

# Protecting the Right of Informed Conscience in Reproductive Medicine

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*This essay sets down three directives for conscientiously objecting clinicians—physicians, particularly obstetrician/gynecologists, trained in NaProTechnology by the Pope Paul VI Institute and Creighton University School of Medicine and any medical professionals who share their natural law vision of reproductive health care—to protect their right to well-formed conscientious objection in reproductive medicine. Directive one: understand the nature of a well-formed conscience and its rightful exercise. Directive two: fulfill all reasonable American College of Obstetricians and Gynecologists' requirements for conscientious refusal. Directive three: execute a political strategy to protect health-care conscience rights.*

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## I. INTRODUCTION

Launching conscientious objection in health care was the first legal counterpunch to *Roe v. Wade*. Almost immediately after the US Supreme Court struck down state laws prohibiting abortion, states began to enact conscience clauses. Within 1 year of the 1973 Supreme Court ruling, 27 states had already enacted laws protecting health-care professionals who conscientiously refused to perform abortions.<sup>1</sup> Today, 47 states provide varying levels of protection for health-care rights of conscience. Illinois and Mississippi have “broad protections for all health-care providers in all health-care settings;”

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the other 45 states have health-care conscience laws that typically protect physicians who object to abortion (Martin, 2007, 463–4). Some within the last category, however, also protect clinicians who conscientiously object (CO) to a range of elective procedures: euthanasia, sterilization, artificial insemination, abortifacient drugs, and contraception (Kramlich, 2002).

Recently, abortion activists, together with proponents of “full reproductive health services,” have ramped up their campaign<sup>2</sup> against CO through the voice of the American College of Obstetricians and Gynecologists (ACOG), in a statement from its ethics committee (ACOG COE, 2007, 1–6). ACOG sets down limitations<sup>3</sup> on any of its members who conscientiously refuse to participate in abortion, contraception, sterilization, or lesbian parenting. Although difficult to predict, a plausible outcome to this organized attack on CO is unjust discrimination at the least and constitutional controversy at the most.<sup>4</sup> Obstetrician gynecologists (OB/Gyns) might find themselves having to choose between either suppressing their conscientious clinical judgments or withdrawing from the practice of medicine.<sup>5</sup>

In this essay, I am advising a relatively small group of conscientiously objecting clinicians—physicians, particularly OB/Gyns<sup>6</sup>, trained in NaProTechnology (NPT) by the Pope Paul VI Institute and Creighton University School of Medicine.<sup>7</sup> But the directives for protecting CO in health care that I propose here are equally applicable to physicians who have independently decided not to offer abortion, contraception/sterilization, or refer for in vitro fertilization.

## II. DIRECTIVE ONE: UNDERSTAND THE NATURE OF A WELL-FORMED CONSCIENCE AND ITS RIGHTFUL EXERCISE

The etymology of the English word conscience is the Latin derivative *cum scientia* meaning “with knowledge.” This literal meaning of conscience—the ability of a human being to act with knowledge or to act with “a cknowing of the truth” (Ratzinger, 1991)<sup>8</sup>—grounds the Church’s natural law understanding of conscience and its doctrine of living according to conscience. The Church teaches that human beings act conscientiously when they intelligently apply the objective moral truth of their human nature (discovered by reason and confirmed by their faith) to the concrete choices and decisions of their life.

But what is the source of conscience that human capacity to pursue and do the good “with knowledge?” The first is human nature that fundamental organization of human persons by which biologists and psychologists empirically distinguish *homo sapiens* from other animals. We humans, unlike animals, are able to know our innate human needs and their relative importance for our well-being. Thus, conscience at the ontological level involves the knowledge associated with an inner moral sense summoning each of us to the objective truth of loving and pursuing the good and avoiding evil. This natural capacity to make conscientious judgments about our behavior comes

from “the godlike constitution of our being” (Ratzinger, 1991, 21), from the fact that we are made in the image and likeness of an all-good, intelligent, and free Creator. Directly due to our godlikeness, the good reverberates in the moral memory (*anamnesis*) of each of us. Which is to say, you and I have the capacity to hear the echo of that Original Goodness from within, so that, seeing the good, you and I know it: “That’s it,” we declare. “That is what our nature points to and seeks” (Ratzinger, 1991, 20). Or, seeing evil, you and I know it: “That is not good,” we proclaim. “That will not satisfy the basic needs of our nature.” Thus, we all have the capacity to discover a natural law within us which has God as its origin. Due to our connaturality with the good, all of us naturally resonate with certain things and naturally shun, or clash with, other things.

All persons of all cultures, governments, medical societies, and medical professions can settle the veracity of the natural moral law by scientifically studying human nature and its needs. Both commonsense experience and empirical observation lead us to certain reasonable conclusions about human nature. Human persons are, by nature, physical beings. Without health, human beings cannot function well and will eventually die. Therefore, *health* is the most basic human need. Yet we all know that we do not live simply to be physically healthy but to do something with our healthy life. Moreover, children cannot become healthy, physically and psychologically, without help. This truth explains why evolution has adapted the human child to be raised in a *family*, by a father and mother who love each other and who love their children. With the social, psychological, and moral knowledge that rebound to children as a result of their family life, we see that family does much more for children than just assist them to be healthy. Yet, the family alone does not sufficiently satisfy all the needs of its individual members. All human beings, as a result, need a *society* of many individuals, each with their different gifts, skills, and professions, who can assist others in their acquisition of knowledge and in its eventual transmission to others. Finally, *knowledge* (knowing the truth of reality) is the most important of all human needs. Without it, we cannot realize lesser goods such as making a living, healing diseases, and procreating and educating our young. And knowledge is the *sine qua non* of being able to enjoy our integral human fulfillment, and even to transcend it, by knowing world cultures, history, and the wonders of the universe and its wise and good creator—God.

When we search for the moral significance behind the fact that we flourish only when our basic needs are satisfied through intelligent, free acts, we discover the universal, moral law of our human nature. The natural moral law—one we do not impose on, but discover within, our nature—summons us to “Do good and avoid evil.” When we ponder what this natural law of doing good and avoiding evil means, we discover that it is a law calling us to pursue the natural goal of our human life—to act in such a way as to “Do what will lead to true happiness and to avoid what prevents happiness.”

And, when we reflect further upon what acting for our happiness or integral fulfillment means, we conclude that it consists in pursuing those basic good things—health, family, society, knowledge of the truth—because they respectively satisfy every dimension of our nature (physical, social, spiritual), fulfill us integrally, and make us happy. In sum, we infer that we will be integrally happy—that is, acting according to the moral law of our nature—when our basic human needs for health, family, society, and knowledge of the truth are satisfied.

But theoretical knowledge of our basic human needs/goods is not enough. We must have practical knowledge of them in particular situations of our life. That is to say, we will only satisfy our basic needs for health, family, society, and knowledge of truth, when we realize these goods in their proper order in our everyday human behavior—in and through the concrete good choices, decisions, and actions of our life. If, in each of our particular acts with their peculiar circumstances, we instantiate the goods of health, family, society, and knowledge and avoid doing actions that deny these basic needs, we will become good; we will be happy; and we will be integrally fulfilled. By putting the theoretical knowledge of our basic human needs into practice, we will be acting, in the concrete, in ways that realize the basic goods of our nature, together with their respective satellite values.

The second source of conscience, then, is at the level of *praxis*, the level of making actual decisions in the particular circumstances of our life. This practical designation is the traditional or strict sense of conscience, and it is the one operative when we talk about conscientious objection on the part of physicians. On this practical level, conscience is an act of knowledge, an act of judgment, by which persons apply their ontological conscience—their general knowledge of moral truth—to an act they are now doing, they have done in the past, or are about to do in the future. Practical conscience, then, is a well-executed judgment by which persons recognize that a concrete act, because it conforms to their natural moral truth, is a true good, summoning them to do it. Or, practical conscience is a well-executed judgment enabling persons to recognize that a particular action, because it fails to comport with their natural moral law, is truly evil, summoning them to shun it.

As we can see, the concept of a well-executed judgment refers to the complementary work of both the theoretical and practical intellect in acting uprightly in all of life's situations. Thus, though each of us have only one intellect, we use it in two different ways within the moral life: First, to understand theoretical truths: the fundamental moral law of pursuing the natural end of happiness by doing good and avoiding evil. And, second, we use our intellect to grasp practical truths: the ordered fulfillment of practical goods to be obtained in particular human acts that contribute to the person's happiness or integral human fulfillment. When NPT physicians, for instance, assess the morality of a particular medical intervention, they apply their theoretical knowledge of the natural moral law (ontological conscience) to

their practical knowledge of the medical service that they are presently providing, have provided in the past, or are about to provide in the future.

In the conscientious judgments of an NPT physician, then, “the needle” of the basic moral knowledge (ontological conscience) that summons him/her to do good and avoid evil—the universal truth of the natural moral law—“hits the vinyl” of an everyday, concrete medical intervention and its particular moral truth (practical conscience). When conscientiously considering a medical service they have provided in the past, are presently providing, or are thinking about providing in the future, NPT physicians evaluate, by the inner light of their practical conscience, how the particular service conforms to the fundamental norm of the natural law “Do good and avoid evil,” a law summoning them to “Satisfy basic human needs of health, family, society and truth in their order of importance.”

In providing FertilityCare to their patients, NPT physicians conscientiously adjudicate that this method of family planning is particular good because it conforms to the universal moral truth about human fulfillment. By this I mean, the NaPro-trained physician repeatedly observes that the practical knowledge of FertilityCare helps a woman make certain decisions reasonably. First, its system of cyclic charting gives her the biofeedback to better understand her body and what it needs to be healthy. Second, knowledge and appreciation of her fertility enables her to understand family (i.e., sexual) morality and her responsibilities to her husband in keeping their acts of intimate sexual love chaste, that is, open to the procreative good that demands, defines, and activates their “one-flesh” communion. Third, because FertilityCare provides what she needs to maintain reproductive health and to plan her family in a good way, the patient trusts her NPT physician—an important feature of a good society. She is convinced that, in recommending the FertilityCare System, her physician is actively honoring his fiduciary responsibility to give first priority to her well-being. Finally, the knowledge she acquires from the use of FertilityCare helps her to know the truth of her vocation as a married woman: to come, with the help of her husband and the quality of the life-giving love they consistently share, to enjoy the ultimate goal of her life: eternal union with God. In this way, the woman fulfills the central teaching of Jesus to “love God above all and neighbor as self,” fulfilling her obligations to her own nature, to that of her husband and children, and to the common good of society.

Their professional experiential knowledge, then, helps NaPro-trained physicians realize how perfectly the Church’s teaching on family planning ratifies the practical truth of the FertilityCare System. They begin to appreciate that Catholic marital and sexual morality is informed, first, by millennia of the Church’s careful attention to, and observation of, human beings. Accordingly, the sole objective of Catholic doctrine on the regulation of fertility is to help married couples nourish the memory of their original goodness, strive for their integral fulfillment, and understand the causal links between their healthy marital sex, raising healthy children, and promoting a more wholesome society.

And, second, they understand more fully that all of Catholic sexual morality is framed by Jesus, God's definitively true Word, who teaches humans who they are and for what they have been made. Having more fully appreciated the synchronous relationship between natural and revealed moral truth, then, NPT physicians better understand why their conscientious judgment of the goodness of the FertilityCare System summons them to "Provide that!"

Similarly, NPT physicians conscientiously evaluate the morality of what they had previously been doing, namely, the prescription of contraception/sterilization. They apply, first, what they learn about contraception when considered in the light of the natural law and, second, what they can confirm about its morality through Catholic teaching. From the application of this general moral truth to their particular professional situation and that of their patients, their practical judgment—contraception destroys or suppresses basic human needs of women and, therefore, prevents their integral fulfillment—summons them to "Stop prescribing contraception!"

We have seen that the conscience of a NaPro-trained physician is a judgment about the moral quality of a particular medical intervention that summons him, "Provide FertilityCare" or "Don't provide contraception." But the command of this practical judgment falls short of execution. In order to fulfill the summons of his conscience, an NPT physician must carry out his conscientious judgments. That is to say, he must *will* not to do evil (not to provide contraception). And he must will to do the good (to provide FertilityCare). And to will to provide FertilityCare in his practice means that the physician's rational appetite or will, "loves the good, wants the particular good apprehended, consents to the means chosen by the intellect to achieve the good, freely chooses the act to be committed ... performs the truly good act, [and] is delighted when the act is done well" (Allen, 2004, 360).

Moral freedom, then, is the human capacity to will the good that a well-formed conscience commands us to do and to refuse to will the evil that an upright conscience commands us to shun. The right and the duty to follow one's well-formed conscience is a capacity conferred on us by nature, and no government can confer or rescind it. Likewise, neither a medical society such as ACOG nor patients can force physicians to give up the right and duty to refuse to participate in medical interventions that their upright conscience commands them to shun.

It is important to focus on the reason why coercing physicians to participate in immoral medical procedures is so humanly destructive. Forcing another human being to act against his/her well-formed conscience is a violation of that person who, by nature, tends to the true and the good and is only fulfilled by doing good. Coercing a human being to do evil radically compromises human dignity and human freedom (Paul II, 74). Hence, to participate in an immoral medical intervention such as the prescription of contraceptives or sterilization creates not only an external effect—the physicians' actions realize evil and its negative consequences outside themselves, that is, in the

patient and in the wider culture or society. But participation in evil also has an internal effect—the physicians themselves become evil in proportion to the wrongdoing involved in their cooperative act.

In the light of the nature of an informed conscientious judgment and the external and internal effects of wrongdoing, the right (and duty) of physicians to refuse to participate in intrinsically evil interventions such as abortion, contraception, and sterilization is absolute.<sup>9</sup> Correspondingly, ACOG has a duty, everywhere and always, to respect the right of OB/Gyns to exercise these well-formed judgments of conscience within their practice of reproductive medicine.

### III. DIRECTIVE TWO: FULFILL ALL REASONABLE ACOG REQUIREMENTS FOR CONSCIENTIOUS REFUSAL

The ACOG ethics committee statement stipulates that OB/Gyn members of ACOG may engage in CO (ACOG COE, 2007, 3–4)<sup>10</sup> if their exercise of conscience meets at least four conditions. Here I will list these specifications and discuss how a NaPro-trained OB/Gyn could, within reason, abide by them.

#### A Physician's CO Must Not Involve Imposition of His/Her Religious or Moral Beliefs on Patients

From the outset I would point out that concern about the imposition of morality could be avoided by means of a comprehensive notification plan. If NPT physicians inform their patients about services offered in their NPT specialty—and do so (1) through letter, in posted notices on waiting room walls, in patient brochures or with explanations from receptionists to prospective new patients and (2) *before* the inauguration of a physician-patient relationship, they will only attract women who want the kind of Fertility-Care/NPT specialty emblematic of their obstetric and gynecologic practice. In short, they will not find themselves in a relationship where their medical-moral convictions diverge drastically from those of their patients.

This kind of front-loaded notification defining a FertilityCare/NPT specialty implicates the provision of specific services and the elimination of others. First, the NPT-trained physician informs prospective patients that instead of prescribing contraceptives (hormonal, intrauterine device, barrier) for family planning purposes, the physician offers the FertilityCare System. This natural method of fertility regulation, with its standardized and prospective system of cyclic charting, provides the necessary biofeedback to empower the patient of normal fertility through acts of “fertility focused intercourse” to achieve or avoid a pregnancy readily and intelligently, that is, sensitive to the circumstances of their marriage and conducive to realizing the basic human goods of procreation and family.

Second, instead of prescribing contraceptives as treatment for the gynecological anomalies of dysmenorrhea, irregular cycles, polycystic ovarian syndrome (PCOS), endometriosis, ovarian cysts and PMS, the NaPro-trained

physician offers a panoply of medical and (near adhesion-free) surgical protocols. All the latter avoid the direct suppression of fertility and are implemented in cooperation with the woman's menstrual and fertility cycle. Furthermore, instead of referring subfertile or infertile patients to, or prepping them for, assisted reproductive technologies, the NPT physician will provide comprehensive diagnostics and surgical interventions that diagnose and treat the pathology underlying the infertility. In this manner, the physician not only offers the patient and her husband the opportunity to try to achieve a pregnancy within their own acts of intercourse but also empowers them to realize the basic good of health.

Third, instead of performing sterilizations, the NPT physician helps the patient to avoid pregnancy, temporarily or even indefinitely in the case of serious health reasons, in a way that respects her human dignity and her need for the goods of procreation and family.

Fourth, it means that in prenatal and perinatal care, instead of recommending or referring for abortion, the NPT physician manages pregnancies, including high-risk pregnancies and those involving chromosomal or genetic abnormalities, in a way that optimally promotes the best possible outcome for baby and mom. It means that, in the case of a woman who wants to attempt a pregnancy after repeat miscarriage, rather than offering minimal prenatal evaluation and treatment, the NPT-trained physician, first, provides thorough diagnostic evaluation and treatment of the underlying causes of repetitive miscarriage. Second, identifies early pregnancy by referencing the woman's chart. Third, administers early and continued support with progesterone and human chorionic gonadotropin to insure full-term delivery. Providing postnatal care means that instead of treating a woman suffering under postpartum depression with sometimes dangerous antidepressants (typically, selective serotonin reuptake inhibitors like Prozac), the NPT physician prescribes naturally compounded progesterone.

We have just focused on one scenario: NPT-trained physicians who are beginning their medical practice, have distributed appropriate notification regarding their FertilityCare/NPT specialty, and have attracted only those patients who want their variety of reproductive services. But what about the case of NPT physicians who are in the midst of transitioning from a contraceptive practice to a FertilityCare/NPT specialty? These physicians may still be phasing out uninterested patients who, because they did not read their notification letter, are not aware of their gynecologist's new specialty and, as a result, request contraception and sterilization as was their custom in the past.

In this situation, I recommend that, subsequent to advising the patient of their informed decision not to provide contraception and sterilization, the transitioning physicians also proffer the medical and moral rationale behind their decision. But, in this scenario, could provision of a medical/ethical explanation constitute an imposition of the physician's morality on the patient, as ACOG alleges?



If we correctly identify the difference between explanation and imposition, the answer is no. The sort of explanation included within front-loaded notification is no more an imposition of the physician's morals on patients than free speech is an imposition of the speaker's views on listeners. Reviewing the style and content of the recommended notification just recounted, we conclude that what the NPT physician is saying bears no resemblance to imposition. It is an infomercial, at best. Just as with any other advertisement, the NPT physician's explanation provides information and then allows the patient the freedom to inquire further, to challenge, to ask for clarification and, ultimately, to opt "for" or "out of" FertilityCare/NPT services. It is fair to say that nothing in the proposed physician's explanation coerces the patient into agreement with the clinician or forces the patient to act against her conscience. ACOG rightly insists that the promotion of patient well-being is the ultimate condition of whether to allow CO. I would contend that the physician notification described here—involving a mature, respectful give and take—encourages, rather than threatens, a patient's well-being.

Furthermore, I am convinced that any attempt by ACOG to restrict this type of expositional exchange on the specious grounds of moral imposition is very shortsighted. Such limitation of CO only helps to reinforce a vapid model of a physician—a technocrat in the mode of a medical vending machine. It also "dumbs down" the patient. It caricatures patients as persons so intellectually shallow as to be incapable of assessing the worthiness of a medical view of reproductive medicine different than their own—or as persons so volitionally weak as to be incapable of the will to either pursue their initial request elsewhere or to choose the NPT treatment alternative after having decided that it promotes their feminine health and well-being.

Related to the allegation of moral imposition is the claim that conscientiously objecting physicians would be acting hypocritically in refusing to provide "standard" OB/Gyn care. But this accusation fails completely. NPT physicians would only be hypocrites if they set the medical/moral standard for others and then did not comply to it themselves. According to their accreditation guidelines, NaPro-trained physicians cannot be certified unless their personal reproductive choices and their professional reproductive services are in line with those emblematic of a Fertility Care/NaProTechnology specialty.

#### A Physician's CO Must Not Negatively Affect Patients' Health

Implementation of the notification process before NPT physicians take on their first patients also circumvents the need to discuss the second of ACOG's concerns. And, when we analyze this criterion in reference to transitioning NPT physicians, we see that what it supposes is a red herring. A conscientious refusal to provide contraception does not, of itself, restrict the transitioning

patient from exiting the office of the NPT physician and getting her prescription renewed by a new gynecologist of her choice.

There is no direct causal link, then, between a transitioning physician's CO and an adverse effect on a patient's health. Just as the feminine consumer will go elsewhere when the first department store fails to carry her preferred brand of clothing without negatively affecting her self-concept as a competent shopper, so a woman wanting contraception or a tubal ligation could go elsewhere in face of her physician's conscientious refusal. And she could do so without suffering setbacks to her health, either psychological or physical. This conclusion is reinforced when viewed from a probability and statistics perspective. The number of OB/Gyns offering "standard" and "legal" reproductive services (in villages, towns, and cities all over the United States) far exceeds that of NaPro-trained physicians. It is safe to predict, then, that the female patient will not only find a physician to provide the medical intervention she wants but also she will do so expeditiously, that is, without undue inconvenience or loss of time and, certainly, without negatively impacting her health, mental, or otherwise.

We need to examine the case that ACOG presents to substantiate their claim that CO could pose a threat to a patient's health or life:

[A] 19-year-old [Nebraska] woman with a life-threatening pulmonary embolism at 10 weeks of gestation ... was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (ACOG COE, 2007, 1).

ACOG seems to imply that the threat to the woman's life from ambulance transfer could have been averted if the woman was granted her request for an abortion from the original physician. But ACOG's implicit approval of abortion as the indicated treatment for a pregnant woman suffering from pulmonary embolism (just because she seeks it) smacks of medical malpractice. In the estimate of several OBs and the neonatologist that I consulted, the patient's life was being threatened, not by her thromboembolism but by the fact that she was pursuing an abortion as "treatment" for her condition, rather than the standard of care for pregnancy-related venous thromboembolism (VTE). That assessment was confirmed by UpToDate, a mainstream online subscription service for OBs that features the latest clinical and medical research in the diagnosis and treatment of diseases associated with pregnancy. In none of its literature on VTE does this obstetric resource recommend abortion as an appropriate way to manage this condition in pregnant women. According to UpToDate, the most currently recommended management of pregnancy-related VTE is *to treat the mother's embolism*<sup>11</sup>:

VTE remains a major cause of morbidity and mortality during pregnancy. While every effort should be made to avoid exposing the fetus to unnecessary radiation, such concerns should not prevent the appropriate diagnostic pursuit of DVT [deep vein thrombosis] or PE [pulmonary embolism]. Documented VTE requires treatment

for the duration of pregnancy with either: Unfractionated heparin that is adjusted to maintain a heparin level of 0.2 to 0.4 U/mL by the protamine titration assay (usually with a PTT [partial thromboplastin time] that is 1.5 to 2.3 times the control value). Or LMW [low molecular weight, heparin] titrated to achieve anti-Factor Xa levels of approximately 0.5 to 1.2 U/mL mixture 4 hours after injection. Regardless of the heparin regimen used, a total duration of anticoagulation of 3 to 6 months (including a 4 to 6 week course of warfarin after delivery, with dose adjustment to maintain an INR [international normalized ratio] of 2.0 to 3.0) should be given.<sup>12</sup>

What would help NPT-trained physicians to take this “negative impact on health” restriction more seriously is if OB/Gyns espousing ACOG’s “standard of care” and “full reproductive services” would also abide by it. A counter-example from an NPT physician illustrates how introduction of a double standard into this requirement has negatively impacted a woman’s health:

A female patient previously treated long-distance for abnormal bleeding by an NPT physician approached her local OB because of another episode of heavy bleeding. She was told she needed to go on birth control pills to solve her problem. The patient protested that she did not want to take oral contraceptives but to pursue a treatment modality that did not suppress her fertility. The physician dismissed the patient with the advice that, since she did not want to go on birth control pills, his office could be of no further help.<sup>13</sup>

And, with that preemptory brush-off, the “mainstream” OB/Gyn not only effectively abandoned his patient but also left her in the midst of active bleeding without basic urgent care and without any discussion of the merits of the alternative she originally requested. It is very easy, with this kind of double standard in avoidance of adverse health effects, to call into question the overall objectivity of the ACOG ethics committee restrictions and their even-handed application.

Finally, ACOG implies that conscientious refusal negatively impacts the patient’s health because it puts the physician’s interests above that of his patient. But, putting the physician’s interest first is sometimes the right thing to do. In fact, there are times when it is perfectly legitimate for the physician to protect his right to follow his conscience before he considers his patient’s rights. Or, better, in forming his conscience, the physician considers his rights and those of the patient and then decides that the patient has no more right to request contraception or abortion—actions that are intrinsically evil no matter the place, time or circumstance—than the physician has the right to commit self-mutilation or suicide.

#### A Physician’s CO Must Not Be Based on Scientific Misinformation

NPT-trained physicians ground their practice on the scientifically sound, evidence-based clinical research summarized in the 90 chapters of *The Medical and Surgical Practice of NaProTechnology* (Hilgers, 2004). As the culmination of three decades of clinical research conducted by Dr Thomas W. Hilgers and his

colleagues, this definitive textbook meticulously documents the study of 8,600 reproductive age women and over 200,000 individual research observations.

Data suggest that these studies resulted in healing not just for the women involved but also for their marriages, families, and the culture. The textbook documents the ineffectiveness of using the oral contraceptive as therapy for gynecological disorders as diverse as PMS, PCOS, endometriosis, unusual bleeding, and ovarian cysts. And it uncovers the physical and moral adverse effects from long-term, contraceptive family planning methods. Garnering the data summarized in previously peer-reviewed publications, Hilgers substantiates the fact that FertilityCare's method- and use-effectiveness rates for avoiding pregnancy are 99.5% and 96.8%, respectively. He also provides a wealth of clinical results documenting NPT diagnostic and treatment breakthroughs for PMS, postpartum depression, repeat miscarriage, PCOS, endometriosis, and ovarian cysts.

But peer-reviewed journal articles and the textbook are not the only source of solid professional formation for NPT physicians. Throughout their training, they are also exposed to theological and philosophical resources that discuss the practical moral dangers for women and couples associated with the direct suppression of fertility and the elimination of those dangers with a natural method of fertility regulation.<sup>14</sup> As a result, NPT-trained physicians are able to scientifically and practically confirm what they know theoretically about the moral truth of human nature. By means of empirical observation, they come to understand, as we have already discussed, that the FertilityCare System realizes the basic human goods of health, family, society, and truth in their order of importance in the women and couples who use it.

Conversely, NaPro physicians are able to observe from their clinical and, perhaps, personal experience that contraception and sterilization fail to satisfy the basic needs of their patients for health, family, society, and knowledge. In the light of the practical truth about contraceptive methods of family planning, physicians trained in NPT can more readily see how its evil contributes to the demoralization of the person, the family, and the culture. They are able to connect the dots from contraceptive sex to the high divorce rate, legalized elective abortions, single mothers/fatherless families, collapse of the nuclear family, and increased confusion over sexual orientation with its negative implications for young persons' lived understanding of sexuality and their universal vocation to chaste love, no matter sexual orientation.

In short, NaPro-trained physicians are immersed in evidence-based medicine. They have concrete proof of how the particular human goods derived from their own FertilityCare/NPT practice fill the basic needs that their patients have for life, health, family, and knowledge. Experientially, they also know why the services they conscientiously refuse to offer fail to realize these goods in women, couples, and in the larger culture.

### A Physician's CO Must Not Create or Reinforce Socioeconomic Inequalities

The front-loaded notification process described above guarantees that NPT-trained physicians will avoid any alleged discriminatory economic and social consequences that might occur in refusing treatment to patients who happen to be economically disadvantaged or lesbian.

For a transitioning NPT physician, however, there could be a patient who comes in ignorance of his NaPro specialty and who, as a result, requests a prescription or a procedure the physician can no longer conscientiously provide. Let us analyze the case for ACOG's charge of economic discrimination, first, and then the claim of social prejudice.

An economically disadvantaged mother of three children comes for her annual gynecological checkup. She asks the transitioning NPT physician for a renewal of her prescription for oral contraceptives. The physician explains that he cannot, in good conscience, comply with her request but describes what he will be providing with the FertilityCare/NPT alternatives. ACOG suggests that the physician's refusal will necessitate additional travel on the part of the patient. Additional travel could cause financial strain on the woman. And financial strain will create an insurmountable barrier to the woman's control over "her reproductive fate and quality of life for herself and her children" (ACOG COE, 2007).

My first response to this case: ACOG is presuming that every poor patient is going to reject the family planning option presented by her physician. But this is a precipitous assumption (and with possible discriminatory overtones of its own, a condescending attitude that "poor women are all alike, they're too lazy or too stupid to seek help elsewhere; they just want an easy, quick fix for their fertility"). ACOG fails to consider that, after the physician explains the services within his NPT specialty, the patient just might like what she hears about FertilityCare. Or—surprise! surprise!—she might resonate with a family planning method that seems to acknowledge the reality that her fertility transcends that of dogs and cats.

A second response: The required travel for the woman who comes to a transitioning NaPro physician and who does not want to try a natural method of family planning may only involve a walk down the hall. Most transitioning NaPro-trained OB/Gyns are in group practice within a single building and have worked out an agreement by which partner-clinicians take patients who are not interested in NPT and FertilityCare services into their practice.

Third response: If there would be a case where the requesting patient is required to do extra travel, it is hard to envision, in a nation where Women, Infants and Children (WIC) and other public health services provide monetary aid to women for their office visits and health-care needs, how the expense of a bus trip, say, across town, would constitute economic discrimination.

But what about ACOG's social discrimination case? What ought a transitioning NPT physician do if one of his former patients who happens to be

a lesbian requests insemination with donor sperm to assist her in getting pregnant and in pursuing a family with her female partner? I strongly disagree with ACOG's allegation that refusing services to this patient is, first, based on the woman's sexual orientation and, second, is grounded in a scientifically unfounded theory of parenting (ACOG COE, 2007, 4). An NPT physician would also refuse AI to a heterosexual patient who, unable to find a suitable husband, would like to have kids before her fertility wanes. Hence, any objection on the part of an NPT physician to participate in or refer a patient for AI has nothing to do with the woman's sexual orientation. It does, however, have everything to do with refusing to participate in a medical intervention that will harm the patient and will fail to actualize her hopes for a good family. To fill the lesbian patient's request would be to treat the lesbian couple as if they had a true marriage and as if they could satisfy a child's need for a good family life. But evolution and long human experience, verified by empirical studies, support an opposing conclusion: the chances that children's need for a wholesome family life can be met without a mother and father who love them are tenuous indeed.

#### IV. DIRECTIVE THREE: EXECUTE A POLITICAL STRATEGY TO PROTECT HEALTH-CARE CONSCIENCE RIGHTS

Ready!

The most critical prerequisite to political activism on behalf of CO has already been discussed. NPT-trained physicians must form their conscience according to the truth of human nature and use it as a measure to test the practical truth behind the science of both standard of care reproductive interventions and NPT alternatives.

The following mandate from the *Declaration on Religious Liberty* appropriately describes the natural law basis of an NPT physician's responsibility in respect to political activism on behalf of the right of conscience in health care:

The common good of society consists in the sum total of those conditions of social life which enable men to achieve a fuller measure of perfection with greater ease. It consists especially in safeguarding the rights and duties of the human person. For this reason the protection of the right to religious freedom [including the exercise of conscience] is the common responsibility of individual citizens, social groups, civil authorities, the Church and other religious communities. Each of these has its own special responsibility in the matter according to the particular duty to promote the common good (Flannery, 1975, 803–4).

NPT physicians must understand that promotion of the common good in the arena of conscience rights is not just a matter of working for legal protection

for physicians' right to exercise conscience. Based on historical precedents, we can predict that, once CO in health care is restricted or even eliminated, other professional groups will likely suffer the same fate. To cite just one example, we are currently witnessing how the right to exercise the institutional conscience<sup>15</sup> of Catholic Charities of Denver (to hire people of like faith and of a moral lifestyle to ensure that their mission of service to the poor is faithfully discharged) is being seriously threatened. In the Colorado legislature, there is a concerted effort to rescind an exemption clause that does not require religious and nonprofit organizations to comply with a bill aimed at preventing discrimination in hiring based on sexual orientation or religion (Zenit.org, 2008). Thus, what the political activism of NPT-trained physician does is to establish and/or strengthen the legal precedent necessary to assure *every* American citizen and institution their *fundamental* right to refuse to participate in immoral behavior.

Get set!

NPT physicians should familiarize themselves with the content, intent, and virulence of the anti-CO crowd and the compulsion bills for which they lobby (Kramlich, 2002, 1–2). For example:

- As far back as 1975, Planned Parenthood general counsel, Harriet Pilpel, outlined a litigation strategy that challenged conscience protections on the basis that they restricted the “right” to abortion.
- It was with this right in mind that the Maryland NARAL Hospital Provider Project could boldly proclaim: “The goal of the HPP is to increase access to abortion services by requiring Maryland hospitals to provide abortion and other reproductive health care.”
- In 1997, the Alaska Supreme Court ordered an Alaskan private, nonsectarian hospital with a pro-life policy, to comply with a lawsuit filed by abortion rights activists compelling them to perform abortions, since to do otherwise would be “an unconstitutional restriction of the right to abortion.”
- During the 2000 American Medical Association House of Delegates meeting, the California Medical Association attempted to secure AMA approval for legislation that would require all hospitals to provide a “full range of reproductive services” including abortion.
- In 2006, New York City mayor, Michael Bloomberg, mandated abortion training in all the city's OB/Gyn residency programs.

In and through all these anti-CO legal/political maneuvers, NPT physicians should be aware of the educated opinion that abortion rights activists are working to incrementally undo conscience rights. With the ultimate end of mandating coverage for, participation in, and universal access to elective abortion, abortion advocates' first objective is to mandate coverage for

contraception in all employer benefit plans. They not only claim that contraceptives are basic care but also imply that every woman has the right to access contraceptive drugs and devices and that every physician has the duty to provide these basic health-care services upon request. On the state level, there are legislative mandates in a number of states that mandate contraceptives and, regrettably, most of these laws have inadequate protection from conscience provisions.

### On Your Mark!

NaPro-trained physicians need to be conversant with the federal conscience legislation currently on the books.<sup>16</sup> The Hyde-Weldon Conscience Protection Amendment (added to the Hyde Amendment and signed into law as part of the Fiscal Year 2005 Omnibus Appropriations Bill) protects the right of our nation's health providers and hospitals to CO to abortion. In part, the law was in response to a federal district court decision seeking to require a Catholic hospital to perform sterilizations (Kramlich, 2002, 1). It rules that, even if various health programs within a hospital or individual health-care entity (HCE) receive federal funds, the hospital/HCE cannot be forced to participate in abortion and sterilization procedures. The amendment also forbids federally funded hospitals from making the willingness or unwillingness of their health-care employees to participate in abortion or sterilization procedures a condition of their employment. The Hyde-Weldon Amendment, though not comprehensive enough, is a much needed corrective on a pervasive misinterpretation of *Roe v. Wade* especially from the side of abortion activists. The latter insist that *Roe entitles* women to an abortion and imply that the US government should be in the business of promoting and providing abortion. Hyde-Weldon makes it clear that what *Roe* actually guarantees, though still a legal travesty, is much more restricted in nature: the right of a woman to be free from governmental interference in her decision to get an abortion.

### Go!

If they live in a state with health-care conscience protection legislation, NPT physicians need to strengthen/expand the law in respect to whom and to what kinds of CO it protects. I suggest the following line of attack: (a) Determine what and whom your state health-care conscience legislation covers; the Web site of Americans United for Life provides analysis of the content of each of the 47 state health-care conscience protection laws. (b) If you live in a state with health-care conscience protection legislation, identify the inadequacies of the legislation and compile amendments that would expand its scope. (c) If you live in a state without any health-care conscience protection (i.e., New Hampshire, Vermont, Alabama), start from scratch and compile an ideal piece of legislation of your own. A good place for help in getting started is Americans United for Life's Web site. They have posted a template



for comprehensive state health-care conscience protection legislation (SHCCPL).<sup>17</sup> (d) Work closely with state legislators who will sponsor your proposed SHCCPL, particularly as they introduce the bill, conduct public hearings, advance the legislation by committee (probably that of Human Health and Services) to the general legislature, and eventually submit the bill for a vote.

## V. CONCLUSIONS

What I advise here is based on the well-tested strategy that a good defense is the best offense. NaPro physicians (and any medical professionals who share their natural law vision of reproductive health care) must reject the equally untenable options—participating in evil or abandoning their medical profession—by practicing what John Paul II described as the “middle way” of well-formed conscientious objection.

Toward that end, I contend that OB/Gyns trained in NaProTechnology will most effectively protect their right to exercise conscience—the *right to deny* provision of immoral services: abortion, contraception, sterilization and the *right to offer* morally acceptable and medically effective alternatives—when they implement a comprehensively conceived plan of action. First, form and exercise their conscience according to the truth of reason and faith that tells human beings who they are and for what they are made. Second, accommodate without moral compromise the reasonable conditions set down in ACOG’s ethics committee statement. And, third, engage in a political activist agenda that advances comprehensive state and federal conscience protection laws and defeats “compulsion” bills.

## NOTES

1. These bills include immunity for conscientiously objecting physicians from legal, disciplinary, financial, and professional retaliation.

2. Cf. the bulleted items in section IV “Get set!” for a list of the comprehensive legal/political maneuvers and the accompanying vitriol that has the single end of suppressing both personal and institutional conscience in health care.

3. Some argue that The American Board of Obstetricians and Gynecologists (the body responsible for certification of OB/Gyns) has joined forces with ACOG to restrict CO. In its procedure for renewal of certification, it discusses what constitutes “cause” for revocation of certification: “Cause in this case may be due to, but is not limited to, licensure revocation by any State Board of Medical Examiners, *violation of ABOG or ACOG rules and/or ethics principles* or felony convictions” (ABOG, 2008, 11, emphasis added). The ACOG ethics committee statement on CO restriction is labeled as “opinion” so it is difficult to say whether it counts as official ACOG “ethics principles.”

4. Since the completion of this article, members of the U.S. Congress have advised Dr. Kenneth L. Noller, President of ACOG of their deep concern that its (Ethics) Committee Opinion #385 “could destroy the rights of conscience for pro-life obstetricians and gynecologists across our nation” and “force valuable pro-life OB-Gyns out of the practice of medicine for exercising their rights of conscience.” Furthermore, these Congressional leaders requested clarification of the “general intent, import and force” of ACOG’s Ethics Committee opinion #385 as applied to board certification of ACOG membership.

Mike Leavitt, Secretary of Health and Human Services, expressed similar objections in his letter to Dr Noller and ABOG executive director Dr Norman Grant cautioning both organizations to honor the conscience rights of physicians (practicing in federally funded healthcare entities) as protected by two federal discrimination laws and an appropriation rider that is renewed annually by Congress.

5. Julian Savulescu (2006, 294–7) opines that since CO introduces “inequity and inefficiency” into medical practice and opens the door to “idiosyncratic, bigoted, discriminatory medicine,” it ought to be severely restricted. According to Savulescu, when conscientious objectors compromise their patients’ care (deny care that is legal, beneficial, and requested), they must be disciplined through revocation of their license to practice. And he implies that when conscientiously objecting OB/Gyns are not ready to commit themselves to delivering legal reproductive health services, they ought not become doctors. Maureen Kramlich and Cardinal George predict that an equally devastating outcome may befall Catholic hospitals if abortion activists prevail in forcing them to provide “full reproductive services.” It will mean the collapse of Catholic health care as we know it (Kramlich, 2002).

6. I am presuming that NaPro-trained OB/Gyns are members of ACOG and certified by The American Board of Obstetricians and Gynecologists (ABOG) that examines and certifies nearly 1,700 obstetrician-gynecologists and subspecialists in maternal-fetal medicine, reproductive endocrinology/infertility, and gynecologic oncology each year. I have argued here that a good defense is the best offense and that NPT-trained physicians should be prepared to withstand the worst case scenario: ACOG and ABOG taking disciplinary measures against them based on their failure to follow the ACOG ethics guidelines, measures that could include trying to force them out of their OB/Gyn practice.

7. Within a 20-period, the Pope Paul VI Institute for the Study of Human Reproduction has trained approximately 350 physicians as Natural Family Planning Medical Consultants. This training focuses on the medical and surgical applications of NPT, the umbrella term covering the whole panoply of protocols included in this obstetric/gynecologic/family planning system of women’s health care. The FertilityCare System is the specific term used to describe the method of cyclic charting that is the basic diagnostic tool used by all women who access NPT and a natural method to regulate their fertility. Some of the NFP medical consultants—the group I have described as *NaPro-trained* or *NPT physicians*—have also sought certification as FertilityCare Medical Consultants from the professional organization of the Pope Paul VI Institute, The American Academy of FertilityCare Professionals.

8. Here I rely on several sources: First, see Ratzinger, 1991, which was especially helpful in understanding the relationship between general and practical conscience. Second, conversations with Father Benedict Ashley, OP in which he explained his theory of the natural moral law as integral human fulfillment/happiness that results from the satisfaction of man’s basic needs. These exchanges referenced other works especially *Health Care Ethics: A Catholic Theological Analysis*, 5th edition (Ashley, DeBlois, & O’Rourke, 2005) in which Ashley discusses natural law and human decision making; third, an article by Sister Prudence Allen (2004), which helped me identify the error of ACOG’s theory of conscience—a “transferred conscience”—where morality is synonymous with legality and group consensus and where a univocal application of codified law or prevailing medical opinion fails to (a) examine the morality of the legal norm or of mainstream medicine itself and (b) analogically apply objectively true principles to the morality of the practical truth of concrete actions.

9. Ratzinger points out that when conscience and authority seem to be “locked in struggle with each other,” human freedom is rescued in an appeal “to the classical principle of moral tradition that conscience is the *highest norm* which man is to follow even in opposition to authority” (8).

10. The ethics committee’s preference is the term conscientious refusal; I prefer CO. I use “refusal” and “objection” synonymously throughout this article. I admit that both terms are negative in focus and might obfuscate the *positive* dimension of conscientious objection. But here I have tried to underline the dual nature of CO: the right not to participate in immoral medical interventions and the right to offer a medically effective and morally acceptable alternative, one that is genuinely able to promote the well-being of the patient which is, as ACOG states in its Code of Professional Ethics, central to the physician-patient relationship.

11. The following explanation accompanied the Web site’s recommended treatment of VTE in pregnancy: “UpToDate performs a continuous review of over 375 journals and other resources. Updates are added as important new information is published. The literature review for version 15.3 is current through August 2007; this topic (VTE in pregnancy) was last changed on September 20, 2007. The next version of UpToDate (16.1) will be released in March 2008.” The results of the search for treatment information on VTE in pregnancy were compiled by David R. Schwartz, MD, Atul Malhotra, M.D., FRCPC, and Steven E. Weinberger, M.D. <http://www.uptodate.com/home/index.html>.

12. Cf. footnote 18.

13. Dr Thomas W. Hilgers received the report of this incident from the involved patient because he had previously treated her long distance. Curiously, after he included this woman's true story in a letter to the editor of the Journal of ACOG to protest the double standard in respect to observation of its restrictions, he was told that the Journal does not publish letters that respond to its ethics committee statements! If it is difficult for conscientiously objecting OB/Gyns to get ACOG's attention, perhaps it is time to let their patients do the talking. If the thousands of women across the United States who have been helped through NPT and FertilityCare were to write letters or send e-mails telling ACOG that they have no intention of losing OB/Gyns that are dedicated to optimizing their reproductive health through services that are both helpful and healthful, ACOG *would* take notice.

14. The educational curriculum for accreditation in NaProTechnology includes lectures/discussions on *Humanae Vitae*, *Donum Vitae*, John Paul II's series of Wednesday audiences on his personalist philosophy of human sexuality (*Theology of the Body*) and hands on case studies that brings to life a lecture on the theoretical and practical understanding of the Church's basic moral principles in health care: totality, double effect, and legitimate cooperation in evil. Book II of the training manuals, *The Creighton Model FertilityCare System: A Standardized Case Management Approach to Teaching* (Hilgers, 2002), discusses the moral import of FertilityCare/NPT health-care services for the person, the family, the institution of marriage, and the culture. And chapter 3 of *The Medical and Surgical Practice of NaProTECHNOLOGY—“NaProTECHNOLOGY and the New Humanism”* (Hilgers, 2004)—makes the same case.

15. On November 14, 2007, the United States Conference of Catholic Bishops (USCCB) issued the document “Forming Consciences for Faithful Citizenship.” It highlights the critical goal of maintaining the conscience of faith-based institutions: “The USCCB actively supports conscience clauses, opposes any effort to undermine the ability of faith-based groups to preserve their identity and integrity as partners with government, and is committed to protecting long-standing civil rights and other protections for both religious groups and the people they serve. Government bodies should not require Catholic institutions to compromise their moral convictions to participate in government health or human service programs” (USCCB, 2007, 29).

16. Health-care professionals who want to exercise conscience within their practice potentially also have rights under the free exercise clause of the federal constitution and their state constitution, as well as rights under Title VII, the federal civil rights law (and its state counterparts) that prevents employment discrimination on the basis of religious belief.

17. The model state health-care conscience protection legislation covers not only every sort of individual health-care professional but also a wide swath of health-care institutions including “hospitals, clinics, medical centers, ambulatory surgical centers, private physician's offices, pharmacies, nursing homes, university medical schools and nursing schools, medical training facilities, or other institutions or locations wherein health-care services are provided to any person.” (AUL Model Legislation [aul.org] 485–6.)

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