins v. Mercy Medical Center*, a Catholic hospital refused to renew the plaintiff's staff privileges because he would not sign an agreement to practice medicine in accordance with the Directives.¹⁵² The district court denied the plaintiff's injunction to reinstate his privileges, stating that the Church Amendments could not require a hospital to allow certain procedures to be performed on its premises.¹⁵³ Upon review, the Ninth Circuit reinstated the physician's privileges so long as he would comply with the Directives while on the Catholic hospital's premises; he remained free to offer religiously-prohibited services at separate and unrelated facilities.¹⁵⁴

Watkins provides the medical profession with three important take-away points. First, a hospital may neither revoke nor deny a physician's privileges because the physician supports certain religiously-repugnant procedures.¹⁵⁵ Second, a physician's privileges *may* be revoked or denied if he/she refuses to refrain from performing those procedures at the private religious institution.¹⁵⁶ Finally, a private religious hospital may mandate compliance with the Directives on its own premises.¹⁵⁷ It may not, however, forbid a physician from violating the Directives in other courses of employment.¹⁵⁸

¹⁵⁰ Monica Sloboda, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140, 143 (2001).

¹⁵¹ See *Watkins v. Mercy Medical Center*, 520 F.2d 894 (9th Cir. 1975).

¹⁵² *Watkins v. Mercy Medical Center*, 364 F. Supp. 799, 800 (D. Id. 1973).

¹⁵³ 364 F. Supp. 799 at 803–04.

¹⁵⁴ *Watkins v. Mercy Medical Center*, 520 F.2d 894 at 895–96.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

Despite case law upholding physicians' rights under the conscience clause statutes, violations do undoubtedly occur. Take for example, the case of Dr. Yogendra Shah, chair of the OB/GYN department at St. Elizabeth's Catholic Hospital.¹⁵⁹ Dr. Shah regularly performed abortions at a non-affiliated private clinic.¹⁶⁰ St. Elizabeth's, which had known of his activities for five years, eventually replaced Dr. Shah after succumbing to pressure from an anti-abortion group.¹⁶¹ In a press interview, the hospital alluded to the federal conscience statutes, admitting that it had been unable to fire Dr. Shah outright or revoke his privileges.¹⁶² In a similar case, Dr. Schales Atkinsons was denied privileges at Deaconess (Methodist) Hospital for demanding that he be allowed to perform abortions at a separate, non-Catholic facility.¹⁶³ The problem in these cases is that the physicians had no effective means of redress. Because the Obama Final Rule mandates enforcement of the federal conscience statutes, physicians whose rights have been violated may now file complaints with the Office of Civil Rights.¹⁶⁴ This strengthens the health care provider's claims for protection.

V. CONTEMPLATING BELIEFS—THE PROFESSIONAL PLAN

Many scholars acknowledge the growing tension between a physician's personal beliefs and her professional responsibilities.¹⁶⁵ In a creatively-titled law review article, one scholar phrases the issue of religiously-restricted care

¹⁵⁹ Jon Dougherty, *Abortionist Replaced at Catholic Hospital*, WORLDNETDAILY.ORG (Dec. 14, 2000, 1:00AM), <http://www.wnd.com/index.php?fa=PAGE.printable&pageId=2261>.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ Eisenstadt, *supra* note 98, at 152.

¹⁶⁴ 45 C.F.R. § 88.1-2 (2011).

¹⁶⁵ Martha S. Swartz, *"Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL'Y L. & ETHICS 269 (2006).

in terms of "conscience clauses versus unconscionability."¹⁶⁶ Another academic has presented it more delicately, characterizing it as the competition between patient care and religious integrity.¹⁶⁷ However posed, the underlying question is clear: Whose autonomy wins—the patient's or the provider's? The relevant academic literature has focused predominantly on the answer's implications for patients. However, another demographic deserves equal attention: medical students. This section suggests one method for communicating to medical students and residents the role this issue will play in their education and careers.

In 1998, the Association of American Medical Colleges ("AAMC") published a report announcing its official key learning objectives for medical students, the first of these being the trait of altruism.¹⁶⁸ The AAMC guidelines describe the altruistic physician as one who understands the ethical precepts of the profession as well as her own legal obligations.¹⁶⁹ A physician must "act with integrity, honesty, respect for patients' privacy, and respect for dignity of patients . . . [and] avoid being judgmental when the patients' beliefs and values conflict with [her] own."¹⁷⁰ Medical schools must ensure that

¹⁶⁶ *Id.*

¹⁶⁷ Boozang, *supra* note 77.

¹⁶⁸ AM. ASSOC. OF MED. COLL., LEARNING OBJECTIVES FOR MEDICAL STUDENT EDUCATION: GUIDELINES FOR MEDICAL SCHOOLS 4 (1998) [hereinafter LEARNING OBJECTIVES]. The AAMC represents 137 accredited U.S. medical schools and approximately 400 teaching hospitals and health systems. ABOUT THE AAMC, AAMC.ORG, <https://www.aamc.org/about> (last visited Apr. 15, 2011). It strives to "lead its [member institutions] in the advancement of medical education in the United States, and the establishment of a common policy among medical colleges in the more important matters of college management." AAMC HISTORY, AAMC.ORG, https://www.aamc.org/about/history/130726/aamc_history.html (last visited Apr. 15, 2011). Together with the American Medical Association, the AAMC co-sponsors the LCME. SERVICES, AAMC.ORG, <https://www.aamc.org/services> (last visited Apr. 15, 2011)).

¹⁶⁹ LEARNING OBJECTIVES, *supra* note 168.

¹⁷⁰ *Id.*

students receive all pertinent training and are able to demonstrate prior to graduation "knowledge of the theories and principles that govern ethical decision making, and of the major ethical dilemmas in medicine, particularly those that arise at the beginning and end of life."¹⁷¹ These objectives, published during the hospital industry's "merger mania," lay the groundwork for the formation of what this article refers to as the medical student's "professional plan."

The legal and moral issues discussed in this article may heavily impact medical students' decisions regarding where to complete their studies and seek employment. Therefore, in order to purposefully direct their medical careers according to their own personal belief-system, medical students should be required to: (1) engage in an active contemplation of their moral and religious beliefs prior to entering a graduate medical program; and (2) use the results of that process to form a professional plan. Development of the professional plan will ideally take place in two contexts: an undergraduate advising session and a mandatory graduate bioethics course.

A. UNDERGRADUATE ADVISING SESSION

All pre-med undergraduate students are tasked with an important decision that will shape the remainder of their medical training, where to apply to medical school. Because the offering of curricular experiences varies between programs, it is important for medical school hopefuls to select the one most in-line with their career goals.¹⁷² This, however, requires pre-med students to have developed some career goals by the time they apply.¹⁷³ To assist the formation of those goals, pre-med students should be required to meet with a career advisor in the fall semester of the third year of

¹⁷¹ *Id.*

¹⁷² AM. ASSOC. OF MED. COLL. GETTING INTO MEDICAL SCHOOL, <https://www.aamc.org/students/considering/85114/gettingin/> (last visited Mar. 20, 2011).

¹⁷³ *See id.*

undergraduate study.¹⁷⁴ The advisor's dual responsibilities in the advising session are to provide the student with a background in the legal issues discussed herein and encourage the student to weigh his/her moral and religious beliefs in the context of those issues. At the completion of this advising session, the advisor should present the student with the "professional plan"—a document or folder that will be kept both in the student's educational and personal records as a basis for his/her medical education decisions.¹⁷⁵

In the event that the undergraduate institution cannot afford to fund the suggested one-on-one advising sessions for its pre-med students, two feasible alternatives may be implemented. First, the undergraduate institution might consider holding a one-day group advising session for its pre-med students. Second, the AAMC might sponsor the advising session as a part of the Medical College Admissions Test ("MCAT[®]") process. Interestingly, the AAMC has already taken a step in this general direction, announcing in its March 2011 "Preliminary Recommendations for [the] New MCAT[®] Exam" that it may revise the exam to place more emphasis on behavioral and social studies.¹⁷⁶

¹⁷⁴ The AAMC reports that 90 percent of medical students apply at the end of their junior (third) year. *Id.* Holding the advising session in the fall semester of that year ensures students will be presented with pertinent information far enough in advance to play a realistic role in the application process.

¹⁷⁵ While part of the student's official academic record, the professional plan shall be kept separate from the transcript and other documents which accompany the medical school application. The professional plan shall be kept confidential and shall not be submitted to the prospective medical school programs.

¹⁷⁶ Ass'n of Am. Med. Coll., *AAMC Releases Preliminary Recommendations for New MCAT[®] Exam* (Mar. 31, 2011), <https://www.aamc.org/newsroom/newsreleases/2011/182652/110331.html>. The proposed changes aim to "direct attention to the behavioral and social sciences by: (1) Adding a new test of the behavioral and social sciences concepts that lay the foundation for medical students' learning about the human and social

B. MANDATORY BIOETHICS CURRICULUM

To provide ethical medical care, physicians must receive adequate education concerning the controversial and ever-changing aspects of ethical medical practice. This includes the issue of religiously-restricted care.¹⁷⁷ Therefore, once a student enrolls in medical school, the professional plan should be further developed through a mandatory bioethics course. Bioethics, a "branch of applied ethics that studies the philosophical, social, and legal issues arising in medicine and the life sciences," is ideal for addressing the issues discussed herein.¹⁷⁸ The course ideally would allow students to confront both the legal and moral realities of the practice of medicine and how those realities may be influenced by the beliefs of the physician or institution.

The Liaison Committee on Medical Education ("LCME") accreditation standards ED-22 and ED-23 currently require medical schools to provide training in "medical ethics" and "cultural bias."¹⁷⁹ However, nowhere in its standards does the LCME reference bioethics or legal issues specifically.¹⁸⁰ While accreditation organizations require medical schools to provide professional ethics training to their students, the bar for compliance is set relatively low and many courses omit important subjects that bioethics

issues of medicine; and (2) Revising the current verbal section to test the way examinees reason through passages in ethics and philosophy, cross-cultural studies, population health, and other subjects to communicate the need for students to read broadly in preparing for their medical education." *Id.*

¹⁷⁷ S. Van McCrary, *The Role of Bioethics in Medical Education: A Crucial Profession Under Threat*, ACTIONBIOSCIENCE.ORG (Apr. 2001), <http://www.actionbioscience.org/biotech/mccrary.html>.

¹⁷⁸ *Bioethics*, ENCYCLOPEDIA BRITANNICA ONLINE, <http://www.britannica.com/EBchecked/topic/65851/bioethics> (last visited Mar. 20, 2011).

¹⁷⁹ LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL 11 (2010), <http://www.lcme.org/functions2010jun.pdf>.

¹⁸⁰ *See id.*

addresses.¹⁸¹ Thus, while every medical program must arguably provide some degree of ethics training, their approaches are far from uniform.¹⁸² According to one source, the range of instructional hours devoted to bioethics currently spans anywhere from four to two hundred hours.¹⁸³ For some institutions, a stand-alone course in ethics is not even required.¹⁸⁴ In light of this gross disparity, mandatory bioethics curriculum is the most effective way to ensure adequate education concerning ethical controversies and current legal standards.¹⁸⁵

If feasible, the course should be taught by a bioethicist in order to guarantee that legal information is reliably relayed to physicians by a person from the legal field.¹⁸⁶ Bioethicists are professionals who are frequently trained in specific aspects of medical law and may themselves be physicians, making them capable of relating to students on a medical level.¹⁸⁷ The bioethicist must challenge students to identify their individual views on

¹⁸¹ Van McCrary, *supra* note 177.

¹⁸² See AM. SOC'Y FOR BIOETHICS AND HUMANITIES, ASBH TASK FORCE ON ETHICS AND HUMANITIES EDUCATION IN UNDERGRADUATE MEDICAL PROGRAMS 2 (2009), <http://www.asbh.org/uploads/files/pubs/lcmereport.pdf>.

¹⁸³ *See id.*

¹⁸⁴ See, e.g., UNIVERSITY OF KENTUCKY COLLEGE OF MEDICINE, CURRICULUM OVERVIEW, <http://www.mc.uky.edu/meded/curriculum/curriculumoverview.asp> (last visited Mar. 20, 2011). To be sure, the University of Kentucky College of Medicine does include "Medical Ethics and Professionalism" as a topic within the broad scope of the courses, "Introduction to Clinical Medicine," "Introduction to Clinical Medicine II," and "Internal Medicine and Emergency Care." However, the only separate bioethics or medical ethics courses are offered as Spring electives.

¹⁸⁵ (Research suggests that after a course in bioethics, physicians have a more subtle understanding of ethical issues and are better able to analyze relevant issues critically.) Van McCrary, *supra* note 177.

¹⁸⁶ Van McCrary, *supra* note 177.

¹⁸⁷ *Id.*

current issues, such as the extent and ethicality of religious providers' influence on the provision of care. Specifically, students should participate in conversations and exercises designed to determine which schools of thought to which they proscribe.

For example, there are generally two opposing views on the topic of religious restriction on care. One camp believes that physicians who prioritize personal moral objections over patient health fail to fulfill their professional responsibilities.¹⁸⁸ On the other side of the argument are many scholars and medical professionals who believe that religion not only shapes our morals, but constitutes the "ethical rubric" by which physicians should perform their medical duties.¹⁸⁹ The medical student's education and practice will inevitably be affected by which view (if either) he/she shares. Perhaps religious objection will deter him/her from pursuing a career in certain specialties or encourage him/her to pursue Catholic health care. Another outcome might be that a student's lack of religious objection would steer him/her toward non-sectarian residency programs and hospitals. Yet a third result might be that a student's revelation of personal beliefs might encourage him/her to join or form an advocacy group either against or in support of certain medical procedures.

The student's reflections and modified career goals should be duly recorded in the professional plan. Specifically, any religious objections identified by the student should be documented in addition to a plan for addressing situations in which such objections might materialize. Finally, the student should identify her intended recourse for discrimination if it were to arise. Although this article has focused predominantly on abortion training, bioethical conversations should include all areas of potential controversy, e.g., sterilization, end-of-life decision-making, contraception, etc. Finally, the course should stress the necessity of continued medical education, and in particular the ever-changing field of bioethics.

¹⁸⁸ Eisenstadt, *supra* note 98, at 150.

¹⁸⁹ Edmund D. Pellegrino, *The Medical Profession as a Moral Community*, 66 BULL. N.Y. ACAD. MED. 221, 222–23 (1990).

VI. CONCLUSION

Most students enter into medical school programs with aspirations of helping others, gaining prestige, and earning large incomes. Few enter with a full understanding of the complex legal and bioethical issues they will inevitably face throughout the course of that education. Would those students pursue the practice of medicine if they did? And, if so, would they pursue the same area of specialty?

It is the job of undergraduate and graduate medical institutions to compel their medical students to confront these important issues in order to determine if and how their personal belief-systems accord or conflict with the chosen institution and the course of study. Morality is not simply a personal trait that dictates the actions in our personal lives and relationships. Rather, "[m]orality is part of the unavoidable, bittersweet drama of being persons who think and feel and choose."¹⁹⁰ It influences every aspect of our lives *including* our professions. Thus undergraduate and graduate medical institutions must endeavor to take on this important task in order to better prepare their students for what lies ahead.

¹⁹⁰ David Bard, *Cool Quotes for Bioethics*, CSS Bioethics Blog (Feb. 3, 2010), <http://cssbioethics.blogspot.com/2010/02/cool-quotes-for-bioethics.html>.