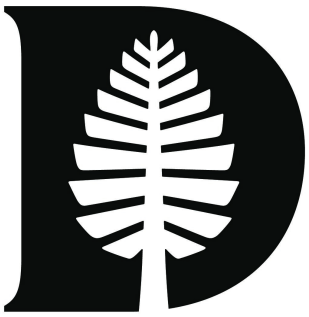
On Religious Grounds:
The Practice of Medicine, Conscientious Objection, and Moral Compromise



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I. INTRODUCTION

On March 12th, 2023, 27-year-old Sarah Collins receives a standard mid-pregnancy ultrasound from an obstetrician at a large secular hospital in Michigan. Sarah is in the second trimester of her first pregnancy. She and her partner are thrilled at the prospect of having their first child.

Within the first minutes of the anatomy scan, the doctor identifies anencephaly, a severe birth defect characterized by the absence of large parts of the brain and cranial structure. Anencephaly is almost always fatal, resulting either in stillbirths or infants surviving at most a few days. In most cases, anencephaly is treated with an abortion. At Sarah's stage of pregnancy (week 23), and in her state of residence (Michigan), the abortion would be a legal procedure. The doctor is Dr. Elena Ramirez, a seasoned obstetrician. She recognizes the severity of Sarah's case, and that the unborn child is extremely unlikely to survive outside of the womb.

However, Dr. Ramirez harbors deep personal convictions against abortion. As a practicing Catholic, she believes that life begins at conception and should be protected without exception. Dr. Ramirez knows that performing the procedure would cause her significant moral distress. She decides to ***conscientiously object*** *to performing the abortion. After informing Sarah about her objection, Dr. Ramirez follows hospital protocol in filing for conscientious objector status. She then initiates the process of referring Sarah's case to another doctor within the hospital. Upon seeing that doctor, Sarah decides to terminate the pregnancy and receives the abortion.*

In the United States, doctors, medical professionals, and healthcare providers have a legal right to object or refuse to provide a specific medical treatment based on personal moral or religious beliefs. Conscientious objection has been formally protected in law since 1973, when Congress passed the Church Amendments. In the scenario above, conscience protections grant Dr. Ramirez the right to object to performing the abortion procedure. By conscientiously objecting, Dr. Ramirez maintains her moral and religious integrity while using the referral process to ensure that Sarah can receive the procedure.

However, conscientious objections do not always proceed this smoothly. In recent years, conscience rights have come under an increasing amount of scrutiny for two key reasons. First, the scope of individual conscience protections has expanded. Originally, they only explicitly protected a doctor's right to object to performing a procedure; today, they cover refusals to refer, inform, or even disclose the objection itself. Opponents of these expansions argue that conscientious objection is no longer just a personal moral exemption but a way for doctors to effectively obstruct legal medical care. Second, conscience protections have expanded to institutions, most relevantly to Catholic healthcare institutions. Since institutions, especially religious ones, embody a collective moral identity grounded in shared doctrines, there is an argument that they should be protected from state coercion just as individuals are. These institutional expansions allow hospitals or a broader hospital system to object to performing or referring patients for procedures such as abortion. In effect, hospitals can now demand that their employees not perform the procedure or refer patients. Opponents of these expansions argue that it grants too much institutional power to hospitals, especially in rural areas, which can leave

patients with no alternative access to care and doctors with their hands tied.[1] Overall, these expansions demonstrate that a conscientious objector—whether that be an individual, hospital, or hospital system—holds significant power to allow or *not* allow patient access to care. An expansive rationale for conscience rights "reaches beyond any one person" and undermines "the larger spirit of openness to dissent that sustains a diverse society and dynamic profession."[2]

By threatening patient access, expansions of conscientious objection rights can paradoxically harm the doctors they aim to protect. Conscientious objection was framed as a way to reduce the moral stress put on doctors by allowing them to avoid direct involvement in procedures they believe to be immoral. Invoking this right carries profound moral weight and demands serious reflection. But as the scope of these protections had widened to include refusals to refer, inform, or disclose, many doctors now find themselves constrained and conflicted rather than supported. When institutions exercise their right to object, they restrict how doctors might use conscientious objection to balance professional and religious obligations. As calls to expand the conscientious objection right continue, these tensions only deepen.

The American political and social landscape has also shifted dramatically since the introduction of conscience rights into healthcare in the 1970s. In June 2022, the Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization* overturned the Court's 1973 ruling in *Roe v. Wade*. *Dobbs* returned the question of abortion to the states, which has created widely diverging state laws. Stories continue to emerge of patients dying or suffering serious harm stemming from inadequate or non-existent abortion services in states with restrictive abortion

[1] Lori A. Hasselbacher, Laura E. Hebert, Yan Liu, and Debra B. Stulberg, "'My Hands Are Tied': Abortion Restrictions and Providers' Experiences in Religious and Nonreligious Health Care Systems," *Perspectives on Sexual and Reproductive Health* 52, no. 2 (2020): 107–15, https://doi.org/10.1363/psrh.12148.
[2] Dov Fox, "Medical Disobedience," *Harvard Law Review* 136, no. 4 (2023): 1033, https://harvardlawreview.org/print/vol-136/medical-disobedience/.

laws.[3] A post-*Roe* America raises immediate concerns of patient access to safe abortion care. Expansions of the conscientious objection right are part of that concern.

In the last two decades, the executive branch of the U.S. Government has been primarily responsible for expansions to conscience rights. Beginning with President George W. Bush in 2008, every presidential administration has issued a "Final Rule" on conscience rights through the Department of Health and Human Services. The Trump administration's 2019 "Final Rule" aimed to broaden and enforce conscience protections, which heightened concern about potential patient discrimination and access. Only a few years later, the Biden administration's 2024 "Final Rule" rescinded large parts of the Trump administration's rule, which heightened concern about doctors' abilities to invoke their conscience rights. Most recently, this past January, Senator Josh Hawley (R-MO) introduced the *Defense of Conscience in Healthcare Act*,[4] which would restore the Trump "Final Rule." These "Final Rules" polarize medical and civil society groups, as their back-and-forth nature introduces ambiguity as to what the law permits, requires, or protects. The legal instability creates confusion for doctors in clinical settings and undermines efforts to establish consistent standards for conscientious objection in healthcare.

In the wake of this instability, the question becomes: *in a post*-Roe *landscape, where conscience rights are expanding in scope (objections to referral) and in power (institutional objections), to what extent should the United States accommodate a doctor's right to conscientious objection?*

[3] Center for Reproductive Rights, "Zurawski v. State of Texas," last modified May 31, 2024, https://reproductiverights.org/case/zurawski-v-texas-abortion-emergency-exceptions/zurawski-v-texas/.
[4] Josh Hawley, *Restoring Healthcare Workers' Conscience Rights Act* (Washington, D.C.: Office of Senator Josh Hawley, January 2025), https://www.hawley.senate.gov/wp-content/uploads/2025/01/Hawley-Restoring-Healthcare-Workers-Conscience-Rights-Legislation.pdf.

This project provides a glimpse into the complex elements involved in answering that question by tracing the theological origins and historical development of conscientious objection accommodations in American healthcare. By examining the evolution of conscience rights alongside key developments in Catholic moral theology, the project demonstrates that any legal effort to establish clear standards for conscientious objection must begin with a nuanced analysis of what it means to act in accordance with one's conscience. Because of the profound influence of the Catholic tradition in the American healthcare landscape, this project focuses on the Catholic conception of conscience. Notably, the Catholic conception provided much of the original moral reasoning for the legal recognition of conscientious objection in healthcare.

Doctors and medical professionals can conscientiously object to performing many medical procedures. The most common examples include abortion, assisted suicide or euthanasia, and contraception and sterilization. Although all of these debates have contributed in various ways to development of conscience rights in American healthcare, abortion has stood at the center. Conscientious objection was introduced the same year as the Court's ruling in *Roe v. Wade*. To this day, the abortion debate functions as the primary moral and political catalyst for the expansion of conscience rights. In turn, this project will approach the question of how to accommodate conscience through the lens of abortion—a divisive and morally fraught procedure. Since abortion is the main procedure to which doctors conscientiously object, understanding the state of the abortion debate is central to grasping the past, present, and future state of conscientious objection in the United States. As the Court's recent ruling in *Dobbs* reaffirmed, the question of the morality of abortion remains far from settled.

The Abortion Debate in a Stalemate

While the legal standing of abortion continues to evolve, the deeper moral debate has long been in a stalemate. Americans deeply disagree on the morality of abortion. Those most staunchly in favor of expanding abortion rights argue that every person has a right to make decisions about their own body, including their pregnancy. They maintain that restricting or banning abortion does not reduce rates of abortion, but rather, forces people to seek out the procedure through other, more dangerous means. Therefore, restricting abortion degrades the health landscape. They add that access to abortion is crucial to gender equality because unwanted pregnancies can exacerbate financial, personal, or other stressors. And on an institutional level, they argue that basing abortion laws on religiously grounded moral frameworks violates the separation of church and state.[5] They believe that restricting abortion will violate the bodily autonomy of pregnant individuals and have profound negative healthcare and social outcomes. Since we as a society know of these negative outcomes, it is our moral obligation to allow the patient to choose and to maintain access to abortion.

Meanwhile, those most staunchly in favor of restricting abortion rights argue that a fetus has a right to life and that it, therefore, deserves to be protected. Fetal life must be respected as a demonstration of society's commitment to its most vulnerable members. Some proponents of this view have increasingly pushed for laws that recognize fetal personhood from the moment of conception, despite the fact that the state has historically granted legal rights at birth.[6] In their view, legal personhood protections should be extended to the fetus to reflect this moral truth.

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[5] Yung Liu, Lisa E. Hebert, Lori R. Hasselbacher, and Debra B. Stulberg, "'Am I Going to Be in Trouble for What I'm Doing?': Providing Contraceptive Care in Religious Health Care Systems," *Perspectives on Sexual and Reproductive Health* 51, no. 4 (2019): 193–99, https://doi.org/10.1363/psrh.12125.

[6] Planned Parenthood Action Fund, *MEMO: The Growing Threat of "Fetal Personhood" Measures Across the Country*, February 29, 2024, https://www.plannedparenthoodaction.org/pressroom/the-growing-threat-of-fetal-personhood-measures-across-the-country.

While this side recognizes that abortions can also be damaging to the mother, protecting fetal personhood is paramount: restricting, and even eliminating abortion completely, is the right thing to do.

The moral question in the abortion debate concerns whether, and under what circumstances, abortion is morally permissible. While both sides of the debate appear to address this same core question, they are often not speaking to one another. This breakdown in communication stems from their fundamentally different ways of engaging with the moral question. More precisely, each side operates within a distinct moral framework that shapes how the question is understood and answered.

One side grounds their moral stance in outcomes. They argue that the patient will suffer financial and mental harms if forced to carry an unwanted pregnancy. Within this consequentialist framework, although abortion may not be ideal, it is morally justified because it supports patient well-being. The other side acknowledges these effects but interprets them differently. Grounded in a deontological framework that categorically protects unborn life, they view abortion as inherently immoral. The moral debate becomes more than just *whether* abortion is morally permissible; the driving question becomes: *how* do we determine what is moral in the first place? These distinct methods of moral reasoning—one consequence-based and the other principle-based—lead each side to answer that driving moral question in different ways. Ultimately, this means the two sides talk past each other and dismiss each other's core arguments. When one side argues that denying abortion causes serious harm, the other side does not address those harms but claims that the act itself is inherently wrong. Likewise, when one side insists that abortion is murder, the other side rejects that serious claim and points, again, to the outcomes of denying an abortion. Although this framing vastly generalizes the two sides of

the debate, it demonstrates part of the reason why the conversation is in stalemate—and why it's been this way for decades.

The stalemate between these moral frameworks stems from their lack of critical engagement with each other. However, this lack of critical engagement has not limited legal and political change. Abortion is not just a moral issue, it has direct practical implications that make it profoundly interpersonal, legal, and political. It prompts questions of bodily autonomy, healthcare access, and individual choice. When unresolved moral questions like abortion enter the realm of policy and politics, each side tries to translate their beliefs into laws and action that support those beliefs. The legal sphere becomes the site where the opposing sides attempt to advocate for and enact their moral visions. The legal sphere becomes an extension of the moral debate, reflecting rather than resolving the moral stalemate.

In the legal sphere, where the debate centers around whether we should expand or restrict abortion rights, there are various conceptions of how to work toward those visions. In 1973, for the first time in American history, the federal government spoke decisively about the legality of abortion. In guaranteeing nationwide access to abortion in the first trimester of pregnancy, the Supreme Court's 1973 decision in *Roe v. Wade* sided with those in favor of expanding abortion rights. Since Catholicism has long maintained that abortion is immoral, this decision outraged many American Catholics, making *Roe* a legally *destabilizing* moment in the abortion debate.

In *Roe*, the Court understood itself as ruling on the constitutional legitimacy rather than the morality of abortion. In the majority opinion, Justice Harry Blackmun framed it the following way:

> We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious

> tradition, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion…Our task, of course, is to resolve the issue by constitutional measurement, free of emotion and of predilection.[7]

Justice Blackmun describes the multitude of factors that may determine one's moral position on abortion. He acknowledges that it is not up to the Court, or to the government in general, to affirm or deny a particular moral stance on the question. Individuals should be free to live according to their moral values, experiences, and religious traditions. And although they were explicit about the nature of their ruling—that it was a constitutional, *not* a moral judgment—the Court's ruling in *Roe* inevitably intensified the moral debate over abortion on account of the fact that, as already mentioned, the legal sphere functions as an extension of the moral. However, changes in the legal landscape inevitably affect the moral debate because, as described, the legal sphere functions as an extension of the moral. By potentially compelling doctors to perform or assist in abortions against their will, *Roe* would marginalize one side of the debate. To restore what they saw as equal access to the legal realm—and to keep the moral debate open, as Justice Blackmun had ostensibly intended—pro-life advocates began calling for a legal counterbalance.

The Legal Origins of Conscientious Objection

Conscientious objection—the legal right to refuse to perform a procedure for reasons of conscience—emerged as that counterbalance. Just months after the Court's ruling in *Roe*, Congress passed the first of the Church Amendments. The Church Amendments explicitly introduced conscientious objection protections, first for doctors and soon after for institutions.[8] These protections allowed doctors to practice medicine in accordance with their individual

[7] United States Supreme Court, *Roe v. Wade*, 410 U.S. 113 (1973).
[8] Mary Ziegler, "Disobedience, Medicine, and the Rule of Law," *Harvard Law Review* 136, no. 5 (2023): 322–23, https://harvardlawreview.org/forum/vol-136/disobedience-medicine-and-the-rule-of-law/.

moralities. In this way, conscience protections became the legal counterweight to the legalization of *Roe*. It restored moral agency within the legal framework by allowing doctors to align their medical practice with their moral convictions. This project primarily conceives of the Church Amendments as a legally *stabilizing* moment in the abortion debate. It was, in effect, an institutionalized form of "agree to disagree."

By shifting the legal balance, *Roe* and the subsequent Church Amendments brought the moral debate over abortion into the healthcare setting. While *Roe* destabilized the legal balance by effectively endorsing one moral vision, the Church Amendments restored a form of balance by accommodating for objection. Together, these two legal developments embedded the moral debate into the practice of medicine and established a fragile balance between access and conscience.

Much has changed since 1973. Social, political, and institutional shifts have undermined the fragile legal balance and destabilized the "agree to disagree" compromise. Expansions to the conscientious objection right have developed largely in response to the precariousness of that framework. These legal expansions to conscience rights have, in turn, been met with further demands for expanded abortion protections. The result: a continuous escalation marked by intensifying polarization in the legal sphere as each side seeks to secure its moral vision through law.

Catholicism and Conscientious Objection

While the opening scenario revealed how conscientious objection can coexist with patient care, not all cases unfold as smoothly, especially in today's landscape. To demonstrate some of these changes, let's consider another scenario:

On November 14th, 2024, 19-year-old Anna Mitchell arrived alone at Riverside Medical Center in Montana. She's a first-year college student from out of state. She's far away from her parents. She doesn't have a car. Earlier that morning, she took a pregnancy test and the result was positive. Her relationship with her college boyfriend ended weeks ago, and she has yet to tell her parents. She's struggling to keep up with classes, missing work shifts, and has started to experience panic attacks. Anna doesn't know what to do, but she knows she needs to seek help. So, she makes an appointment with the first available doctor at Riverside with the hope that someone can talk her through her options.

Within the hour, Anna is seen by a doctor who asks her to explain the reason for her visit. Anna openly shares the circumstances, including her likely intention to terminate the pregnancy. Anna believes she's about eight weeks pregnant, which puts her well below the Montana abortion limit of 24 weeks.[9] *Anna assumes that, at this stage, she will at least receive help navigating her options. The doctor is Dr. Laura Hastings who nods along as Anna speaks. Hearing Anna explain her situation—her fear, her financial instability, her desire not to terminate the pregnancy—Dr. Hastings listens with compassion. She doesn't dismiss Anna or judge her. Internally, however, her thoughts turn to her faith. Dr. Hastings identifies as Catholic, and in her view, Catholic tradition teaches that any degree of participation morally implicates her in the procedure. To refer Anna to another doctor, or even to describe her options in practical terms, would constitute cooperation with evil. To counsel Anna toward abortion would render her complicit in a grave moral wrong. As Anna gives more details, Dr. Hastings knows that performing the procedure herself—or referring Anna to someone who would—would cause her,*

[9] Center for Reproductive Rights, "Montana," *After Roe Fell: Abortion Laws by State*, accessed May 1, 2025, https://reproductiverights.org/maps/state/montana/.

as the involved doctor, significant moral distress. It's not just about what she does with her own hands; it's about being part of a chain of decisions that, to her, result in the ending of a human life.

Dr. Hastings debates her options. She wants to be transparent with Anna about these personal convictions, but her beliefs about complicity restrain her. She knows that Montana law protects her right not to refer or inform.[10] *Ultimately, Dr. Hastings determines that providing any clear information about Anna's options morally implicates her in the abortion that Anna would likely receive. She conscientiously objects to perform, refer, or inform Anna. Furthermore, she decides not to disclose any information about the objection. Dr. Hastings thanks Anna for sharing, maintains a calm and professional tone, and tells her that follow-up care will need to happen elsewhere. She offers no names, no numbers, and no list of clinics. She does not explain why. Anna is confused. She came expecting, at the very least, a conversation. Instead, she leaves the exam room with no plan and no idea where to turn next. The visit has left her more isolated, as she leaves the hospital feeling disoriented and discouraged to seek care elsewhere. Dr. Hastings leaves work that day feeling conflicted over the consequences of her objection.*

Dr. Hastings invoked her conscience rights—rights deeply informed by a moral outlook that sees any involvement in abortion as morally impermissible. Dr. Hastings believes her silence was the only morally acceptable option. As it turns out, Riverside Medical Center is the product of a recent merger between a Catholic hospital and a nearby secular hospital. Almost all Catholic hospitals operate under the Ethical and Religious Directives *which explicitly prohibit abortions*

[10] Liu et al., "'Am I Going to Be in Trouble,'" *Perspectives on Sexual and Reproductive Health* 51, no. 4 (2019): 193.

and referrals for abortions within their facility. When she worked in the openly Catholic hospital, Dr. Hastings never encountered a patient seeking an abortion; most patients would seek that kind of reproductive care and guidance at other hospitals. For the past six months, however, Riverside has grappled with the ethical ambiguity around the integration of the Directives *within the guidelines of the secular hospital. Dr. Hastings worries the institutional ambiguity increases the possibility of something like this happening again.*

In contrast to the opening scenario where the objection did not disrupt patient care, this scenario reveals how an expansive understanding of conscientious objection can harm patients and even the doctors they are meant to protect. The doctor's objection to perform, refer, and inform endangers the patient, compromises the patient-doctor relationship, and convolutes the relationship between Catholic doctrine and seemingly secular care. Although this scenario is only one of many ways that a conscientious objection can intersect with abortion laws and religious institutional doctrine in this country, the scenario highlights key aspects of the conscientious objection landscape today.

The scenario takes place in Montana, a state with relatively liberal abortion laws. After *Dobbs* and the overturn of *Roe*, Montana enacted constitutional protections for abortion which "expressly…prohibit government from denying or burdening the right to abortion prior to fetal viability."[11] There is a perception that the *Dobbs* ruling restricted abortion access in those states that enacted bans and affirmed or expanded abortion access in states that now guarantee it in their state constitutions. *Dobbs* did, in fact, return the abortion question to the states. From a

[11] Center for Reproductive Rights, "Montana."

strictly legal perspective, therefore, Montana loosened rather than tightened abortion laws. Nonetheless, the scenario above complicates that perception.

Notably, conscientious objection is an objection to *legal* care. Were Anna to request an abortion in a state like Texas—where abortion is illegal in nearly all circumstances—a doctor could not provide the abortion even if they wanted to. A doctor in Texas who theoretically objects to performing abortions for reasons of conscience would not need to conscientiously object, as they would not legally be allowed to perform the procedure. In a state like Montana, however, Dr. Hastings needs to object to avoid breaking state law. Conscientious objection can thus limit abortion access even in states that guarantee the right in their constitutions. As it turns out, states with expansive legal protections for abortion also tend to have some of the most expansive legal protections for conscience.[12]

It also reveals the profound influence of Catholicism in the American healthcare landscape. As of 2020, one out of six short-term acute care hospitals in the United States is Catholic owned or affiliated.[13] In five states—Alaska, Iowa, South Dakota, Washington, and Wisconsin—40 percent or more of acute care hospital beds are under Catholic jurisdiction. In another five states—Colorado, Missouri, Nebraska, Oklahoma, and Oregon—between 30 and 39 percent of beds are in Catholic or Catholic-affiliated facilities. Four of the 10 largest health systems in the country are Catholic, including the largest non-profit health system. Unlike secular hospitals where 80.3% of hospitals are part of a health system, over 98% of Catholic hospitals belong to such a system. It is through these health systems that authorities—in the

[12] Hasselbacher et al., "'My Hands Are Tied,'" *Perspectives on Sexual and Reproductive Health* 52, no. 2 (2020): 107-15.
[13] Tess Solomon, Lois Uttley, Patty HasBrouck, and Yoolim Jung, *Bigger and Bigger: The Growth of Catholic Health Systems* (Boston: Community Catalyst, 2020), 4, https://communitycatalyst.org/resource/bigger-and-bigger-the-growth-of-catholic-health-systems/.

Catholic case, the United States Conference of Catholic Bishops (USCCB)—provide centralized guidance on ethical questions such as abortion. From a practical standpoint, Catholic health systems dominate the market. No other religious tradition even comes close.

Furthermore, mergers between Catholic and secular hospitals are creating new ethical horizons for doctors and patients alike. These mergers often create so-called "Catholic-affiliated" institutions, which, many times, still tie the merged hospitals to the Catholic *Ethical and Religious Directives*, albeit in complicated, ambiguous ways.[14] Mergers raise transparency concerns since patients may be unaware that a formerly secular health care facility operates under the Catholic *Directives*. This ambiguity does not just affect patients; it can leave doctors and medical professionals caught between secular and Catholic ethics codes.

Beyond the outsized market share of Catholic hospitals, Catholic doctrine undergirds the ways that conscientious objection rights have expanded in scope. In contrast to the first scenario, this second one raises the question of referral. While Dr. Ramirez objected and then referred Sarah to a willing provider, Dr. Hastings refused to refer Anna to another provider. For many Catholic doctors, any participation in the abortion procedure—even the act of referring the patient to another doctor who will perform the abortion—can be construed as cooperation in an immoral act. Based on this framework, if objection is meant to protect one's conscience from serious harm, and referral causes such harm, shouldn't doctors be able to conscientiously object to referring patients? If informing patients about abortion as an option causes such harm to the doctor's conscience, shouldn't doctors be able to object to informing the patient? To what extent should a doctor be able to claim complicity in the procedure? Can there be *any* limits to the objection? Catholic conscientious objectors and leading Catholic moral theologians disagree on

[14] Ibid.

the question of complicity. While most agree that performing the abortion constitutes complicity, many view referral as morally sound. Others disagree, claiming anything less than complete objection constitutes cooperation with evil. And they all derive their stance from Catholic moral theories of action.

Conscience rights are expanding. They did not originally extend to referral objections. That expansion—among others—has occurred over the last fifty years. This project will show how leaders representing a particular strand of Catholic thought, from American public theologians to the Pope, have provided the theological legitimacy that undergirds these expansions. Analyzing how their understanding of conscience, ethical action, and moral complicity contributed to the expansion of legal conscience rights will help clarify how those rights are interpreted and applied in practice today. Additionally, observing and analyzing the ways conscientious objection functions in healthcare reveals one significant way that religion—in this case Catholicism—integrates into the structure of institutions and influences public debates. Any effort at drawing legal limits in conscience protections must acknowledge the moral theology that undergirds their existence in the first place.

This project also comments on the nature of compromise in American democracy. By focusing on conscientious objection in the context of abortion, it engages with one of the most polarizing and enduring moral debates in American public life. At its core, conscientious objection is an attempt at compromise on a morally fraught question. If we accept that abortion is a morally disagreed-upon issue, then examining how those disagreements are expressed, restricted, and accommodated can reveal how Americans and citizens of a democracy grapple with and settle moral disagreement. Exploring the development of that effort and evaluating its current expression can help clarify hidden dynamics and reveal shared values. Liberal

democracies gain their strength and legitimacy from a commitment to pluralism. They embrace diversity, foster coexistence among differing perspectives, and accommodate diverse moral and ethical beliefs. By tracing the moral, theological, and legal development of conscience rights, this project offers one model for how liberal democracies might more effectively grapple with moral disagreement.

Central Argument and Chapter Breakdown

This project argues that the current state of conscientious objection does not adequately protect American doctors or their patients. The current expression of conscience rights is rooted in an absolutist interpretation of moral complicity, drawn from a particular strand of Catholic moral theology. And while this absolutist understanding is deeply entrenched in American institutions and conscience legislation, it is only one strand. The absolutist moral interpretation has engaged in a centuries-long debate with an alternative strand—proportionalism. By weighing intentions, circumstances, and consequences when evaluating moral action, proportionalism offers a theologically and democratically viable path forward within the Catholic tradition. To understand how we got here, and how we might proceed, this project examines the last fifty years of the Catholic debate between traditional absolutism and proportionalism. It locates that debate in the American context and maps it onto the legal expansion of the conscientious objection right. Ultimately, the project identifies how proportionalism offers the potential to reshape how some Catholic doctors conceive of conscience and morality in contemporary America.

This first chapter sketched out the legal origins of conscientious objection as related to the moral debate over abortion. It briefly introduced the practical influence of the Catholic

tradition in healthcare. Lastly, it hinted at the theological influence of the absolutist interpretation within Catholic moral thought, and a potential alternative to that interpretation.

Chapter 2, titled "A Changing Landscape," provides an interpretive framework for understanding the introduction and expansion of conscientious objection in the American healthcare context. It describes the ways in which the major players in Catholic moral theology—absolutism and proportionalism—influenced the conscience question. The Second Vatican Council in 1962, touched off an intra-Catholic debate that spurred the introduction and expansion of conscientious objection in American healthcare. I will argue that this intra-Catholic debate remains core to understanding the current state of conscientious objection.

Chapter 3, titled "Referral as Morally Justified," demonstrates how a proportionalist theory of action morally sanctions the act of referral. In light of continuing expansions of conscience rights, this chapter reveals how proportional reasoning deploys moral categories to build a case for legal limits to those expansions. Sustainable legal change, in other words, begins with theology.

Finally, the conclusion, titled, "Moral Compromise and the Work of Pluralism," asks why we should protect conscience at all. By briefly laying out a comparative case study of how Sweden has approached the accommodation of conscience in healthcare, this chapter explores how the distinction between negative and positive rights influences the consideration of conscience in a democracy. In addition to summarizing the main themes of the project, this final chapter also comments on the ethical function of religion. Religious debates can bring perspective and depth to an otherwise incomprehensible and rapidly changing world.

II. A CHANGING LANDSCAPE

From the Pope to a "Secular" American Hospital Room

To diagnose the state of conscientious objection today, we need to trace its development from its origins to the present. As conscientious objection is inherently intertwined with questions of law, ethics, medicine, liberty, and religion, this requires a comprehensive approach. With this interdisciplinary approach in mind, this project focuses primarily on the role of religion. It is only a piece of the story of conscientious objection, but it is a crucial piece.

Few groups or religious traditions have had such a profound impact on the healthcare landscape as the Roman Catholic Church. The previous chapter introduced some aspects of this influence. One in six hospital beds in the U.S. is in a Catholic hospital;[15] 98% of these Catholic hospitals belong to a health system operating under the Catholic *Ethical and Religious Directives* (ERDs), a set of moral guidelines issued by the United States Conference of Catholic Bishops (USCCB).[16] Mergers between Catholic and secular institutions are increasingly common which creates ambiguity for both patients and doctors. Several states now allow doctors to object not just to performing a procedure, but to referring the patient to a willing provider or informing the patient of their options.

The 1973 Church Amendments were the first federal laws to protect healthcare professionals who refused to perform or assist in procedures on moral or religious grounds. As discussed in Chapter 1, these amendments did not explicitly include the right to object to *refer* patients; that right has developed over time. Proponents of these expansions grounded their support on notions of cooperation and complicity. To them, any participation in the abortion

[15] Solomon et al., *Bigger and Bigger*, 4.
[16] Ibid., 10.

procedure, even the act of referring the patient to another doctor, can be construed as cooperation with evil. Although the legal expansion allows for doctors of all faiths or no faith to conscientiously object to referring, Catholic theology—more specifically, a particular theory of action within Catholic theology—has been the driving force behind the expansion of conscientious objection to include objection to referral. Although observing and categorizing the ways in which states are expanding these rights legally is significant to the conversation, that expansion is constantly in flux. Rather than focus on the *what* and the *where*, this project seeks to examine the *how*. How can an interpretation of religious doctrine influence the care received by a non-Catholic patient in a seemingly secular hospital?

This chapter details the vast influence of the Catholic tradition on the introduction of conscientious objection in healthcare and the role of key Catholic figures and institutions in pushing for the subsequent expansion of these conscience protections. By chronicling the integration of Catholic moral and religious debates into American healthcare, this chapter provides the historical context to: a) situate the development of competing conceptions of conscience within both the Catholic moral tradition and the American Catholic experience; b) illustrate some ways that religious traditions can influence U.S. policy toward morally fraught questions; and c) highlight the timeliness of this project in light of the 2022 *Dobbs* ruling and the upcoming Vatican conclave on May 7th. Again, this historical context is partial, but it will support the expressed purpose of understanding *how* a particular Catholic interpretation of complicity and cooperation came to undergird the contemporary debate over conscientious objection. As we will see, these doctrinal interpretations have taken a convoluted path from the Vatican and insular theological debates to secular hospital rooms in states like Michigan or Montana.

When considering the Catholic role on the expansion of conscientious objection in healthcare, I argue that there are three moments to pay attention to. Each moment—roughly corresponding to a decade or two—marks a significant shift or turning point in the intra-Catholic debate between the absolutist and proportionalist interpretations of Catholic doctrine. Questions of conscience, complicity, and moral obligation are central to this debate. Inevitably, American Catholic theologians were involved in these deeply divisive debates over Catholic doctrine. As we will see, they helped smooth the integration of magisterial teachings into the American context and, as such, served as translators between the Vatican and American institutions. This integration occurred most explicitly in the field of medicine and bioethics. These Catholic theologians leveraged existing institutions and frameworks, most notably the *Ethical and Religious Directives for Catholic Health Care*, to incorporate a specific interpretation of Catholic doctrine. Since healthcare concerns policy, this integration affected policy conversations on both the state and federal level.

The first moment begins in the 1960s with the advent of the Second Vatican Council. The Second Vatican Council, also known as Vatican II, was an ecumenical council convened in 1962 by Pope John XXIII of the Roman Catholic Church. Vatican II sought to reevaluate the Church's engagement with the modern world. It invited the perspectives of both conservative and revisionist Catholics to theorize about the modernization of liturgy and scripture, to address growing religious pluralism, and to consider the church's role in a secularizing world. Vatican II generated productive intra-Catholic doctrinal debates throughout the 1960s. The question of conscience took center stage in many of these debates, as Catholic thought leaders asserted the importance of conscience to the church of the modern world. One document in particular serves as the symbolic representation of this redefinition: the pastoral constitution *Gaudium et Spes*.

Published on the last day of Vatican II, *Gaudium et Spes* presented the church as a "learning church."[17] In contrast to the rigidity of the pre-modern church, a 'learning church' approaches "the world of knowledge"[18] with humility and openness. The definition of conscience advanced in *Gaudium et Spes* echoed that open approach.

Several American Catholic theologians, most notably John Courtney Murray and Richard McCormick, were pivotal to creating and interpreting Vatican II documents. Murray helped draft the Vatican's Declaration on Religious Freedom—*Dignitatis Humanae*—which was published in the same spirit as *Gaudium et Spes*. This document transformed the church's vision in *Gaudium et Spes* into a legal and civic language, priming it for translation into American law. In many ways, Murray's definition of religious freedom provided the intellectual and theological justification for conscience protections in a pluralistic democracy. By the start of the next decade, revisionist traditions had integrated into the realm of bioethics. In 1971, the Catholic Hospital Association published the *Ethical and Religious Directives for Catholic Health Care Facilities*, the first major revision of the *Ethical and Religious Directives* since 1956. Like Vatican II, these revised *Directives* "did not settle all issues of interpretation."[19] In this way, the *Directives* mirrored the theological diversity within the Catholic Church during the Vatican II years.

Meanwhile, outside these intra-Catholic debates, the American public and courts were considering the question of abortion. When the U.S. Supreme Court ruled on *Roe v. Wade* in January 1973, thereby establishing a federal right to abortion, many Catholics were outraged.

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[17] Massimo Faggioli, "Reading the Signs of the Times through a Hermeneutics of Recognition: *Gaudium et Spes* and Its Meaning for a Learning Church," *Horizons* 43, no. 2 (2016): 332, https://doi.org/10.1017/hor.2016.109.
[18] Ibid., 347.
[19] Kevin D. O'Rourke, Thomas Kopfen-Steiner, and Ron Hamel, "A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services," *Health Progress* 82, no. 6 (November–December 2001): 19.

Catholics have a long-standing anti-abortion position. However, Vatican II asked the Church to carefully consider its role in a modernizing and secularizing world. In the American context, *Roe* and the question of abortion became one of the first tests of the "modernized" post-conciliar Church. As described in the introduction, even though the Supreme Court did not articulate a moral stance on abortion in *Roe*, the ruling affected the moral debate. *Roe* called for a unified Catholic response. Only a couple of months after the Court's ruling in *Roe*, Congress passed the first of the Church Amendments which secured the right for doctors to object to procedures that violated their conscience. Introducing conscientious objection theoretically restored the legal balance and kept the moral debate over abortion open.

The second moment begins in the early 1990s and carries through the early 2000s. While the 70s conceived of conscientious objection as a restoration of the legal balance in order to keep the moral debate open, many did not consider it enough. In the years leading up to the 1990s, the moral rhetoric surrounding abortion had already begun to shift—from a language of individual conscience to one of collective resistance. American anti-abortion activists, led by then-evangelical (and later Catholic) Randall Terry, committed to a public protest campaign known as "Operation Rescue."[20] The group engaged in "civil disobedience" and "inventive…nonviolence"[21] under the motto: "If You Believe Abortion is Murder, Act like it's Murder."[22] By staging mass sit-ins at abortion clinics and displaying graphic pictures of fetal imagery, the group aimed to confront what it saw as a national emergency. This activism signaled a new moral militancy around abortion: one that refused compromise and demanded

[20] Bernard Nathanson, "Operation Rescue: Domestic Terrorism or Legitimate Civil Rights Protest?" *Hastings Center Report*19, no. 6 (November–December 1989): 28.
[21] Joseph Kip Kosek, "'Religion and Nonviolence in American History,'" *Religion Compass* 6, no. 8 (2012): 410, https://doi.org/10.1111/j.1749-8171.2012.00365.x.
[22] Ibid., 28.

absolute adherence to moral norms. Operation Rescue drew heavily from both evangelical and Catholic activists, forging a cross-denominational alliance that would become a defining feature of the anti-abortion movement. Although Operation Rescue lost momentum in the early 1990s, largely due to the passage of the Freedom of Access to Clinic Entrances (FACE), it reflected and enforced the shift toward absolutism underway in Catholic theological circles.

Within the Catholic context, the 1980s and 90s marked a decisively more conservative turn toward magisterial authority. In contrast to the openness of the Vatican II years that allowed for lively intra-Catholic debate and reinterpretations of Thomistic natural law, these years represented an entrenchment of traditional interpretations. In publishing *Veritatis Splendor* in 1993, Pope John Paul II explicitly rejected Catholic revisionist moral theories and emphasized the authority of moral absolutes and a manualist interpretation of Thomistic natural law. Revisionist arguments were sidelined and replaced by this conceptually narrow and absolutist interpretation of doctrine. *Gaudium et Spes* had come to represent the redefinition of Vatican II, which made it particularly vulnerable to the Pope's rejection of revisionist moral theories. On the question of conscience, *Veritatis Splendor* provided a rigorous account of a *true* conscience. By defining a true conscience as one based on adherence to the Church's objective understanding of God's law, Pope John Paul II rejected the creative, inventive, and dialogical view that the Church propagated in the 60s. The pope viewed the encyclical as a decisive way to fight the modern "distortions" created by proportionalism, subjectivity, and relativism.[23]

Doctrinally, *Veritatis Splendor* signified a clear shift toward a more absolutist interpretation of Thomistic natural law and conscience. Several American Catholic theologians, most notably from the New Natural Law tradition, engaged in this shift toward absolutism. By

[23] John Paul II, *Veritatis Splendor*, encyclical, §53, August 6, 1993, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html.

emphasizing practical reason, basic goods, and moral absolutes, they helped integrate this absolutist turn into American Catholic discourse.[24] Revisionist theories such as proportionalism still maintained a significant following, especially in the U.S., but *Veritatis Splendor* dealt a conclusive blow to their influence. The close alignment between the Vatican and the New Natural Law theorists legitimated their theories which allowed for their expansion in the American healthcare space. Within a year of the release of *Veritatis Splendor*, the National Conference of Catholic Bishops (today known as the United States Conference of Catholic Bishops) published a revised version of the Catholic *Ethical and Religious Directives for Catholic Health Care Facilities*. The 1994 revision substantially changed the structure of the *Directives* and notably added an appendix with explicit commentary on the principle of "cooperation in evil."[25] While the 1971 revision of the *Directives* mirrored the relative openness of the post-Vatican II period, this 1994 revision mirrored the Vatican's turn toward absolutism.

Meanwhile, outside these intra-Catholic debates, the American public and courts were once again confronting the question of abortion and its legal implications. In June 1992, a year before the publication of *Veritatis Splendor*, the U.S. Supreme Court reaffirmed the constitutional right to abortion as established in *Roe* through its decision in *Planned Parenthood v. Casey*. Although *Casey* did not address conscientious objection directly, it resurfaced the public debate over abortion and the reopened question of conscientious objection. As described, conscientious objection emerged as a means of legal compromise to the disagreement in the moral debate. In turn, even though the Court reaffirmed the legality of abortion in *Casey*, conscientious objection could preserve the moral disagreement. Less than four years after the

[24] Irene Alexander, "Redefining Direct and Indirect Abortions through 'The Perspective of the Acting Person': A Misreading of *Veritatis Splendor*," *The Linacre Quarterly* 86, no. 1 (2019): 41, https://doi.org/10.1177/0024363919838852.
[25] O'Rourke, "A Brief History," 20.

Court's ruling in *Casey*, Congress passed the Coats-Snowe Amendment which expanded the formal right to conscientious objection. As this chapter will show, Coats-Snowe specified ambiguous language in the original Church Amendments, which legally enshrined the absolutist interpretations of Pope John Paul II and the New Natural Law theorists. Conscience—understood not as personal autonomy but as conformity to objective moral truth—must be protected completely.

The timeline is striking. Within the span of four years, the Supreme Court issued a major abortion ruling (*Casey*, 1992), the Vatican published an authoritative magisterial encyclical (*Veritatis Splendor*, 1993), the *Ethical and Religious Directives for Catholic Health Care Facilities* underwent a major revision (1994), and Congress passed a major expansion of conscientious objection rights (Coats-Snowe, 1996). As in the 1970s, the language of conscience circulated in both theological and legal conversations. However, while the 1970s were marked by an openness to theological debate, the 1990s saw a tightening of doctrine and a turn toward absolutism.

The third moment begins in the early 2010s and carries into the present day. While the second moment was marked by an entrenchment of absolutes, this third moment is distinguished by internal tensions, contradictions, and the partial unraveling of that absolutist framework. Since this moment carries into the present day, its implications are still uncertain. In the Catholic Church, this shift started largely with the election of Pope Francis in 2013. In contrast to his predecessors—Pope John Paul II and Pope Benedict XVI—Pope Francis has taken a pastoral tone, one grounded, in many ways, in the revisionist visions of Vatican II. Instead of focusing on consistency with regards to moral absolutes, Pope Francis has encouraged so-called "spiritual

discernment" toward moral questions.[26] In both *Fratelli tutti* and *Evangelii Gaudium*, two of the major magisterial documents issued during his papacy, Pope Francis hearkens back to the conception of the learning church articulated in *Gaudium et Spes*.[27]

This shift away from an absolutist moral theology has deeply divided the American Catholic community. In the U.S., many bishops, theologians, and institutions continue to uphold the vision of conscience articulated by Pope John Paul II and the New Natural Law theorists. While there are plenty of Catholics who agree with the shifting attitudes of Pope Francis, the power to decide the direction of Catholic doctrine in American society and healthcare rests largely within the institutional structures established over the past fifty years. These include Catholic health systems such as CommonSpirit and Ascension, the USCCB and its doctrinal committees, and hospital ethics boards. Whereas the previous two moments saw a relative alignment between the Vatican and powerful American Catholics, this third moment challenges that pattern. The transformative potential of a more pastoral, dialogical, and responsive Vatican risks being undermined by the enduring influence of entrenched institutional commitments to the Catholic absolutist interpretation.

Aside from the divisions within the Catholic Church, the last decade has also revealed legal uncertainty with regards to abortion and conscience rights. The Supreme Court's 2022 ruling in *Dobbs* overturned the federal right to abortion and returned the question to the states. The fact that states are passing widely diverging abortion laws has prompted a reevaluation of both federal and state-level conscientious objection protections. On the federal level, these reevaluations have moved from the legislative branch to the executive branch. During the first

[26] Francis, *Evangelii Gaudium: Apostolic Exhortation on the Proclamation of the Gospel in Today's World*, §33, November 24, 2013, https://www.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html.
[27] Faggioli, "Reading the Signs of the Times," 332.

Trump administration, even before the *Dobbs* ruling, a 2019 Department of Health and Human Services (HHS) "Final Rule" significantly broadened protections for and enforcement of the federal understanding of the conscientious objection right. This marked an alignment with the conservative and absolutist tradition promulgated by the Church starting in the 1990s. Although the Trump "Final Rule" was later struck down in court, it symbolized a broader movement toward expanding institutional conscience rights. On the state level, expansions of the scope of conscience rights to include objections to refer signal the further integration of absolutism into state constitutions. While these legal and political developments are significant, this chapter will focus on the intra-Catholic debates that continue to shape the theological and ethical foundations of conscience rights in healthcare. We now turn to the persistent influence of Vatican II and the debate between absolutism and proportionalism in Catholic moral theology.

The First Moment: The 1960s-1970s and a Modernizing Catholic Church

The first moment begins at the conclusion of the Second Vatican Council and extends through the Supreme Court's 1973 ruling in *Roe v. Wade*. In light of Vatican II and the calls to modernize the Catholic Church, this section describes how these intra-Catholic debates integrated into the American legal realm, and, further, how conscientious objection rights in healthcare emerged partially as a response to the federal right to abortion guaranteed by the Court's ruling in *Roe v. Wade*. As we will see, the introduction of conscience rights after *Roe* brought the conservative and revisionist Catholic traditions into a temporary if problematic alignment.

The Second Vatican Council

The Second Vatican Council, also known as Vatican II, was an ecumenical council of the Roman Catholic Church held from October 11, 1962, to December 8, 1965. Convened by Pope

John XXIII and concluded by Pope Paul VI, it was the 21st ecumenical council and only the second major revision of the Roman Catholic Church (with the first being the Council of Trent in the 16th century).[28] In contrast to the Council of Trent (1545-1563), which represented a dogmatic response to the Protestant Reformation, the Second Vatican Council took a pastoral and reformative tone. In its three years, Vatican II defined the church's position on questions of religious liberty, pluralism, liturgy, and conscience. Many of these positions challenged the church's traditional positions on these questions and opened the door for political applications beyond strictly Catholic contexts.[29] Prior to Vatican II, "Catholic moral theology conceived its chief task as being the training of priests to hear confessions."[30] Many described the church's magisterium as "highly authoritarian and paternalistic."[31] In the pre-Vatican II years, it would "certainly have been risky" to question the teachings of the church.

The primary goals of Vatican II were to promote ecumenism—unity among Christians—and to reevaluate the church's engagement with the modern world. The Catholic Church knew it needed to modernize, and Vatican II provided the theological and intellectual means to bring about that modernization. Vatican II was also an ecclesiological council in the sense that it systematically re-examined the nature, structure, and function of the church. American Catholic theologian Richard McCormick identifies several important "ecclesiological themes" of the Council.[32] First, Vatican II defined "the church as people of God." This conception introduced "consultative processes" and encouraged the "free flow of ideas" into the debates over moral doctrine. Second, Vatican II defined "the church as servant," which suggested that "moral

[28] Council of Trent. *The Canons and Decrees of the Sacred and Ecumenical Council of Trent*, edited and translated by J. Waterworth. London: Dolman, 1848, https://www.papalencyclicals.net/councils/trent.htm.
[29] Charles E. Curran and Richard A. McCormick, *The Historical Development of Fundamental Moral Theology in the United States* (New York: Paulist Press, 1999), 56.
[30] Ibid., 49.
[31] Ibid.
[32] Ibid., 50.

theology…must continue to probe the relationship between civic unity and religious integrity." Moral theology must find ways to strengthen the connection between religion and society. Third, "the church as collegial," meaning primarily that the church should seek a local expression grounded in the lived experience of individuals. In granting individuals "freedom in the application of moral principles and the formation of conscience," this "collegial" emphasis "question[ed] the use and limits of authority in the moral sphere." Fourth, Vatican II defined "the church as ecumenical," in the sense that Catholic authority must "take account of the experience, reflection, and wisdom" of other Christian churches. And fifth, "the church as eschatological," which encouraged the church to recognize "the messy, unfinished, and perfectible character of the church." In pointing out the ways Vatican II defined and imagined the church as an action *in* this world, McCormick emphasized the true radicalism of Vatican II. At the time of its closing, the Council appeared to have agreed upon an "armistice with modernity."[33] Those three years transformed the Church into the "learning church;" the Catholic Church was to learn from modernity.

The Council produced 16 major documents covering everything from theology, liturgy and ecumenism, and religious freedom. These documents included four constitutions, nine decrees, and three declarations. As prefaced, one of these documents, *Gaudium et Spes*—a pastoral constitution approved by the council on December 7th, 1965—came to represent the "epitome of the council."[34] *Gaudium et Spes* embodies the Vatican's shift toward an entirely new method of doing theology, and, as such, has come to represent Vatican II as a whole.[35] By

[33] Faggioli, "Reading the Signs of the Times," 348.
[34] Ibid., 336.
[35] Ibid., 340.

delving into the core principles of *Gaudium et Spes*, as well as its reception during the past fifty years, we can begin to grasp the radical conception of conscience it inspired.

***Gaudium et Spes* and the "Hermeneutics of Recognition."** At its core, *Gaudium et Spes* is an expansion of the concept of *locus theologicus*.[36] It reimagined the Church's approach to knowledge by defining the current moment as a *locus*, or a source of theological reflection. Traditionally identified *loci* in Catholic theology include scripture, tradition, magisterial teaching, and Church Fathers.[37] Vatican II added the contemporary world to that list. In the first line of the introductory statement to *Gaudium et Spes*, the Vatican states: "the Church has always had the duty of scrutinizing the signs of the times and of interpreting them in the light of the Gospel."[38] The present world, and the ways individuals interact with it, can help the church discern and interpret morality. History itself is a valid source of theological insight. This conception of the present expression of history as a *locus theologicus* shaped the church's emerging historical consciousness, which in turn changed the function of the church. A historically conscious church could no longer consider its primary objective to be "training priests to be confessors in the sacrament of penance."[39] To overcome the "gulf between faith and daily life" as experienced by the modern citizen, the church had to recognize the *locus theologicus* of the present world. It had to present a renewed, "life-oriented" moral theology that "reflect[ed] the totality of the Christian life."[40]

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[36] Ibid., 345.
[37] Ibid., 343.
[38] Vatican Council II, *Gaudium et Spes* [Pastoral Constitution on the Church in the Modern World], §4, December 7, 1965, https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.
[39] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 23.
[40] Ibid.

Villanova University theology professor Massimo Faggioli describes this emerging historical consciousness as the foundation of the church's "'hermeneutics of recognition.'"[41] Hermeneutics refers to the art and theory of interpretation.[42] A hermeneutic posture, then, is the attitude or stance one takes when approaching a text, tradition, or experience.[43] As argued by Faggioli and others, "the appeal to historical consciousness calls for a hermeneutic."[44] If historical consciousness is one's awareness of the current moment in relation to history, one's hermeneutic becomes one's stance toward that history. The Vatican II "hermeneutics of recognition" "called for the end of a walled-in Catholic 'subculture' and the beginning…of a multicultural world."[45]

While "recognition does not mean rejection," it also did not signify uncritical acceptance.[46] A "hermeneutics of recognition" urged the church to recognize not just the "intelligibility" of the "present cultural horizon," but its "validity" in terms of theological content.[47] A "hermeneutics of recognition" challenged the church in its traditional rejection of autonomy and the experience of rationality, and urged it to grapple with the "culture of 'communicative dissent' inherent to 'an age of criticism."[48] A "hermeneutics of recognition" is about a shift "from disavowal to recognition."[49] Although some criticize *Gaudium et Spes* for its optimistic account of the modern world, Faggioli notes that the constitution clearly saw "the ambivalence and underside of modernity," as well.[50] Toward the beginning of *Gaudium et Spes*,

[41] Faggioli, "Reading the Signs of the Times," 340.
[42] Theodore George, "Hermeneutics," *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta and Uri Nodelman, last modified April 30, 2025, https://plato.stanford.edu/entries/hermeneutics/.
[43] Ibid.
[44] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 24-5.
[45] Faggioli, "Reading the Signs of the Times," 342.
[46] Ibid., 340.
[47] Ibid., 341.
[48] Ibid.
[49] Ibid., 340.
[50] Ibid., 342.

the Vatican acknowledged that the modern "crisis of growth…has brought serious difficulties in its wake."[51] To produce coherent and sound moral theology, the church had to observe and recognize the world as it truly is—the bad as well as the good.

Crucially, the church's "hermeneutics of recognition" encouraged it to broaden its audience. The act of recognition inherently means "setting yourself in relation with the Other."[52] It is not an exclusion of others, but a recognition that there are "separated brothers and sisters of other Churches" who are "faithful to other religions."[53] Even if those others are non-believers, they hold fundamental human rights. In this way, Vatican II recognized its "new subjects and their voices: women, young people, the poor, and other cultures in a pluralistic world."[54] Since these voices compose part of the modern world, and since the church must view this world as a *locus theologicus*, these voices become theologically relevant.[55] In this sense, Vatican II recognized the essential theological relevance of its expanded audience: "*Gaudium et Spes* is addressed to all men and women of goodwill, setting a new stage for a church that teaches but also learns."[56]

This call to learn extended the church's recognition beyond simple tolerance; to learn requires recognizing the "church and world in terms of *mutua relatio*—[a] dialogical relationship."[57] In taking a posture of recognition, the church humbly acknowledged that it, too, can learn. This call to learn is a call to listen. The church, but especially church leaders and theologians, must listen before judging the "signs of the times." No longer can the "noninfallible teaching of the hierarchical magisterium on specific moral issues…claim to have absolute

[51] Ibid.
[52] Ibid., 340.
[53] Ibid.
[54] Ibid., 347.
[55] Ibid.
[56] Ibid.
[57] Ibid., 343.

certitude."[58] To embody the humility inherent to learning and "to do justice to the anthropological realities" of a changing and dynamic world, the church must engage with and listen to the "interdisciplinary approaches."[59] This mode of "learning," and its radical call to listen, represented a radical development in the Catholic Church. McCormick describes the development in the following way:

> Through many initiatives of Vatican II (and the theology that led to and formed it) we now are more aware than ever that one of the richest and most indispensable sources of moral knowledge is human experience and reflection. To be ignorant of it or to neglect it is to doom moral theology to irrelevance and triviality…there is a residue of truth in the general assertion that for some decades Catholic moral theology proceeded as if its responsibility was to form and shape experience, but hardly ever be shaped by it.[60]

Gaudium et Spes defined the function of the Catholic Church as an institution that discerns the "signs of the times." It asserted that a church that dismisses these signs undermines its credibility.[61] Theologically significant knowledge is spread across the human experience and it is the church's duty to seek and grapple with that knowledge—to "be shaped by it." Through this simple and logical framing, *Gaudium et Spes* "manifests the 'Copernican revolution' of Catholic ecclesiology for the relations between the church and the world."[62]

***Gaudium et Spes* and the Redefinition of Conscience.** In light of *Gaudium et Spes* and its redefinition of the church as a listening church, the question becomes, to *what* is the church listening? It is already established that the church is listening to the human experience. As described, the church recognizes the theological relevance of the human experience. More specifically, it recognizes the relevance of the human's encounter with God. Crucially, the human conscience is the location of that encounter:

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[58] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 24.
[59] Ibid., 41.
[60] Ibid., 65.
[61] Faggioli, "Reading the Signs of the Times," 338.
[62] Ibid.

> In the depths of his conscience, man detects a law which he does not impose upon himself, but which holds him to obedience…Conscience is the most sacred core and sanctuary of a man. There he is alone with God, Whose voice echoes in his depths. In a wonderful manner conscience reveals that law which is fulfilled by love of God and neighbor.[63]

In locating the human encounter with God in the depths of the individual, the church recognizes its vested interest in respecting that conscience.[64] At the same time, part of the challenge of the "listening church" is to collect and raise the mediations of *all* individuals under equal circumstances—no one mediation is truer than another. Catholic ethics appeals "to the human that mediates the divine will,"[65] but, crucially, does not "absolutize what is only a mediation."[66] No longer did the teachings of the magisterium decide what was moral or not; Vatican II defined "the person as criterion of the morally right and wrong."[67] As McCormick adds, "if the person…is the criterion of moral rightness and wrongness, it means that a different type of evidence is required for our assessment of human actions."[68] Since the objectivity of these individual moral judgments exist at the location of the individual's encounter with God, objective morality exists in the depths of the individual conscience. And since the individual's conscience expresses itself through "the nature of the person and the person's acts," the human actions and human experience become this different type of "evidence" that McCormick references.[69] In this way, *Gaudium et Spes* presented this profoundly personal conception of morality. It presented conscience as both the keeper of, and the means of expressing, moral truths.

McCormick describes how this conception of conscience and recognition of the obscure nature of theologically relevant knowledge, "commits us to an inductive method in moral

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[63] Vatican Council II, *Gaudium et Spes*, §16.
[64] Faggioli, "Reading the Signs of the Times," 347.
[65] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 35.
[66] Ibid.
[67] Ibid., 60.
[68] Ibid.
[69] Ibid.

deliberation about rightness and wrongness."[70] Inductive reasoning draws conclusions based on observations. In medicine, for example, a doctor could observe a consistent array of symptoms and then induce a diagnosis based on those observations. In contrast, deductive reasoning starts with the general principles or laws and then applies them to experiences and contexts. The conception of conscience developed in *Gaudium et Spes* mandates inductive reasoning. Since the individual's encounter with God contains theologically relevant knowledge that the church must recognize, and since that encounter occurs in that individual's conscience, the church must observe and listen to the expression of that conscience to gain access to the knowledge. At first glance this conception of conscience may seem isolated, individualistic, or even relativistic. Closer inspection reveals otherwise.

According to *Gaudium et Spes*, conscience is the binding factor between human beings: "In fidelity to conscience, Christians are joined with the rest of men in the search for truth."[71] Conscience is not a private pursuit; it is the shared human capacity that binds all people together in the pursuit of truth. As individuals start giving their consciences more "sway," they are "striv[ing] to be guided by the objective norms of morality."[72] As conscience and its objective morality acts into this world, it attempts to find the "genuine solution to the numerous problems which arise in the life of individuals from social relationships."[73] The Church also recognized some limits to this conception of conscience. Like any faculty that searches for truth, it can make mistakes. But while it "frequently errs from invincible ignorance," it does so without losing its dignity.[74] Conscience can err in the *expression* of the encounter with God and, therefore in the

[70] Ibid.
[71] Vatican Council II, *Gaudium et Spes*, §16.
[72] Ibid.
[73] Ibid.
[74] Ibid.

expression of objective moral truth. The church and society, as observers of the *expression* of conscience—cannot "make judgements about the internal guilt of anyone" based on those expressions.[75] As stated most clearly in *Gaudium et Spes*, "God alone is the judge and searcher of hearts."[76]

Although radical in its redefinition of the church's function, the conception of conscience advanced in *Gaudium et Spes* is drawn from the work of 13th century theologian St. Thomas Aquinas. Aquinas was a prolific Scholastic thinker and continues to be a central figure in the Catholic Church. Aquinas' conceptions of moral complicity are central to the story of conscientious objection rights in America. As we will see, prominent Catholic theologians grappled with reinterpreting Aquinas' teachings on conscience and moral complicity. His most influential work, *Summa Theologiae*—written nearly 700 years before the Second Vatican Council—outlines his natural law doctrine and emphasizes the importance of conscience. In *Summa Theologiae*, Aquinas emphasized the centrality of *prudentia*—prudence—in maintaining a healthy and functioning conscience. Conscience is a faculty, one charged with discerning and expressing objective moral truths. Like any faculty, it needs to be trained and maintained; it can and will err. According to Aquinas, prudence helps conscience stay on track. Prudence is "right reason about works"—it determines what ought to be done in a particular situation based on one's knowledge of the good.[77] A prudential conscience is engaged in "right reason." Drawing on Aristotle's concept of *phronesis* (practical wisdom), Aquinas frames *prudentia* as the central virtue that enables moral discernment.[78] For Aquinas, prudence allows individuals to draw on

[75] Ibid., §28.
[76] Ibid.
[77] Thomas Aquinas, *Summa Theologica*, I-II, q. 57, a. 4, trans. Fathers of the English Dominican Province, New Advent, https://www.newadvent.org/summa/.
[78] Anthony Celano, "Medieval Theories of Practical Reason," *The Stanford Encyclopedia of Philosophy* (Winter 2022 Edition), eds. Edward N. Zalta and Uri Nodelman, https://plato.stanford.edu/archives/win2022/entries/practical-reason-med/.

synderesis—the innate, rational human capacity to grasp the first principles of moral action. By defining *synderesis* as innate, Aquinas argues for respecting individual conscience and elevates prudence as the virtue that guides and sustains that conscience.

In *Summa Theologiae*, Aquinas also established his famous framework for understanding morality as rooted in a divine order which is the foundation for how conscience is conceived in *Gaudium et Spes*. Within his conception, the divine order exists in four types of laws: divine law, eternal law, natural law, and civil law. Divine law is God's law; it is "nothing else than…Divine Wisdom."[79] This 'Divine Wisdom' is God's way of "govern[ing] all the acts and movements" within each human being.[80] The eternal law is truth, including objective moral truths. All laws, "in so far as they partake of right reason," derive from this eternal law. Natural law is the human ability to *know* the eternal law, and thereby the human ability to access the objective morality of "Divine Wisdom." As Aquinas describes, natural law is nothing else than the "rational creature['s]" participation in the eternal law.[81] As a law, it is not externally imposed onto individuals through instruction; it is intrinsic to our human nature. But by what means does a human access the internal moral truths of eternal law? According to Aquinas, conscience becomes the mechanism through which humans discern and apply natural law and objective moral truths in their life.[82] In defining the human relationship to the eternal and natural laws in this way, Aquinas places conscience at the center of human moral decision-making. As we've seen, *Gaudium et Spes* interprets this centuries-old conception of conscience to shape its modernized vision.

[79] Aquinas, *Summa Theologicae*, I-II, q. 93, a. 1.
[80] Aquinas, *Summa Theologicae*, I-II, q. 93, a. 1.
[81] Aquinas, *Summa Theologicae*, I-II, q. 91, a. 2.
[82] Aquinas, *Summa Theologicae*, I-II, q. 94, a. 4.

While *Gaudium et Spes* built off the Thomistic tradition, which granted it legitimacy as a work of Catholic moral theory, the encyclical advanced a radical interpretation of Thomism that was grounded in a sober analysis of the contemporary world. *Gaudium et Spes* recognized that a prudential conscience is difficult to maintain, especially in a "nontransparent, ambiguous, and ever changing" world.[83] As it describes it, history "speeds along on so rapid a course that an individual person can scarcely keep abreast of it."[84] In a world where individuals find themselves "incapable of battling the assaults of evil successfully,"[85] they start to experience "spiritual agitation."[86] This agitation arises from restrictions on the faculty of conscience. Although optimistic in its recognition of the contemporary world as a *locus theologicus*, *Gaudium et Spes* raised concerns for the ways modernity could bind conscience in "chains."[87] *Dignitatis Humanae*, an encyclical promulgated by the Vatican on the same day as *Gaudium de Spes*, proposed the "solution" to that concern.[88]

***Dignitatis Humanae* and Religious Freedom.** *Dignitatis Humanae*, or the Declaration on Religious Freedom, was published on December 7th, 1965. While *Gaudium et Spes* provided a more comprehensive overview of the Catholic approach to the modern world, *Dignitatis Humanae* served a more specific purpose: to comment on the importance of protecting freedom of religion and conscience. In other words, while *Gaudium et Spes* defined the centrality of conscience in the *locus theologicus* of the contemporary moment, *Dignitatis Humanae* operationalized that definition of conscience. As Concordia University theology professor Rev. Dr. Raymond LaFontaine describes, "[i]n affirming religious freedom as a personal and social

[83] Faggioli, "Reading the Signs of the Times," 346.
[84] Vatican Council II, *Gaudium et Spes*, §5.
[85] Ibid., §13.
[86] Ibid., §5.
[87] Ibid., §13.
[88] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 30.

right, *Dignitatis Humanae* specifically understood this teaching as 'a development of the doctrine of recent popes' on the relation between religion and society."[89] Vatican II tasked Catholic theologians with the practical integration of the church's redefinition as a "learning" church.

While many theologians took up this challenge, few did so as substantially as John Courtney Murray, S.J. Murray was a prominent American Catholic theologian and served a central role in developing the language and argument laid out in *Dignitatis Humanae*.[90] During the Council, "Murray carefully laid the foundations and set the overall context" of the Council's teaching on religious freedom.[91] He was the "principal author" of *Dignitatis Humanae*, and "was widely recognized as its most authoritative interpreter."[92] LaFontaine describes how Murray's interest in religious freedom "was not purely theoretical, but eminently practical."[93] As an American "living in a religiously mixed society, he saw the urgent social and pastoral necessity for cooperation…in the construction of social order."[94] As Murray was writing, "disagreements about the nature of religious freedom and the place of religion in civil society had become particularly divisive."[95] Murray recognized that the church's "historically conscious attention to the 'sign of the times'" in *Gaudium et Spes* was an essential component of any theological reflection on the social and political realities of the day.[96] *Dignitatis Humanae* continued that

[89] Raymond Lafontaine, "Lonergan's Functional Specialties as a Model for Doctrinal Development: John Courtney Murray and The Second Vatican Council's 'Declaration on Religious Freedom'," *Gregorianum* 88, no. 4 (2007): 781-782, https://www.jstor.org/stable/23582792.
[90] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 24.
[91] Lafontaine, "Lonergan's Functional Specialties," 783.
[92] Ibid.
[93] Ibid., 786.
[94] Ibid.
[95] Ibid.
[96] Ibid., 797.

theological reflection, with the aim of implementing it. Murray recognized that he had to "continue to probe the relationship between civic unity and religious unity."[97]

Gaudium et Spes grounded its renewed vision in an interpretation of Thomistic law. As mentioned, Aquinas conceived of the divine order as existing in four types of laws. In addition to divine, eternal, and natural law, there is also civil law. Civil law is "human law:" tax laws, speed limits, etc. Civil law is a determination of natural law—it takes the moral principles of natural law, and thereby the moral principles of natural law and specifies them in concrete situations.[98] Notably, within Aquinas' conception, civil law is only valid if it aligns with natural law. *Dignitatis Humanae* would "perfor[m] the dilemma of modern Catholic natural-law approaches to moral questions" by addressing the connection between natural law and civil law.[99] As Murray maintains, a free conscience is central to that connection.

In the modern world, there are both valid and invalid civil laws. To address the resulting "spiritual agitation" of that ambiguity, Murray emphasized the importance of respecting and protecting conscience. This language of protection translated the Council's theological vision into the sphere of civil action. As stated in *Dignitatis Humanae*: "The Vatican Synod declared that the human person has a right to religious freedom."[100] Through a process grounded in individual inquiry and supplemented by teaching and dialogue, individuals have the right to pursue truth freely. If "inquiry is to be free," the individual must be free from coercion. If individuals are to be free in their search for truth, they must also be free to act on these truths. Granting individuals the right to act on their moral conclusions requires a fundamental respect of the "dignity" of individuals. Respecting this dignity "demands profound respect for human

[97] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 51.
[98] Aquinas, *Summa Theologicae*, I-II, q. 95, a.2.
[99] Lafontaine, "Lonergan's Functional Specialties," 803.
[100] Ibid., 793.

freedom and responsibility."[101] As such, Murray "comes to root the formal right to religious liberty" in the respect of the dignity of the human person.[102] *Dignitatis Humanae* demands that conscience be seen not just as a private faculty, but as something demanding public respect and protection.

As mentioned, John Courney Murray was an American Catholic theologian. He was particularly drawn to understanding the interactions between what Aquinas had defined as the moral order and the legal order.[103] In the context of "constitutional government, especially as it appeared in the United States with the emphasis given to the freedom of the citizen," the differences between the moral and legal order were particularly apparent in America.[104] According to LaFontaine, Murray's American lens "led [him] to a very specific and circumscribed understanding of the right to religious freedom."[105] To Murray, religious freedom was "an absolute immunity against coercion of the conscience in matters of religious belief."[106] Although his French and Belgian colleagues at Vatican II expressed concern that his "political analysis depended too much upon…Anglo-American constitutional law," the content of *Dignitatis Humanae* largely expressed Murray's definition of religious freedom.[107] He became its spokesperson; he was "repeatedly called upon after the Council to defend, clarify, and explain the Church's doctrinal teaching on religious freedom."[108] He transformed the church's theology into a legal and civic category, priming it for integration into American law. His definition of

[101] Ibid., 786.
[102] Ibid., 793.
[103] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 30.
[104] Ibid.
[105] Lafontaine, "Lonergan's Functional Specialties," 793.
[106] Ibid.
[107] Ibid.
[108] Ibid.

religious freedom provided the intellectual and theological justification for conscience protections in a pluralistic democracy.

Proportionalism and Inductive Reasoning

Proportionalism emerged in the decades following the Second Vatican Council as one of the most theologically salient and consequential attempts to institutionalize the Council's vision.[109] The manualist tradition classified actions as either intrinsically good or intrinsically evil, which meant evaluating the morality of an act based on the object of that act. Proportionalism challenged that evaluation of action.

Proportionalism is a Catholic moral theory that evaluates the morality of actions "in their totality."[110] It weighs the actor's intention, the object of the act, and the proportion between the good and the bad effects. Vatican II shifted Catholic moral theology from a manualist tradition to a historically conscious tradition. It treated the contemporary world as a *locus theologicus*, one requiring a "hermeneutics of recognition," and, as such affirmed the importance of listening and observing to the world and its individuals. Proportionalism continued this intellectual project. As Faggioli describes, while the Council initiated the shift toward this renewed hermeneutics "intellectually," it "barely initiated it at the institutional level."[111] The more established and conservative theologians found themselves unable "to deal well with the newer development in orientation and methodology."[112] As a result, the leadership in post-conciliar moral theology in the United States passed to the proportionalist theologians. While these theologians were younger and less established than the leading moral theologians of the time, they were better

[109] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 41.
[110] Bernard Hoose, *Proportionalism: The American Debate and Its European Roots* (Washington, D.C.: Georgetown University Press, 1987), 2.
[111] Faggioli, "Reading the Signs of the Times," 345.
[112] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 23.

equipped to adapt to the changes brought by Vatican II.[113] In turn, the task of operationalizing Vatican II theology fell to a new generation of moral theologians. Institutionalizing Vatican II's vision meant translating the Council's theological principles into concrete structures, practices, and norms of the Catholic Church. While figures like John Courtney Murray and documents like *Dignitatis Humanae* had begun the legal and civil translation of Vatican II's theological vision, it was the proportionalist theologians who actualized the theological project of Vatican II.

Vatican II treated the contemporary world as a *locus theologicus*. By observing and analyzing the "signs of the times," the church could present a renewed, "life-oriented" moral theology.[114] This historical consciousness demanded that the church treat human action, and the consequences of human action, as theologically and morally relevant. Proportionalism agreed. Rather than assessing moral acts solely according to the object of the act, proportionalist theologians argued that human action must be evaluated within the full complexity of historical, social, and personal circumstances. They maintained that both the agent's intention and the foreseeable consequences of an act must be weighed when evaluating its morality. In this view, the contemporary realities faced by individuals—including emerging dilemmas in bioethics—were theologically relevant and morally significant realities that demanded discernment from the church. Proportionalists like Bernard Häring and Richard McCormick embraced Vatican II's call for a historically conscious moral theology by developing frameworks that could responsibly engage the ambiguities and complexities of modern life. These frameworks were more than just theories about the church's function or stance toward modernity; they were moral structures aimed at defining the moral life within the institutional realities of modern life.

[113] Ibid.
[114] Ibid.

Vatican II also defined conscience, and its expression through human behavior and action, as something of primary importance to the "learning" church. Since the human encounter with God occurred in the "depths of [a human's] conscience,"[115] and since the church was careful not to "absolutize"[116] one human conscience as the representative for all, the teachings of the magisterium could no longer decide whether an act was moral or not. Determining the morality of an act would require a "different type of evidence."[117] Since objective morality exists in the depths of the individual conscience, conscience is the keeper and the mode of expressing these moral truths. Observing conscience and its ability to wade through the complexity of modern life became this "different type of evidence." By observing conscience, the church must then inductively reason toward the moral truths. This shift rendered the manualist deductive method of moral evaluation, one rooted in the absolute classification of acts as either intrinsically good or evil, as fundamentally unresponsive to the evolving needs of the church and the modern citizen. Proportionalism, by contrast, took up the Council's inductive method by affirming that evaluating conscience was theologically necessary to the evaluation of morality.[118] Although it theorized about the importance of this inductive method, Vatican II did not provide a detailed method or systematic framework for how such an inductive method could function in practice. Proportionalism built this method, and, as such, operationalized the function of the church defined during The Second Vatican Council.

[115] Vatican Council II, *Gaudium et Spes*, §16.
[116] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 35.
[117] Ibid., 60.
[118] Ibid.

"Geographic Morality" and the 1971 Revision of the Ethical and Religious Directives

Proportionalism and its foundation in inductive reasoning proved especially relevant in the emerging field of healthcare ethics. Medical contexts involve action with multifaceted moral outcomes. A single action in the healthcare context can have profoundly negative and positive effects. In these morally unclear situations, the manualist deductive method would demand that the act not produce *any* bad effects. If it does, the act is deemed immoral and should not be taken. But as new technologies and ethical dilemmas centered in the healthcare sphere emerged, the manualist method inadequately responded to the increasingly nuanced and layered moral decision-making in healthcare. As Richard McCormick describes, within the dynamic and modern world, the realm of bioethics—especially—demands not a detached, rule-based morality, but a profound respect for both conscience and professionalism:

> Finally, what is increasingly obvious in medicine…is that an ethics of medicine can degenerate into a lifeless and detached body of knowledge that one dusts off now and then when faced with a nasty dilemma. That is the result of identifying with 'dilemma ethics.' What we have come to see as essential to a genuine ethics is a formational dimension and therefore a spirituality of and for the professional person. When that is in place, decisional ethics will have a nourishing and supportive context and it will certainly flourish.[119]

Proportionalist moral theology aimed not merely at solving isolated dilemmas, but at shaping healthcare professionals who understood their vocation as a Christian calling—as a deeply lived ethic, not as a rulebook. Instead, they implicitly affirmed the need for prudential judgment when facing complex questions or situations with a double moral character. Proportionalism moved beyond deductive reasoning and its rigid classifications of acts as intrinsically good or evil. By reasoning inductively, the theory enabled medical professionals to consider the multifaceted

[119] Ibid., 58.

reality of action in healthcare. It developed tools for considering intention and circumstances and allowed for the proportionate weighing of good and bad effects.

Although proportionalism had not been formally named or universally accepted by the late 1960s, its theological instincts—grounded in historical consciousness, personalism, and the centrality of prudential judgment—had already begun to reshape Catholic bioethics.[120] As influential theologians spread proportionalist moral reasoning across the United States, doctors, hospitals, and entire dioceses saw its appeal. There was a "lack of consistency" as "two different methodologies appear[ed] to be at work in official hierarchical teaching."[121] As described by scholar of Catholic ethics Rev. Kevin O'Rourke, "the *Directives*…began to be interpreted more liberally in certain dioceses."[122] This patchwork of liberalization "led to the phenomenon known as 'geographical morality.'"[123] Rev. O'Rourke describes how this geographic morality meant that an act (such as referral) "that was prohibited because of immorality in one diocese might be allowed in another."[124] In response to this growing threat of uneven moral evaluations, the "[Catholic Health Association] board of trustees requested that the National Conference of Catholic Bishops (NCCB; the former name of the United States Conference of Catholic Bishops) compose and promulgate a set of *Directives* that would be uniform for the entire country."[125] The board hoped that, "if the *Directives* were composed by a conference of bishops and promulgated by individual bishops, 'geographic morality' would disappear."[126]

[120] Hoose, *Proportionalism*, 1.
[121] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 41.
[122] O'Rourke "A Brief History," 19.
[123] Ibid.
[124] Ibid.
[125] Ibid.
[126] Ibid.

By November 1971, the Catholic Health Association published the revision of the *Ethical and Religious Directives for Catholic Health Care Facilities*.[127] This revision was an attempt "'tighten things up' in the church" by "authoritative intervention into theological work considered suspect or dangerous."[128] Moral theology—and proportionalist reasoning, in particular—posed the primary threat. Although these revised ERDs were "overwhelmingly approved by the NCCB, they were not greeted with acclaim by many theologians."[129] The revised *Directives* "were rather legalistic; they did not attempt to explain the reasons for church teaching, but merely stated rules."[130] The legalistic and authoritative tone of the 1971 revision reflects a deeper methodological shift toward the absolutism of manualist and physicalist interpretations of natural law theory. Many "[t]heologians became freshly aware of the inadequacy of a heavily juridical notion of the moral teaching office" and they "became more sensitive to their own responsibilities, especially their occasional duty to dissent in light of their own experience with the faithful."[131] Proportionalism, and the "geographic morality" with which it was associated, persisted—but only temporarily.[132]

The Strategic Alignment: Roe v. Wade and the Church Amendments

In January 1973, the Supreme Court legalized abortion nationwide in their ruling in *Roe v. Wade*. Although several states had already begun liberalizing their state abortion laws throughout the 1960s, the *Roe* decision dramatically reshaped the landscape of reproductive rights because it demanded the provision of abortion across all American healthcare. For the Catholic Church, which had long taught the inviolable sanctity of human life from conception,

[127] Ibid.
[128] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 62.
[129] O'Rourke, "A Brief History," 19.
[130] Ibid., 20.
[131] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 56.
[132] O'Rourke, "A Brief History," 19.

the *Roe* ruling plunged the American Catholic community into a moral crisis. *Roe* called for a rapid, unified Catholic—and arguably broader Christian—response, particularly within healthcare institutions where the Catholic stance on abortion was most visible. Faced with the prospect of being compelled to participate in abortion services against their teachings, Catholic leaders recognized the urgent need to secure legal protections for conscience rights. The result: a strategic political alignment between Catholic institutions, other Christian denominations, and sympathetic legislators to advocate for protections of conscience in healthcare. And although arguments for conscience protections had begun to emerge before 1973 in response to the state-level liberalization of abortion and sterilization laws, the post-*Roe* moment intensified and nationalized these efforts.[133]

By June 1973, less than six months after the Court's ruling in *Roe v. Wade*, conscience rights were enshrined in law. The Church Amendments, included in 42 U.S.C. 300a-7, were a series of legislations passed by Congress that provided the initial right for healthcare professionals and religious institutions that receive federal funding to object to performing procedures if they felt that performing the procedures violated their personal, religious, or moral beliefs. The first provision protected individuals from forced participation in a procedure:

> The receipt of any grant, contract, loan, or loan guarantee…by any individual or entity does not authorize any court or any public official or other public authority to require such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions.[134]

Following the first of the Church Amendments, any doctor working in a hospital that receives federal funding has the legal right to conscientiously object to performing or assisting in a procedure.

[133] Fox, "Medical Disobedience," 1033.
[134] U.S. Code. Title 42, Public Health and Welfare. § 300a-7 (1973) (Church Amendments).

It is worth noting the ambiguity of the term "assistance" here. While "performance" refers to directly carrying out a procedure, "assisting" is far less precise. It raises interpretive questions about how closely connected an action must be to the procedure itself in order to qualify as "assistance." Understood narrowly, it could be limited to physical or clinical participation. Understood broadly, it could encompass any activity that facilitates access to the procedure—including referring or informing the patient. Chapter 3 will explore how two Catholic theories of action differ on what constitutes assistance—or "cooperation with evil" within the Catholic context. For now, it is important to recognize that the ambiguity in the statutory language of these early conscience protections has allowed for diverging interpretations. This ambiguity has enabled both narrow and broad readings to justify their differing claims about the proper scope of conscience rights. As we'll see, in the next major expansion of federal conscience rights—the Coats-Snowe Amendment of 1996—the broader interpretation prevailed, which extended protections to *explicitly* include objections to referral.[135]

Crucially, this post-*Roe* landscape finalized the undergoing alignment within the American Catholic bioethics community. As described in the section above, the revised *Ethical and Religious Directives* in 1971 did not immediately align all Catholic theologians and proportionalism continued to have a broad appeal.[136] The *Roe* ruling and the subsequent protection of conscience in federal law actualized the intra-Catholic alignment. Rev. O'Rourke describes how the "[a]ctual promulgation in each diocese was encouraged…by the response of the NCCB to the Roe *v.* Wade decision of the U.S. Supreme Court in 1973."[137] The then-President of the NCCB, Cardinal John Krol of Philadelphia, "pointed out to the bishops that they

[135] U.S. Code. Title 42, Public Health and Welfare. § 238n (1996) (Coats-Snowe Amendment).
[136] O'Rourke, "A Brief History," 20.
[137] Ibid., 19.

might have a difficult time using the federal conscience clause…unless they were on record as prohibiting such procedures."[138] With conscience protections defined, all bishops—both the ones who supported the revised *Directives* and those who did not—were incentivized to align behind the 1971 revision. By promoting uniform direction for Catholic hospitals and bioethicists, the revision sidelined the proportionalist method and its proponents.

The Second Moment: The 1990s-2000s and the Entrenchment of Moral Absolutes

The second moment begins in the early 1990s and extends through the early 2000s. In contrast to the post-Vatican II years of theological openness, this period demonstrates the decisive return to moral absolutes in Catholic teaching. This section will trace how Pope John Paul II's *Veritatis Splendor* sought to delegitimize proportionalist moral theories and to reassert a manualist and absolutist interpretation of Thomistic natural law. It will also show how this theological realignment, through the work of the closely aligned absolutist interpretation of the New Natural Law theorists shaped the revisions to the Catholic *Ethical and Religious Directives* in 1994 culminated in legal expansions of the conscientious objection right. As we will see, this moment marks the institutionalization of an absolutist Catholic moral framework with both Church doctrine and American healthcare policy.

Planned Parenthood v. Casey

In 1992, the U.S. Supreme Court issued its decision in *Planned Parenthood v. Casey*. Although the *Casey* ruling allowed for greater regulation by the states, it reaffirmed the fundamental right to abortion established in *Roe v. Wade*. While *Casey* did not directly address conscientious objection rights, it did revitalize national debates over abortion and conscience.

[138] Ibid.

Within the framing of this project, the *Casey* ruling is significant because it provided the theological and political legitimacy to expand conscientious objection rights. This laid the groundwork for Congress passing another conscience Amendment only four years later. Before that, however, we need to consider how American theologians, particularly a group of conservative non-revisionist Catholic theologians, integrated the Vatican's rejection of proportionalism into Catholic bioethics. As it turns out, their work informed the significant revision and expansion of the Catholic *Ethical and Religious Directives* in 1994.

Veritatis Splendor and Pope John Paul II

In August 1993, Pope John Paul II issued *Veritatis Splendor*, a landmark encyclical that decisively rejected proportionalist moral theories and reaffirmed moral absolutism. Addressing what he perceived as widespread moral confusion in the post-Vatican II Church, the Pope condemned proportionalism and consequentialism as falling to the "relativistic, materialistic, atheistic, and pantheistic culture of the sixties."[139] He insisted that certain acts are intrinsically evil regardless of intentions, circumstances, or consequences. While the document sought to uphold the integrity of moral truth, its effect was to constrain moral analysis within narrow boundaries. The encyclical left little room for discernment in cases where moral norms and human needs come into conflict.

As Faggioli describes, within the context of magisterial teaching, *Veritatis Splendor* was a definitive rejection of Vatican II and everything it had inspired. After its publication in 1965, *Gaudium et Spes* produced "a reception divided along theological fault lines." In *Veritatis Splendor*, the Vatican advanced "the idea that Catholic theology was an accomplice in the destruction of the old moral system and that Gaudium et Spes was the manifesto of that." The

[139] Faggioli, "Reading the Signs of the Times," 336.

encyclical was "for better or worse, the epitome of the council," and, as such, it became the primary target of this "'anti-Vatican II sentiment.'" The Vatican's rejection of it then became a "theological-political rejection of Vatican II in general."[140] By suggesting that moral reasoning must consider circumstances and outcomes, proportionalism appears, from the perspective of John Paul II, to blur the line between universal moral norms and context dependent discernment. Therefore, in much of *Veritatis Splendor*, the Pope critiques the definition of the contemporary world as a legitimate *locus theologicus*:

> The great concern of our contemporaries for historicity and for culture has led some to call into question *the immutability of the natural law* itself, and thus the existence of 'objective norms of morality' valid for all people of the present and the future, as for those of the past.[141]

For proportionalists, the contemporary world and the individuals in that world are of central concern. By observing the ways that modern individuals apply their consciences to navigate moral reasoning within the complexities of modern life, proportionalist reasoning gives a dynamic and personal account of conscience. For John Paul II, this emphasis on historicity risks relativizing moral truths. If "historicity" and "culture" become sources of theological and moral knowledge in themselves, then the universal truths of the moral law are no longer secure.[142]

Pope John Paul II continues his critique of proportionalism by stating that it provides "an inadequate understanding of the object of moral action."[143] By arguing that intention and consequences of the action are necessary for a legitimate evaluation of the moral meaning of an act, proportionalism directly challenges the absolutist argument that the moral object must be assessed prior to and independently of intentions and consequences. *Veritatis Splendor* treats

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[140] Ibid.
[141] John Paul II, *Veritatis Splendor*, encyclical, §53, August 6, 1993, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html.
[142] Ibid., §53.
[143] Ibid., §75.

"the object of the human act" as the "primary and decisive element for moral judgment,"[144] and labels the proportionalist framework as a "false solutio[n]" to the evaluation of moral truths.[145]

Although proportionalism, with its roots in the Second Vatican Council, became the primary target of critique in *Veritatis Splendor*, the Pope also denounced "consequentialism" with much the same structure of critique.[146] He called them both "relativistic conception[s] of morality," both responsible for the church's fall into moral "arbitrariness."[147] However, this assertion overlooks crucial differences between proportionalism and consequentialism. While consequentialism evaluates actions purely by their outcomes, proportionalism still insists on the consideration of the moral object.[148] Outcomes matter in proportionalist reasoning, but proportionalists explicitly resist reducing morality to outcomes alone. They still assess the moral object of the act—and the importance of moral objectivity—and, in turn, cannot be treated as pure consequentialists. By collapsing proportionalism and consequentialism into a single category of moral reasoning, *Veritatis Splendor* does not adequately attend to their distinctions. In the words of McCormick: "I think [the objection of proportionalism] misses the point of what proportionalists are saying. When contemporary theologians say that certain disvalues in our actions can be justified by a proportionate reason, they are not saying that *morally wrong actions* (*ex objecto*) can be justified by the end."[149] In this way, the encyclical treated proportionalism "more with dismissal and contempt than through theological critique."[150]

By misrepresenting proportionalism rather than engaging in thorough theological critique, McCormick describes how "the vast majority of moral theologians known as

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[144] Ibid., §79.
[145] Ibid., §75.
[146] Ibid.
[147] Ibid., §48.
[148] Hoose, *Proportionalism*, 2.
[149] John Wilkins, *Considering Veritatis Splendor* (Cleveland: Pilgrim Press, 1994), 18.
[150] Faggioli, "Reading the Signs of the Times," 336.

proportionalists will *rightly* say that they do not hold or teach what the encyclical attributes to them."[151] As McCormick writes a year after the publication of *Veritatis Splendor*, the encyclical will have "zero" effect on the public because "[i]t is too technical and abstract to address anyone but specialists" and it provides "nothing new" for bishops.[152] Earlier, we saw how the proportionalists helped actualize the vision laid out in *Gaudium et Spes* and Vatican II by operationalizing inductive reasoning within, most notably, the healthcare space. In the case of *Veritatis Splendor* and its perceived ineffectiveness, a group of anti-proportionalist theologians attempted to operationalize the vision of Pope John Paul II by addressing its lack of adequate "theological critique."[153] This group, who would later come to be called the New Natural Law theorists, proposed a radical reinterpretation of Thomistic natural law designed to address the perceived weakness of manualist and traditional natural law while defending moral absolutes. Their work would prove instrumental in reshaping Catholic contributions to the abortion and conscience debates by providing the intellectual foundation that any cooperation with abortion—including referrals—is immoral.[154]

New Natural Law Theory

The rising influence of New Natural Law Theory (NNLT) was closely aligned with the absolutist turn in *Veritatis Splendor*. Although the theory originated in the 1960s, the years directly preceding and following the encyclical's publication helped legitimize and consolidate its place within Catholic moral theology. Spearheaded by French-American theologian Germain Grisez and Australian philosopher John Finnis, NNLT offered a rigorously deductive and rule-

[151] Wilkins, *Considering Veritatis Splendor*, 20.
[152] Ibid., 19.
[153] Faggioli, "Reading the Signs of the Times," 336.
[154] Alexander, "Redefining Direct and Indirect Abortions," 30.

based moral framework.[155] This framework, grounded in the reinterpretation of Thomistic natural law, charted a new path within conservative Catholicism. While past conservative traditions such as manualism drew on traditional natural law to uphold moral absolutes through a physicalist focus on the moral object alone, NNLT sought to preserve those absolutes through a more action centered approach. The "underlying theoretical difference" between traditional natural law (TNL) and New Natural Law concerns the definition of a moral act as "intrinsically evil."[156] Within TNL, the "moral object" of an act is rooted in the natural and objective structure of the act itself. An act is good or evil depending on how it conforms to or violates divine wisdom. It is the church's role to articulate and demand adherence to these objective structures.

In contrast, New Natural Law theorists locate objective morality in basic goods—such as life, knowledge, friendship, and religion.[157] These basic goods are "self-evident" and known through practical reason.[158] On the surface, this appears similar to the historicity advanced in *Gaudium et Spes*. Recall that Vatican II viewed human behavior and action as theologically relevant in the church's desire to grasp moral truths. Things like friendship and religion, examples of basic goods within NNLT, seem to fit that category. However, NNLT and *Gaudium et Spes* disagree on how those moral truths are expressed. While *Gaudium* emphasizes the mediating role of conscience, NNLT describes the basic goods as "self-evident." They are known through direct insight without mediation from the church or one's conscience. Grisez describes the connection between the basic goods and the moral truths:

> [T]he moral norm simply is human nature as it is given—given of course, not to sense experience but to rational understanding. Moral goodness and badness can be discerned simply by comparing the essential patterns of human actions with the intelligible

[155] Joshua D. Goldstein, "Rescuing the New Natural Law Theory: From Absolute Values to a Theory of Autonomy," *Canadian Journal of Political Science* 45, no. 2 (2012): 455, https://doi.org/10.1017/S0008423912000406.
[156] Alexander, "Redefining Direct and Indirect Abortions," 30.
[157] Ibid., 41.
[158] Ibid.

> structure of human nature both in its inner complexity and in its essential relationships. The judgment whether an action conforms or not to human nature is completely objective.[159]

The "self-evident" nature of NNLT's basic goods framework also challenged the *is-ought* connection drawn in TNL. As described, the moral structure of an act in TNL is rooted in the natural structure and finality of the act itself. Within this framing, morality is derived from a metaphysical claim about an intrinsic evil (abortion) and transformed into a universal moral norm about what one *ought* never to do (participate in an abortion). David Hume was the first to note that this derivation of *oughts* from *is* requires a value premise to reasonably bridge the gap.[160] In *A Treatise of Human Nature*, Hume notes how philosophers often describe the facts of the world and then, without justification, derive what ought to be done from those facts. There must be a bridge value, some claim that this fact is good, desirable, and obligatory. Traditional natural law theorists addressed the *is-ought* gap by claiming that the human participation in eternal law is rational and ordered toward the good. Since humans have the capacity to reason, they can perceive the intrinsic purposes of life and to recognize that fulfilling them is morally good. Humans have reason and are ordered toward certain goods—the *is*—therefore, humans *ought* to act to fulfill these goods and avoid violating them. By claiming that nature is inherently normative, TNL proposes a metaphysical bridge across the *is-ought* gap.

The New Natural Law theorists rejected the traditional need to derive "ought" from a metaphysical "is." They claimed that even TNL fell victim to relativism: since "[t]he natural teleology of human functions does not necessarily require absolute moral respect," there needs to

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[159] Mark S. Massa, "Germain Grisez and the 'New Natural Law,'" in *The Structure of Theological Revolutions: How the Fight Over Birth Control Transformed American Catholicism* (New York: Oxford University Press, 2018), online ed., Oxford Academic, August 23, 2018, https://doi.org/10.1093/oso/9780190851408.003.0006, 109.
[160] David Hume, *A Treatise of Human Nature*, vol. 1 (England: J. M. Dent & Sons Ltd.; E. P. Dutton & Co., 1911), Book III, Part I, Sec. I.

be something else that grounds morality and demands moral respect as absolute.[161] NNLT proposed that humans directly recognize certain things as basic goods. These goods are "self-evident" to practical reason, which removed the need for metaphysical deduction. Individuals have a "moral obligation to never go against [these] essential or basic human goods."[162] Within this conception, morality flows from the rational recognition of self-evident basic goods. Basic goods are not inferred from human nature; they are pre-theoretical, known by a direct act of practical reason.

In replacing the metaphysical bridge for a practical one, the New Natural Law theorists distinguished their moral system from TNL. The "entire 'new natural law' project undertaken by Grisez and Finnis could be viewed as being about saving natural law by reestablishing it on conceptual foundations that avoided any appeal to metaphysical claims, which modern science had long rejected as outdated and unscientific.[163] This shift toward practical reason also allowed NNLT to more directly critique the proportionalist tendencies of *Gaudium et Spes*. If practical reason is the faculty through which individuals derive the self-evident nature of the basic goods there is no need for prudence (*prudentia*). Recall that *Gaudium et Spes* located objective moral truth in an individual's encounter with God and that the truths are expressed through conscience. But since conscience could still "err," this process required a healthy conscience.[164] Prudence, the intellectual virtue that perfects the practical reason, keeps a conscience on track.[165] The New Natural Law theorists replaced the faculty of conscience with the faculty of practical reason. From their perspective, rather than depend on the obscure faculty of conscience—and

[161] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 25.
[162] Ibid.
[163] Massa, "Germain Grisez and the 'New Natural Law,'" 106.
[164] Vatican Council II, *Gaudium et Spes*, §16.
[165] Thomas Aquinas, *Summa Theologica*, I-II, q. 57, a. 4, trans. Fathers of the English Dominican Province, New Advent, accessed May 2, 2025, https://www.newadvent.org/summa/.

prudence—to perceive moral truths, NNLT provides clarity through its sole reliance on practical reason.[166] Within NNLT, the discernment of moral truths does not require a faculty engaged in prudential reason (conscience). Once a basic good is recognized, actions are deemed moral if they conform to those goods. In turn, NNLT distinguishes itself from proportionalist theories by removing the need for prudence and by redefining and minimizing the role of conscience to a narrow definition of practical reason.

By distinguishing their moral system from both the proportionalist and traditional interpretations of natural law, the New Natural Law theorists provided an alternative vision adjusted to the realities of modern life. Its rigorous theological structure, and its foundation in practical reason, allowed it to more effectively counter the proportionalist account. John Finnis, a founding figure of NNLT, described these practical implications in the following way:

> Socrates, Plato, and Aristotle did not have to face explicitly elaborated proportionalist philosophical proposals…Since we do, we need to articulate a full range of reasons for rejecting such proposals.[167]

Proportionalism grew out of the desire to modernize the Catholic Church in the 1960s. Instead of appealing to authority and retreating to traditionalism, Finnis and NNLT recognized the need to critically engage with proportionalism's theological arguments and to modernize alongside it. Rather than returning to a metaphysical understanding of moral absolutes, NNLT found clarity in the "self-evident" moral absolutes accessed by practical reason.

The 1994 Revision of the Ethical and Religious Directives

Although there is no public record confirming the direct involvement of New Natural Law theorists in drafting the 1994 *Ethical and Religious Directives*, the revision does reflect

[166] Alexander, "Redefining Direct and Indirect Abortions," 41.
[167] John Finnis, *Moral Absolutes: Tradition, Revision, and Truth* (Washington, D.C.: Catholic University of America Press, 1991), 51.

several notable characteristics of NNLT. While the 1971 *Directives* were legalistic, the 1994 revision "moved beyond proscriptions to describe Catholic identity in more positive terms."[168] The more theologically grounded articulation of Catholic healthcare ethics in the 1994 revision parallels many of NNLT's central commitments.

Just as John Finnis recognized the need to modernize by engaging with proportionalism's arguments in a substantial way, the National Conference of Catholic Bishops (NCCB) determined the need to "prepare a more complete, effective, and theologically nuanced set of *Directives*" in response to a changing landscape.[169] In contrast to the 70s where the main concern was the ability of individual doctors or individual hospitals to object to performing abortions, the 90s presented new issues in clinical medicine, insurance, and organization. The new clinical issues included, among many others, an expansion of medical research within health care and the continuous introduction of new techniques for artificial reproduction and genetic testing.[170] The NCCB "enlisted the help of several Catholic organizations and centers, theologians, and ethicists to prepare a new set of *Directives*" that could provide theological commentary on these questions.[171] In November 1994, "[a]fter 11 major drafts," the NCCB approved the "*Revised Ethical and Religious Directives for Catholic Health Care Services*."[172] The revised *Directives* "recognize[d] the social obligation of Catholic health care services to serve the poor, to be responsible stewards of limited resources, and to collaborate with other providers to improve the health of the community."[173] Catholic healthcare authorities aimed to create a more comprehensive Catholic identity within healthcare. In the spirit of NNLT's commitment to

[168] O'Rourke, "A Brief History," 20.
[169] Ibid.
[170] Ibid.
[171] Ibid.
[172] Ibid.
[173] Ibid.

engage critically with proportionalist theories, the *Directives* provided "theological backing for all moral claims made."[174] In turn, the new *Directives* "were more than a mere 'updating' of earlier editions," they were an effort to reassert theological control over revisionist theories.[175]

The question of cooperation became the center of this attempt at theological control. Beyond the clinical changes mentioned above, the 1990s also brought organizational changes to American healthcare. The "[s]urvival of Catholic health care…necessitated collaboration among health care providers."[176] The bishops "recognized that such partnerships might prevent Catholic providers from implementing the *Directives* in a consistent way."[177] This concern over consistent implementation calls back to the NCCB's concern over "geographic morality" in the 1970s.[178] However, while the 1971 revision provided strict legal directions on primarily clinical issues, the 1994 revision took a different approach to the perceived inconsistent implementation. In this new era, the bishops "forecasted the ethical dilemmas that would ensue"[179] and framed the "growing phenomenon of partnerships as a way of promoting the church's social teaching and influencing the health care profession."[180] Instead of mandating conformity to a legalist series of demands, the bishops chose to embrace the organizational challenges so they could address them proactively.

One of the central organizational challenges was the question of cooperation with non-Catholic healthcare institutions. To address this challenge, the bishops added an appendix to its Ethical and Religious Directives which "detailed the traditional principle of material

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[174] Ibid.
[175] Ibid.
[176] Germain Kopaczynski, "Catholic Identity in Health Care and the Relevance of the 1994 Ethical and Religious Directives for Catholic Health Care Services," *The Linacre Quarterly* 89, no. 1 (February 2022): 12, https://doi.org/10.1177/00243639211069777.
[177] O'Rourke, "A Brief History," 20.
[178] Ibid., 19.
[179] Kopaczynski, "Catholic Identity in Health Care," 12.
[180] O'Rourke, "A Brief History," 20.

cooperation."[181] The appendix "sought to explain the principle of 'cooperation in evil,'" by expanding on *Directives* 67-69, which explained the role of each diocese in overseeing collaborations. Directive 67 highlights the challenge of cooperation:

> Each diocesan bishop has the ultimate responsibility to assess whether collaborative arrangements involving Catholic health care providers operating in his local church involve wrongful cooperation, give scandal, or undermine the Church's witness. In fulfilling this responsibility, the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision.[182]

Catholics have long considered the concept of cooperation with evil—or complicity in an immoral act. The bishops recognized that cooperation is an "elusive concept to pin down" because "[i]mplicit formal cooperation can creep into the picture."[183]

To clarify the complicity assigned to each form of cooperation, the bishops distinguished between formal cooperation, material cooperation, and implicit formal cooperation. In formal cooperation, "the person supplying the cooperation desires that the evil happen."[184] For example, a doctor willingly performs an abortion because they agree with the decision to terminate the pregnancy. In this case, the doctor intentionally assists another person's immoral act. In material cooperation, "the person supplying the cooperation does not desire that the evil happen, but chooses to cooperate in the evil." For example, a doctor provides post-operative care to a patient who has just undergone an abortion. In this case, the doctor does not support the abortion but continues to care for the patient out of an obligation to care for the patient. Finally, implicit formal cooperation occurs when "the cooperator denies intending the wrongdoer's object [but] no other explanation can distinguish the cooperator's object from the wrongdoer's object." In

[181] Ibid.
[182] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: United States Conference of Catholic Bishops, 2018), [33].
[183] O'Rourke, "A Brief History," 19.
[184] Kopaczynski, "Catholic Identity in Health Care," 19.

contrast to formal and material cooperation, implicit formal cooperation occupies a morally ambiguous space. For example, a doctor claims that they do not share the intention of the abortion, but they cannot reasonably distinguish their objective. In this sense, their action resembles formal cooperation to an extent that cannot be justified as material cooperation.

Although this may initially seem like a proportionalist approach because it weighs intentions, circumstances, and outcomes, the approach proceeds from a different theological conclusion. Proportionalism separates the good and the bad effects of an action based and judges the moral permissibility of an action by considering the intention of both effects. Chapter 3 will provide a much more detailed account of the proportionalist theory of action as it relates to cooperation with evil. In contrast, implicit formal cooperation does not separate the good and the bad effects, but considers the inseparability of the cooperator's action from the morally illicit act itself. If the action cannot be clearly separated from the morally illicit act, then the cooperation takes on the same moral character as the act itself. In turn, implicit formal cooperation does not reflect a balancing of goods and evils, but a failure to maintain moral clarity when acting.

This concern for moral clarity, derived from the theory of cooperation and complicity laid out in the 1994 appendix, transformed into the concept of "correct conscience."[185] In this process, conscience is not treated as a faculty of moral discernment, but as a tool for conformity to the objective moral norms established by the Catholic Church. This alignment resurfaces the is-ought question. Recall that traditional natural law bridges the "is-ought" gap metaphysically: humans are ordered toward certain goods and ought to act to fulfill these goods. In contrast, New Natural Law theorists turned to practical reason to bridge the gap. Since the basic goods are self-evident to practical reason, there is no need for metaphysical deduction. The 1994 *Directives*

[185] Ibid., 17.

built on this tradition. As described by a Bishop in a newspaper article a couple years after the publication of the 1994 ERDs:

> Catholic health care providers work out of the conviction that there are moral norms written in the hearts of all persons and articulated by the teaching office of the church. These moral norms, usually referred to as the natural moral law, determine what is right and wrong, what is good and what is evil. The world of Catholic health care technology, with all its ability to do so many things, is guided by the recognition that not everything we can do should be done. Rather, Catholic health care begins with the principle that we should do only what we ought to do.[186]

Within this conception, the church articulates the moral norms. Catholic doctors are asked to conform to these articulated moral truths by adopting "a correct conscience based on the moral norms for proper health care."[187] Conscience is not a faculty for discernment but a way to conform to *already knowable* moral truths. By providing clear moral boundaries to, for example, "technology," the church acts as the bridge between what *is* medically possible and what *ought* to be done. As in NNL, the is-ought distinction is preserved through authoritative articulation of moral norms, which conscience is expected to recognize and obey.

This emphasis on moral clarity and absolute conformity to articulated moral norms—grounded in a reinterpretation of the is-ought framework—had far-reaching impacts beyond the intra-Catholic debates. The renewed account of cooperation helped prime the legal understanding of "assistance" in conscientious objection legislation.

The Coats-Snowe Amendment and Expansions of Conscientious Objection

The 1996 Coats-Snowe Amendment to the Public Health Service Act marked the legal codification of absolutist Catholic bioethics. Although the amendment primarily addressed

[186] Rev. Donald W. Wuerl, "Health care ethical and religious directives revised," *Pittsburgh Catholic* (Pittsburgh), November 10, 2000.
[187] Kopaczynski, "Catholic Identity in Health Care," 17.

discrimination in medical training contexts, its specific language signaled a shift from ambiguity to certainty:

> The Federal Government, and any State or local government that receives Federal finance assistance, may not subject any health care entity to discrimination on the basis that…the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide **referrals** for such training or such abortions.[188]

Recall the ambiguity surrounding the term "assistance" in the original Church Amendments: "[No court can]...require [an] individual to perform or assist in the performance of any…abortion if his performance or assistance in the performance …would be contrary to his religious beliefs or moral convictions."[189] The word "assistance" raised interpretive questions about how closely connected an action must be to the procedure itself in order to qualify as "assistance." Understood narrowly, it could be limited to physical or clinical participation. Understood broadly, it could encompass any activity that facilitates access to the procedure—including referring or informing the patient.

While the ambiguity in the statutory language of these early conscience protections allowed for diverging interpretations, the Coats-Snowe amendment explicitly endorsed the broader understanding of "assistance." By naming referral as part of what could be objected to under the term "assistance," Coats-Snowe granted doctors the right to conscientiously object more expansively. This broader reading reflected the logic behind implicit formal cooperation; even seemingly indirect actions such as referral are morally indistinguishable from the wrongful act itself. The legal codification solidified the legal position of the absolutist interpretation of moral complicity and signaled a deepening alignment between Catholic moral absolutism and American conscience protections. Over the next two decades, this alignment deepened through

[188] U.S. Code, Title 42, § 238n.
[189] U.S. Code, Title 42, § 300a-7.

subsequent federal and state-level conscience legislation. However, by the early 2010s under the leadership of Pope Francis, a renewed emphasis on pastoral care and moral discernment has challenged this alignment and reopened space for proportionalism within Catholic moral theology.

The Third Moment: The 2010s-Present and the Struggle for Renewal

The third moment begins in the early 2010s and continues into the present day. With the election of Pope Francis in 2013, the Catholic Church appeared to return to the pastoral and dialogical spirit of Vatican II. In encyclicals such as *Fratelli tutti* and *Evangelii Gaudium*, Francis reopened space for discernment, complexity, and proportionalist reasoning in Catholic moral theology. However, the entrenchment of the absolutist interpretations of the 90s makes integrating that vision of conscience into American conscientious objection rights difficult. Finally, this section briefly explores how new legal and social developments like the *Dobbs* decision might destabilize entrenched Catholic absolutism in America.

Pope Francis and a Renewal of Vatican II

Pope Francis made no secret of his desire to reconnect the Church with the pastoral and dialogical vision of Vatican II. His pontificate consistently returned to the Council's emphasis on discernment, historicity, and the evolving complexity of the world. In contrast to his predecessors—Pope John Paul II and Pope Benedict XVI—Pope Francis encouraged so-called "spiritual discernment" toward moral questions grounded in the conception of the learning church articulated in *Gaudium et Spes*.[190] In *Fratelli tutti*, the third encyclical published in the

[190] Francis, *Evangelii Gaudium: Apostolic Exhortation on the Proclamation of the Gospel in Today's World*, §33, November 24, 2013, https://www.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html.

Francis pontificate, Francis hearkens back to this method—one of inductive humility and cooperation:

> Together, we can seek the truth in dialogue, in relaxed conversation or in passionate debate. To do so calls for perseverance; it entails moments of silence and suffering, yet it can patiently embrace the broader experience of individuals and peoples…Wisdom is not born of quick searches on the internet nor is it a mass of unverified data. That is not the way to mature in the encounter with truth…The process of building fraternity, be it local or universal, can only be undertaken by spirits that are free and open to authentic encounters.[191]

Francis emphasizes that the Church must learn from the "signs of the times," and remain open toward other cultures and moral understandings. Grasping moral truths is a process of discernment, which requires recognizing the theological relevancy of every "revealed message." Moral truth is not rejected, but encountered through dialogue, complexity, and pastoral discernment. As such, Francis frames *Gaudium et Spes* as a living resource for theology *today.*

Francis' appointments of cardinals from regions the world not traditionally recognized in cardinal leadership echo the Second Vatican Council's recognition of the essential theological relevance of an expanded audience.[192] Francis' renewed attention to the poor, the excluded, and the socially vulnerable reflect a theological realignment beyond just a geopolitical strategy. In expanding the audience of the Catholic Church, Francis may have staged a return to what dominant American bishops have long feared: geographic morality—the idea that moral truth, while universal, must be interpreted and applied in ways that reflect lived realities. By approaching the application of moral truths in this way, Francis implicitly affirmed the proportionalist claim that moral reasoning must attend to context, relationship, and the lived

[191] Francis, *Fratelli tutti: Encyclical Letter on Fraternity and Social Friendship*, §50, October 3, 2020, https://www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20201003_enciclica-fratelli-tutti.html.
[192] Faggioli, "Reading the Signs of the Times," 347.

realities of conscience. Although Francis did not revive proportionalism by name, he reopened the space it once occupied.

The Endurance of Absolutes

Even as Pope Francis reoriented global Catholic moral theology toward discernment and dialogue in the last decade, American Catholic institutions, such as the United States Conference of Catholic Bishops, continue to follow the precedent set in the 1990s and early 2000s. In fact, *The Ethical and Religious Directives* have not undergone a substantial revision since 1994.

The USCCB's current posture reveals not only a rejection of Francis' pastoral re-centering of *Gaudium et Spes*, but also a deep theological divergence. As Faggioli notes, "The problematic reception of *Gaudium et Spes* in the United States is part of the problematic relationship between some sectors of the Catholic Church in the United States and Pope Francis."[193] This disconnect is particularly stark in bioethics. Recent drafts of possible revisions to the ERDs—proposed in light of new challenges in reproductive care and partnerships—suggest an even more rigid enforcement of moral prohibitions, with increasing concern for eliminating any risk of "complicity." Cooperation and the question of complicity is still interpreted broadly, not narrowly. Rather than reintroducing prudence, formation, or context into Catholic moral evaluation, these revisions would further entrench a static model of moral action and conscience—one that leaves little room for pastoral flexibility or historical consciousness. As described in Chapter 1, mergers between Catholic and non-Catholic hospitals are increasingly common in the American healthcare space.[194] In these contexts, the broad interpretation of complicity and cooperation—enforced primarily through the *Ethical and Religious Directives*—

[193] Ibid., 336.
[194] Hasselbacher et al., "'My Hands Are Tied,'" *Perspectives on Sexual and Reproductive Health* 52, no. 2 (2020): 107-15.

integrates into the secular contexts, often without transparency or the consent of those affected by its demands.

While conscience rights were conceived of as a space for pastoral discernment and the preservation of moral integrity within a pluralistic society, they increasingly serve a political function. In the American context, conscience rights become entangled in legal battles not just over abortion and contraception, but also questions such as LGBTQ rights and transgender care.[195] As Oakland University professor Abram Brummett describes, "[r]ecent developments have brought public attention to the issue of conscientious objection related to LGBTQ rights."[196] Trump's 2019 "Final Rule" "substantially expanded the scope of who can object and what can be objected to in the medical context" by, among other things, "overtur[ning Biden era] referral requirements for individual medical providers or institutions exercising conscientious objection."[197]According to Brummett, the approach to conscience in the 2019 "[Final Rule] does not place *any* substantial constraints on the exercise of conscience." It "effectively permit[s] clinicians to conscientiously object to serving members of the LGBTQ community."[198] In early November 2019, a federal judge struck down the "Final Rule," following immediate legal complaints.[199] Now, during the Second Trump administration, this HHS "Final Rule" is back on the table.[200] In these contexts, the absolutist framing continues to provide an effective legal and rhetorical tool.

[195]Abram Brummett and Lisa Campo-Engelstein, "Conscientious Objection and LGBTQ Discrimination in the United States," *Journal of Public Health Policy* 42, no. 2 (June 2021): 322, https://doi.org/10.1057/s41271-021-00281-2.
[196] Ibid., 323.
[197] Ibid.
[198] Ibid.
[199] Ibid.
[200] Hawley, *Restoring Healthcare Workers' Conscience Rights Act*.

Destabilizing Potential of Dobbs

If *Roe v. Wade* provided the legal and cultural conditions that enabled the rise of the absolutist understanding of conscience and complicity, then *Dobbs v. Jackson Women's Health Organization* may offer a corresponding opportunity for theological realignment. In the 1970s, the post-*Roe* landscape incentivized Catholics to strategically align behind the conscientious objection right. Crucially, this sidelined the proportionalist method and its proponents by promoting a uniform, absolutist direction for conscience protections in American healthcare.

But *Dobbs* fractures that coalition. By overturning *Roe* and returning abortion regulation to the states, Catholics are now faced with a pluralistic legal landscape. In some states, Catholic healthcare institutions operate within majorities that share their moral commitments; in others, they are embedded in highly liberal environments where state laws protect access to abortion and reproductive care. This pluralism places pressure on the absolutist model of moral evaluation.

We have encountered this kind of pluralism before in the form of "geographic morality"—the recognition that Catholic moral responses often vary across dioceses and regions depending on context, leadership, and institutional pressures.[201] While dominant voices throughout history framed this variance as inconsistent implementation of doctrine, it may now reflect the Church's deeper call to contextual pastoral engagement. In the decentralized legal landscape after *Dobbs*, proportionalist reasoning—with its emphasis on discernment, intention, consequences, and local realities—offers a viable and theologically grounded framework for navigating pluralism. Unlike the absolutist model, which demands strict adherence to exceptionless norms, proportionalism can engage more constructively with the diverse moral contexts that Catholic healthcare now inhabits. *Dobbs*, then, is not just a political disruption—it

[201] O'Rourke, "A Brief History," 19.

is a theological opportunity. It destabilizes the uniformity that made absolutist conscience protections so strategic in the *Roe* era. In doing so, it invites a return to the pluralistic and dialogical moral theology envisioned by *Gaudium et Spes*.

As this chapter has shown, there are deeply rooted disagreements over how to interpret action, complicity, and the scope of moral responsibility within the debate over conscientious objection. These disagreements are not simply abstract—they shape how Catholic doctors engage real patients in moments of deep vulnerability. The next chapter compares the absolutist and proportionalist theories of action. A closer analysis of their differences reveals that the proportionalist approach provides the theological means to narrow the conscientious objection right.

III. REFERRAL AS MORALLY JUSTIFIED

A Proportionalist Theory of Action and Complicity

Catholic moral theology is not a monolith. There have been and continue to be deeply rooted disagreements over how to live a moral life. Chapter 2 demonstrated how proportionalist and absolutist interpretations of Catholic moral theology influenced the legal development of conscientious objection rights in the United States. It described how the absolutist rather than the proportionalist interpretation of complicity drives the expansion of conscience protections. Given this context, the question becomes: how far can and should conscience rights be expanded? Even if grounded in sincere theological commitments, should doctors be able to object to referring patients? Should they be allowed to object to informing patients? Where should the line be drawn?

Conscience rights have always been subject to some limitations. For example, healthcare providers cannot invoke conscience rights to engage in discrimination based on race, sex, or disability; notably, these discrimination laws limit the objections based on intent.[202] Doctors are also legally mandated to ensure the delivery of emergency care; the Emergency Medical Treatment and Labor Act of 1986, known as EMTALA, can override individual objections to ensure that patients receive life-saving treatment.[203] Discrimination clauses and emergency medicine mandates are *legal* restrictions on doctors' conscientious objection rights and, as such, constitute legal attempts to draw the line.

Chapter 2 demonstrated that the debate over conscientious objection is not just a legal question; it is a theological one. In recognizing the theological dimension, this third chapter

[202] Brummett and Campo-Engelstein, "Conscientious Objection and LGBTQ Discrimination," 322.
[203] U.S. Department of Health and Human Services, Office of Inspector General, "The Emergency Medical Treatment and Labor Act (EMTALA)," last modified September 11, 2024, https://oig.hhs.gov/reports/featured/emtala/.

proposes a theological answer to the line-drawing question by employing the proportionalist Catholic moral theory of action. Because the line-drawing is derived from Catholic moral theology, it primarily offers guidance to Catholic doctors. The final chapter will speak more broadly to public policy debates about the limits of conscience rights in a pluralistic society.

Since decisions in healthcare are particularly complex—involving competing goods and uncertain outcomes—a doctor's decision to conscientiously object is rarely taken lightly. Objections almost always arise in these situations that have a complex moral character. Moreover, doctors often must make these decisions under serious time constraints. To begin building the case that proportionalist reasoning offers a clearer, more pluralistic answer to the line-drawing question, let's revisit the second scenario introduced in Chapter 1. This time, pay particular attention not only to how Dr. Hastings grapples with the moral ambiguity of the situation, but how her understanding of complicity shapes her response to the situation. Notice, also, how the absence of guidance and support affects the patient, Anna:

On November 14th, 2024, 19-year-old Anna Mitchell arrived alone at Riverside Medical Center in Montana. She's a first-year college student from out of state. She's far away from her parents. She doesn't have a car. Earlier that morning, she took a pregnancy test and the result was positive. Her relationship with her college boyfriend ended weeks ago, and she has yet to tell her parents. She's struggling to keep up with classes, missing work shifts, and has started to experience panic attacks. Anna doesn't know what to do, but she knows she needs to seek help. So she makes an appointment with the first available doctor at Riverside with the hope that someone can talk her through her options.

Within the hour, Anna is seen by a doctor who asks her to explain the reason for her visit. Anna openly shares the circumstances, including her likely intention to terminate the pregnancy. Anna believes she's about eight weeks pregnant, which puts her well below the Montana abortion limit of 24 weeks. Anna assumes that, at this stage, she will at least receive help navigating her options.

The doctor is Dr. Laura Hastings who nods along as Anna speaks. Hearing Anna explain her situation—her fear, her financial instability, her desire not to terminate the pregnancy—Dr. Hastings listens with compassion. She doesn't dismiss Anna or judge her. Internally, however, her thoughts turn to her faith. Dr. Hastings identifies as Catholic, and in her view, Catholic tradition teaches that any degree of participation morally implicates her in the procedure. To refer Anna to another doctor, or even to describe her options in practical terms, would constitute cooperation with evil. To counsel Anna toward abortion would render her complicit in a grave moral wrong. As Anna gives more details, Dr. Hastings knows that performing the procedure herself—or referring Anna to someone who would—would cause her significant moral distress. It's not just about what she does with her own hands; it's about being part of a chain of decisions that, to her, result in the ending of a human life.

Dr. Hastings debates her options. She wants to be transparent with Anna about these personal convictions, but her beliefs about complicity restrain her. She knows that Montana law protects her right not to refer or inform.[204] *Ultimately, Dr. Hastings determines that providing any clear information about Anna's options morally implicates her in the abortion that Anna would likely*

[204] Center for Reproductive Rights, "Montana," *After Roe Fell: Abortion Laws by State*, accessed May 1, 2025, https://reproductiverights.org/maps/state/montana/.

receive. She conscientiously objects to perform, refer, or inform Anna. Furthermore, she decides not to disclose any information about the objection. Dr. Hastings thanks Anna for sharing, maintains a calm and professional tone, and tells her that follow-up care will need to happen elsewhere. She offers no names, no numbers, and no list of clinics. She does not explain why.

Anna is confused. She came expecting, at the very least, a conversation. Instead, she leaves the exam room with no plan and no idea where to turn next. The visit has left her more isolated, as she leaves the hospital feeling disoriented and discouraged to seek care elsewhere. Dr. Hastings leaves work that day feeling conflicted over the consequences of her objection.

Dr. Hastings invoked her conscience rights—rights deeply informed by a moral absolutism that sees any involvement in abortion as morally impermissible. Dr. Hastings believes her silence was the only morally acceptable option. As it turns out, Riverside Medical Center is the product of a recent merger between a Catholic hospital and a nearby secular hospital. Almost all Catholic hospitals operate under the Ethical and Religious Directives *which explicitly prohibit abortions and referrals for abortions within their facility. When she worked in the openly Catholic hospital, Dr. Hastings never encountered a patient seeking an abortion; most patients would seek that kind of reproductive care and guidance at other hospitals. For the past six months, however, Riverside has grappled with the ethical ambiguity around the integration of the* Directives *within the guidelines of the secular hospital. Dr. Hastings worries the institutional ambiguity increases the possibility of something like this happening again.*

Dr. Hastings' objection to referring and informing Anna emerges not from indifference but from a sincere moral conviction rooted in an absolutist framework. Counseling Anna toward abortion, even if that counseling comes in the form of a referral to another doctor who may or may not provide the abortion, would constitute cooperation with evil. By treating all cooperation as cooperation with evil, absolutist moral reasoning leaves doctors like Dr. Hastings with only one option: complete objection. Dr. Hastings did not object lightly. She recognizes Anna's fear, her financial instability, and her desire to seek an abortion. This chapter is addressed primarily toward those Catholic doctors who feel the tension between their professional obligations as doctors and their faith's moral teachings. With that said, how would the scenario unfold if Dr. Hastings employed proportionalist reasoning in her decision to object? Would it compel her to inform Anna of her options or refer Anna to another doctor? Proportionalism acknowledges that decisions in healthcare are often morally ambiguous, especially ones that may call for a conscientious objection. In light of that ambiguity, proportionalist reasoning calls for an evaluation of the totality of the act of referring or informing the patient; it evaluates the object, intention, and consequences of the referral.[205] In evaluating how proportionalism allows for referral, this chapter operates under the assumption that informing the patient follows the same moral logic. If referral can be justified as moral, then informing, which is less proximate and carries less moral weight, requires even less justification.

Notably, the bulk of this chapter does not focus on the act of objection itself, because absolutists and proportionalists disagree that objection constitutes an action: while proportionalists view conscientious objection as an act in itself, absolutists view conscientious objection as a *refusal* to act and, therefore, not an action. However, both traditions do interpret

[205] Hoose, *Proportionalism*, 2.

referral as an action. As a result, the analysis below primarily focuses on how absolutists and proportionalists evaluate the act of referral. With reference to action, the absolutist interpretation of complicity relies on a sequential view of human acts (in this case the act of referral) that assess the human act in a fixed order according to a sequential process. Proportionalism rejects that fragmentation and therefore allows us—or the Catholic doctor—to assess the totality of the act. By assessing the totality of the referral and by using proportional reasoning to weigh the intention and the proportionate good of the referral, proportionalism allows us to determine that referral is a morally licit act. Within the proportionalist framing, since the referral is a unified act oriented toward a moral good, the foreseen but indirect bad consequence (the likely abortion) can be tolerated—not because it is desired or morally endorsed, but because it is unintended and proportionally outweighed by the moral good. As such, a proportionalist analysis lets us draw a theologically grounded line between what constitutes morally licit and illicit conscientious objections. I argue that refusing to refer or inform is not a defensible exercise of conscience but rather an unsustainable extension of conscientious objection that undermines both patient care and a properly nuanced account of moral cooperation. This account is both theologically grounded and timely. For one, the Vatican's renewed emphasis on pastoral discernment, especially under the leadership of Pope Francis, has opened new space for proportionalist thought within Catholic ethics. Second, in the wake of the *Dobbs* ruling and the rapid transformation of the abortion landscape in the United States, proportionalism offers a moral tool for decision-making in an increasingly complex, fragmented, and pluralistic legal landscape.

The Absolutist Theory of Human Action

To understand why the absolutist interpretation views referring a patient to another doctor as a morally illicit act, we need to dive into the absolutist interpretation of human action. As

described, absolutists operate from a deontological moral framework. Deontological theories, particularly those within the Catholic moral tradition, argue that "there are at least some actions whose moral quality is completely independent from their consequences."[206] Certain actions are understood to be intrinsically evil. For example, Catholic deontological theories would claim that an abortion would always be wrong, no matter the consequences of not performing the abortion might be."[207] The same logic applies, by extension, to any act that is construed as cooperation with abortion, including referral.

Crucially, when "Catholic tradition is described as sponsoring [this] deontological ethical methodology, it should be understood in this strict sense."[208] Deontological frameworks operate on an is-ought logic by moving from a metaphysical claim about an intrinsic evil (abortion) to a universal moral norm about what one *ought* never to do (participate in an abortion). What is deemed an evil act externally becomes the sole basis for what one *ought* never to do. Absolutism is grounded in a strict deontological framework with rigid moral absolutes. Naturally, "[m]oralists of the catholic tradition" were aware of this rigidity and of the "the extreme hardships which a strict interpretation of deontological prohibitions will give rise to."[209] The "moralists" recognized the inadequacy of strict deontological reasoning as it applied to real life.

In absolutist moral theology, the human act is not evaluated as a single, integrated whole.[210] Instead, it is broken into a sequential process, in which each component—the object, intention, and consequences—is assessed in a fixed order. First, the moral object of the act is identified. If the object is deemed intrinsically evil, the action is deemed immoral and the

[206] Lucius Iwejuru Ugorji, *The Principle of Double Effect: A Critical Appraisal of Its Traditional Understanding and Its Modern Reinterpretation* (Frankfurt am Main: Lang, 1985), 22-3.
[207] Ibid., 20.
[208] Ibid., 23.
[209] Ibid., 54.
[210] Ibid., 53.

evaluation stops there. If the object is deemed good or neutral, the evaluation proceeds to the second criterion: the intention of the agent. If the intentions are good, the evaluation proceeds to the third and final criterion: the consequences.[211] If both the object and intention are deemed permissible, the bad consequences are considered acceptable. The sequencing of the act—into object, intention, and consequences—fragments human action. The absolutist theory of action is a fragmented one. Think of it as a checklist; if the object is judged intrinsically evil—then the act cannot, ever, be moral. Once the act is deemed morally wrong *ex objecto*, the motivation, context, and outcome of the act become morally irrelevant.

Since the object comes first, it is given primacy in the sequence. In granting the object absolute primacy, the absolutist interpretation collapses the definition of the object with the foreseeable effects of the act. Once the object is defined in terms of its anticipated effect, the intention and the consequences of the act are rendered morally irrelevant. In the context of referring a patient to another provider, the anticipated abortion becomes a part of the object. Since abortion is the object of the referral, the act of referral itself becomes intrinsically evil. It is in this manner that the absolutists merge the object of the act and the consequences of the act.

The moral absolutists trace this theory of action to their interpretation of Aquinas' discussion of self-defense in *Summa Theologiae*.[212] As they faced increasing pressure to defend their rigid interpretation of Aquinas in the 20th century, they configured the sequence as a conditional framework: the Doctrine of Double Effect (DDE). DDE was a systematized four-part doctrine, making it particularly useful for guiding moral action in the bioethics realm. Its very existence reveals that absolutist frameworks struggled to handle complexity without contradiction. The framework aimed to resolve tensions in situations with a double moral

[211] Ibid.
[212] Aquinas, *Summa Theologicae*, II-II, q. 64, a. 7.

character where bad effects could result from otherwise good or neutral acts. It was intended to preserve deontological rigor, while allowing for some flexibility in hard cases.[213] Under certain conditions, DDE granted that "a person may perform an action even though [they] foresee that one of the effects will be evil, either physical or moral."[214] Notably, DDE was developed as a theological tool within Just War Theory—an ethical framework for evaluating the moral legitimacy of war. Just War Theory and its associated concept of "selective conscientious objection," was one of the earliest, large-scale applications of Thomistic ethics to questions of social justice and state coercion.[215] Its utility in the complex terrain of war suggests that the framework can provide a conceptual tool for applying Thomistic insights to healthcare—another complex terrain. Although outside the scope of this project, the use of DDE in war reveals that despite the framework's theoretical flexibility, DDE can be interpreted in ways that preserve moral boundaries instead of engaging with moral complexity. This tendency is important to keep in mind as we continue analyzing DDE within the absolutist and proportionalist theories of action.

At first glance, DDE allowed the maintenance of moral absolutes even in morally ambiguous situations. Although it introduced a small degree of flexibility, satisfying DDE required passing a very rigorous series of conditions.[216] In the Doctrine of Double Effect, one's action is justified if it fulfills four conditions: 1) "the action which is to be performed by the agent must be morally good, or at least morally indifferent by its nature," 2) "the bad effect may only be permitted; it may not be willed in itself, 3) "The good effect must be caused at least as

[213] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 145.
[214] Ibid.
[215] Larry May, "Selective Conscientious Refusal," in *Contingent Pacifism: Revisiting Just War Theory* (Cambridge: Cambridge University Press, 2015), 236.
[216] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 145.

directly as the bad effect. In other words, the bad effect may not be a means to produce the good effect. In the order of *causality*, the good effect must be at least equally immediate with the bad effect," and 4) "The good effect must be sufficiently beneficial to compensate for…permitting …the bad effect. Many factors must be considered in determining this condition. Thus, a greater good is *per se* required to compensate for…permitting…a *morally* bad effect (the sin of another) than for permitting…a *physically* bad effect; a greater good is required when the bad effect is sure to follow than when it will only *probably* follow; a greater reason is required only when the bad effect is injurious to the *common* good than when it is harmful only to an *individual*."[217] In simpler terms, the four conditions are: 1) the act itself must be good or neutral, 2) the bad effect must not be intended, 3) the bad effect must not be the means to the good, and 4) there must be a proportionate reason to allow the bad effect. This fourth condition may seem oddly familiar—that's because it is. The fourth condition employs proportionate reasoning to determine that an act can be morally good even if a physical bad effect occurs as a result of the act.

In theory, the Doctrine of Double Effect nuanced the deontological rigor of the absolutist interpretation of human action. In practice, however, since absolutists conceived of human acts as sequential and collapsed the object of the act with the consequences of the act, DDE proved useful very rarely. In this way, DDE functioned more as a symbolic concession than as a practically applicable tool: the high threshold of the four conditions would prove nearly impossible to meet. Most moral dilemmas would not go further than the first condition—the evaluation of the object. In many ways, the incorporation of DDE allowed the absolutists to acknowledge the complexity of moral life without actually incorporating that complexity into their theory of action. As a result, DDE did not offer a genuine path for resolving moral

[217] Ibid., 146.

ambiguity in a context-sensitive manner. It failed to account for the lived complexity of cases like referral, where intention and consequences are integrated in the moral analysis.

The Proportionalist Theory of Human Action

Proportionalists expressed "uneas[e] about the absolutist fragmentation of the human act," and argued that it artificially separated the components of an action.[218] They criticized the absolutist use of a reductive moral framework in which unintended consequences of an act could be construed as morally evil, claiming the reductionist approach used rigid categories and predetermined absolutes to obscure the full moral meaning of an act. Proportionalists also rejected the way in which the absolutist theory of action collapsed the object with its consequences. Beginning with Peter Knauer, the European founder of "proportionalism,"[219] and continuing with theologians such as W.H.M. Van der Marck and Richard McCormick, proportionalists advanced an alternative account of human action.

Proportionalism spoke of "two aspects of one and the same action," and, as such, "safeguard[ed] the unity of the human act."[220] Rather than speaking of an act that causes two effects—where one could be good and the other bad—Knauer insists that we must evaluate the entire act in its moral totality. This considered the good and the bad aspects as integrated in a single moral action. Uniting the human act allowed for the consideration and weighing of intention in morally ambiguous situations; it softened the rigid first condition proposed by the absolutists because it allowed for the evaluation of *intention*—what the absolutists considered only second after the moral evaluation of the object.[221] While the traditional interpretation of

[218] Hoose, *Proportionalism*, 1.
[219] Ibid.
[220] Ibid., 2.
[221] Ugorji, *Principle of Double Effect*, 53.

Thomism considered directness vs. indirectness, it did so in the context of the act. Essentially, if the individual acts, the object, intention, and consequences of that action are direct; if the individual withdraws from action, then the object, intention, and consequences of the *in*action are indirect. The indirectness absolves the individual from cooperation with evil. In contrast, proportionalism considers not the directness of the act, but the directness of the morally *bad* effect. Knauer maintains that the actor's intention of the physical good can be evaluated as *separate* from the physical bad. In turn, an act with an associated physical bad can still be a morally good act. If the "physical evil associated with [the "simply" good] is objectively beyond the intention of the person willing," it is "the simply good that determines the intention."[222]

Distinguishing the good and bad intentions of the actor allows Knauer to define the bad effect as either direct or indirect "depending on the presence or absence of a proportionate reason."[223] As Knauer describes, "the moral subject may permit an evil effect of his act only if this effect is indirect, being counterbalanced by a proportionate reason."[224] If the bad effect is direct, the act becomes morally evil; however, if the bad effect is indirect, the act becomes morally good. And "for the bad effect to become indirect, the good reason must occupy the entire field of the direct object of the act, so that the direct object is fully identified with the good reason of that same act." In this case, the proportionate reason becomes "nothing other than the direct object." To satisfy proportionate reason, the good needs to be the proportion of the act to its end. In other words, the moral weight of the intended good must be strong enough to justify permitting the act's foreseen negative consequences. However, when "the act performed

[222] Hoose, *Proportionalism*, 2.
[223] Ibid.
[224] Ibid.

undermines the very value being pursued, the act lacks the proportionate reason to justify the act as good."[225]

By granting access to proportionate reason, Knauer reinterprets Thomism: "For St. Thomas, he says, 'what remains outside of the intention' is 'accidental.'"[226] However, if the physical evil is not "justified by a proportionate reason," namely the intention of the "simply" good, the act becomes morally evil. In such a case, the evil is not "accidental:" "it enters into the very object of one's act."[227] Within this framing, the moral legitimacy of permitting an evil extends beyond intention—it's about whether, in the totality of the act, there is a proportionate reason to act in a way that has both good and bad consequences. Instead of describing the "physical act or object as morally wrong, this theory speaks of premoral, ontic, or physical evil that can be justified for a proportionate reason."[228] When acting, an individual must not intend the evil and they must have a serious moral justification for permitting it—it's that moral justification that becomes the proportionate counterweight to the bad effect of the act.

The use of "proportionate reason" is a reference to the fourth condition of the conditional framework of the Doctrine of Double Effect—that there must be a proportionate reason to allow the bad effect. Although the fourth condition was very rarely reached in its absolutist context, Knauer "asserts that 'rightly understood' the rule of double effect functions as the fundamental principle of normative ethics which specifies when the permission or causation of a physical evil is justified and when it is not."[229] Knauer recognized proportionate reason as the "fundamental principle" of the moral evaluation of an act. In granting access to the fourth condition—

[225] Ibid., 4.
[226] Ibid., 2.
[227] Ibid.
[228] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 260.
[229] Ugorji, *Principle of Double Effect*, 13.

proportionate reason—the proportionalist theory allows for the consideration of proportionate reason in *all* doubly moral situations. However, proportionalism does not claim that any action can be justified simply because it aims at a desirable outcome. In grounding its revised theory of action *back* in the Doctrine of Double Effect, proportionalism also addresses concerns about their theory as relativistic. DDE places real moral limits on the act: the agent must not intend the bad effect; the bad effect must not be the means to the good; and the good must be sufficiently proportionate to justify tolerating the unintended harm. In this sense, proportionalism evaluates an action in light of its context *and* affirms the moral norms that undergird the action.

In contrast to the deontological absolutist interpretation, proportionalism presents a teleological interpretation of a human act. Teleological theories "assert that the moral rightness or wrongness of an act is 'always determined by its tendencies to produce certain consequences which are intrinsically good or bad."[230] In his work, McCormick considered these "diverse ethical theories on a scale."[231] On one end of the scale are the "absolute deontologists."[232] These thinkers include Kant, Catholic tradition, Grisez (New Natural Law Theory), and Anscombe. At the other end of the scale are the "absolute consequentialists," which include Joseph Fletcher and some utilitarians. McCormick then names the "moderate teleologists," which include "Fuchs, Knauer, Schüller, Curran, and so on." [233] As described in Chapter 2, although McCormick expressed hesitancy toward Knauer's early proportionalism due to its relativistic tendencies, he viewed moderate teleology, of which Knauer was a part, as the "golden mean" between the deontologists and the consequentialists.[234] Teleologists "agree that it is their task to provide

[230] Ibid., 20.
[231] Ibid.
[232] Ibid.
[233] Ibid.
[234] Ibid.

guidelines for the good…life."[235] In employing a teleological framework, proportionalism provides guidelines in morally ambiguous situations. Such guidelines allow the individual in question to live "the good life."

Referral as Justified

The proportionalist reinterpretation of the absolutist theory of action provides a way to distinguish between morally licit and illicit acts. According to proportionalist reasoning, refusing to refer or inform a patient is not a defensible exercise of conscience but rather an unsustainable extension of conscientious objection that undermines both patient care and a properly nuanced account of moral cooperation.

To illustrate this, consider the classic trolley problem as an analogy. A runaway trolley is heading toward five people on the tracks. A bystander has the option to pull a lever and divert the trolley to another track with only one person. The question becomes: knowing that diverting the trolley will kill one person but save five, is it morally permissible for the bystander to divert the trolley to the track with one person? Under absolutist logic, pulling the lever and killing one person would constitute direct cooperation with evil. By not pulling the lever, the bystander avoids direct cooperation. Even though the bystander knows the trolley will now kill five people, they will not have *acted*—and therefore they are not cooperating with evil. This may seem reasonable in theory, but in the context of healthcare, the consequences of such inaction cannot be overlooked.

In the healthcare context, the doctor becomes the bystander. The five people on the track represent the doctor's professional and ethical obligation to ensure patient well-being, obligations that are embedded in medical standards of care or commitments such as the

[235] Ibid.

Hippocratic Oath. The moving trolley represents the patient's autonomy, in this case the patient's expressed desire to seek an abortion. The one person on the second track represents the likely abortion that the patient will receive from the referral. If the doctor intervenes (pulls the lever by offering a referral), the patient may be granted an abortion. If the doctor does nothing (conscientiously objects to pulling the lever), the doctor's professional obligation to ensure patient well-being is actively compromised, not passively avoided.

The absolutist framework would argue that the doctor should do nothing—that they should conscientiously object to the act. Recall that if the object of the act is deemed immoral, the moral evaluation ends and the act is deemed morally impermissible. Recall also that the absolutist theory of action collapses the object with its consequences. When the doctor pulls the lever and refers the patient to another provider, the object of the act is both the doctor's obligation to patient well-being *and* the likely abortion that results from the referral. Since abortion is deemed immoral, the object of the act is deemed immoral. And when the object of the act is immoral, the act becomes morally impermissible. By absolutist reasoning, the doctor cannot, in good conscience, refer the patient to another doctor. Therefore, the doctor should conscientiously object to the act of referring the patient. Even if the doctor's obligations to patient well-being (five people on the track) are compromised, the doctor cannot refer the patient because it renders them complicit in an immoral act.

By contrast, the proportionalist framework would argue that the doctor should pull the lever—that they should refer the patient to another doctor. Since proportionalist moral reasoning treats the act as a unified whole, both the good effect (upholding the doctor's obligation to patient well-being) and the bad effect (the likely abortion) are considered in the moral evaluation. In considering directness not in terms of the act but in terms of intention,

proportionalism argues that the bad effect is indirect if unintended. Since the object of the doctor's referral is morally good (obligation to patient well-being), and since the bad effect (the abortion) is "objectively beyond the intention of the person willing," the good effect "determines the intention" and the referral would be morally permissible.[236] The doctor can, in good conscience, refer the patient to another doctor.

Although not a perfect analogy, the trolley problem is useful because it clarifies the structure of certain moral dilemmas. Just as the trolley problem forces one to choose between two ethically fraught options, Catholic doctors facing conscience-based conflicts—whether to object, to refer, or to inform—are confronted with unavoidable moral decisions. As medical professionals, they cannot simply opt out; they must act, often under urgent conditions. Ethical guidelines like the Catholic *Ethical and Religious Directives* are intended to help doctors structure these decisions. However, as demonstrated, the Catholic *Directives* offer a limited and inadequate theory of action that does not account for the doctor's obligation to patient well-being. In contrast, the proportionalist theory of action offers a more morally responsible framework, one that acknowledges the complexity of moral acts in healthcare contexts.

Let's return to the initial scenario presented at the beginning of this chapter to demonstrate the way proportionalism provides a normative moral framework for the doctor. Recall that Dr. Hastings conscientiously objected to referring Anna to another doctor and to informing Anna of her options. By treating all cooperation as cooperation with evil, absolutist moral reasoning left Dr. Hastings with only one option: complete objection. Proportionalism provides an alternative. If Dr. Hastings employed the proportionalist theory of action, she could, in good conscience, refer Anna to another doctor. At the very least, she could inform Anna of her

[236] Hoose, *Proportionalism*, 2.

options. Here's a shortened version of the scenario to demonstrate how the proportionalist theory could be employed in the healthcare context:

It's November 14th, 2024, and 19-year-old Anna Mitchell arrives alone at Riverside Medical Center in Montana. Within the hour, Anna is seen by a doctor who asks her to explain the reason for her visit. Anna openly shares the circumstances, including her likely intention to terminate the pregnancy.

The doctor is Dr. Laura Hastings who nods along as Anna speaks. Hearing Anna explain her situation—her fear, her financial instability, her desire not to carry the pregnancy—Dr. Hastings listens with compassion. She doesn't dismiss Anna or judge her. But internally, her thoughts turn to her faith. Dr. Hastings identifies as Catholic, and she knows that she cannot, in good conscience, perform an abortion. Dr. Hastings debates her options. Out of an obligation to transparency and patient well-being, she tells Anna that she does not perform abortions for reasons of conscience. Dr. Hastings files for conscientious objection status in the hospital, informs Anna of her options, and offers to refer her to another doctor.

Anna leaves the visit with a scheduled appointment to see another doctor in two hours. Dr. Hastings leaves work that day feeling confident that she fulfilled her professional obligations and stayed true to her faith. Furthermore, now that she's filed for conscientious objector status in the hospital, she's confident that she'll be able to handle any future situations responsibly and ethically.

The proportionalist theory of action allowed Dr. Hastings to make the theologically sound decision to refer and inform Anna. But what would happen if Dr. Hastings wasn't working in a newly merged hospital that allowed doctors to refer? As described, the Catholic *Directives* for healthcare explicitly prohibit doctors from performing or referring patients for abortions.[237] The *Directives* operate largely under the traditional absolutist theory of action. In light of their obligations to patient well-being, could proportionalist reasoning not only permit but *mandate* that a Catholic doctor refer the patient? In turn, would proportionalism demand that all doctors—even those in Catholic hospitals—refer patients?

Referral as Mandated

From a proportionalist perspective, conscientious objection to referral is not a morally neutral withdrawal from action—it *is* an action. This chapter presented two competing methods for evaluating the morality of an action. Since proportionalist reasoning will be used to define the objection as an action, this section makes the argument for mandated referral by continuing to employ proportionalist reasoning.

Proportionalists hold that the moral significance of an act lies in its intentional and relational context, not exclusively in its external form. An act that may appear, externally, to be a refusal to participate may in fact carry deep moral consequences. Those consequences define the objection as an act. As proportionalist theologian Francis J. Connell describes, "[t]he omission of an act, to be voluntary and imputable, must proceed from a positive act of the will, deliberately choosing not to perform the act, or at least deliberately choosing not to will to perform the

[237] USCCB, *Ethical and Religious Directives*, 24.

act."[238] In the proportionalist framing, objecting constitutes an action and must therefore be evaluated as such.

Early proportionalist thinker William Van der Marck proposes a method of evaluation that depends on understanding the act's effects on the community: "[t]wo human acts may be *externally* and *materially* much the same, and yet one may be entirely different from the other."[239] The moral evaluation of the objection must concern itself with the "immanent finality of the material act within the sphere of intersubjectivity."[240] In other words, if the sphere of intersubjectivity is "community," the expected consequences of the objection must take into account the effects of that objection within the community:

> The real (formal) difference between acts which are externally (materially) completely alike arises from the essentially inter-subjective character of all human-acts…The most fundamental and ultimate thing that can be said about a human act is that it is community-forming or community-breaking—it makes for a communal relationship, or rejects it.[241]

Van Marck believed the absolutist account committed "a fundamental error" by treating an act that breaks the community as "completely alike" to one that forms the community.[242] Moral actions must be judged by how they shape, sustain, or sever relationships. The morality of the act is based on its "totality," which essentially means its effects on community. Within this method of evaluation, a "community-breaking" act is immoral, while a "community-forming" act is moral.

The act of refusing to refer cannot be understood as a morally neutral withdrawal—it is a "community-breaking" act in the sense that it disrupts the communal relationship between doctor

[238] Curran and McCormick, *Historical Development of Fundamental Moral Theology*, 136.
[239] Hoose, *Proportionalism*, 9.
[240] Ibid.
[241] Ibid.
[242] Ibid.

and patient. When a doctor refuses to refer, they are rejecting the relational obligation that undergirds the patient-doctor relationship. Even if the doctor cannot perform the procedure in question, the refusal to assist the patient in accessing further care, especially when done without explanation or redirection, breaks that relationship. In Van der Marck's terms, it is a "community-breaking" act and, therefore, immoral. Referral is not just a justified act, it is a morally mandated act.

This community-based moral evaluation challenges the dominant moral logic of the American legal and cultural framework. Although the next chapter contains a more exhaustive description of the distinction between positive and negative rights to the conscience conversation, suffice it to say here that the American approach to rights—especially rights of conscience, free speech, and religious freedom—operates from a *negative* rights framework. Negative rights are protections *from* government interference. Conscientious objection is, in essence, a negative right. *Positive* rights, by contrast, require the government to provide a right such as access to healthcare. In the context of conscientious objection, positive rights would imply an *obligation* to refer and inform the patient. But since the American legal tradition is far more reluctant to enforce positive rights, especially in the realm of conscience and religion, the Courts have generally not recognized a positive right to be referred or informed. So while a community-based moral evaluation, such as the proportionalist one, emphasizes the positive obligations that flow from the doctor's obligation to the patient-doctor relationship, it is unlikely a theological argument for the obligation to refer will be codified into law through this specific framework. In this sense, I suggest the community-based moral evaluation more as an internal Catholic critique. Catholic ethics have long affirmed that moral duties can and should exceed

what the law demands. Even the absolutist-influenced *Ethical and Religious Directives* recognize the "social obligation" of Catholic healthcare.[243]

This internal Catholic critique, grounded in proportionalist moral reasoning and its conception of conscience as acting in community, could compel Catholic hospitals to adopt policies that mandate referral. Even though objections to referral are federally guaranteed, Catholic institutions are not tied to those restrictions. If, as the *Directives* affirm, Catholic healthcare carries a "social obligation" to serve the common good, then referral—a "community-forming" act—could be mandated. Since objections to referral mostly occur in Catholic hospitals, a proportionalist evaluation challenges Catholic institutions to consider whether the prohibition on referral is compatible with their teachings. While the state may, at this point, be unable or unwilling to enforce referral mandates, Catholic hospitals have both the theological resources and the moral responsibility to lead by example. Since 98% of Catholic hospitals strictly adhere to the *Ethical and Religious Directives*, such change should likely begin with a consideration and revision of the *Directives*.[244]

Theological Restraints on Attempts to Legally Limit Conscientious Objection

Doctors make decisions every day—sometimes these are decisions with high moral stakes. While doctors may not use the language of moral theology in their decision to conscientiously object or not, they are making decisions of theological *depth*. This chapter has attempted to show that there are theological tools that acknowledge and illuminate the complexity of these choices. Proportionalism is especially well-suited to this task. As described in Chapter 2, proportionalism as an explicit tradition emerged in American theological debates

[243] O'Rourke, "A Brief History," 20.
[244] Solomon et al., *Bigger and Bigger*, 10.

after the Second Vatican Council. Its origin story is grounded in the American Catholic experience. While it is not a legal answer, proportionalism can drive legal change. If Catholic doctors, theologians, and institutions engage with the proportionalist tradition, they can help establish the theological foundation needed to justify and implement the necessary legal limits on conscientious objection rights.

This chapter has presented a theologically grounded argument for why conscientious objections to refer are a theologically inadequate extension of Catholic moral reasoning and should not be granted the same legal protections as refusals to directly participate in a procedure. Conscientious objection rights have expanded profoundly since their introduction into healthcare in the 70s. That expansion continues, and referral protections are at the forefront of that expansion. The lack of theological solutions limits the viability of any attempts at legal limits. While this chapter laid out a theological attempt to draw a limit, the next chapter will consider why we should protect conscience at all.

IV. MORAL COMPROMISE AND THE WORK OF PLURALISM

When discussing this project with friends, classmates, and professors over the last year, the first response was almost always some mix of the following: "If doctors know that they might be asked to provide abortions, why should they be allowed to object? By voluntarily choosing a career in healthcare, aren't they also accepting its professional obligations? Should they really be entitled to further exemptions in the form of conscience rights?" These questions get at the core of my initial interest in the question of conscientious objection.

In Sweden, doctors have no right to conscientious objection. Along with Finland and Ethiopia, Sweden is one of three countries in the world that do not provide the right.[245] If a doctor is asked to perform an abortion within the legal limit of 18 weeks, they must perform the procedure. Why have two democratic countries, Sweden and the United States, taken essentially opposite approaches to accommodating conscience in healthcare?

Chapter 2 identified one potential explanation for these divergent legal approaches to conscience: religion. In the U.S., the Catholic tradition has been a primary advocate for the development and expansion of conscientious objection rights. In Sweden, however, Catholicism holds little institutional influence. Differing legal priorities offer another explanation: American law emphasizes individual rights and Swedish law traditionally prioritizes the collective. Despite these differences, the dominant approaches in both countries are more similar than they might seem.

The debate over conscientious objection runs the gamut from complete accommodation to no accommodation of conscience. The preceding chapter laid out the theological and moral

[245] Agustina Ramón Michel and Dana Repka, *Global Map of Conscientious Objection to Abortion (2024)* (Buenos Aires: Center for the Study of State and Society (CEDES), June 10, 2024), http://dx.doi.org/10.2139/ssrn.5100299.

argument for allowing, and even requiring, doctors to refer patients for abortion procedures. Chapter 3 began at one pole of the debate, namely that conscience is something to be completely accommodated. It approached restrictions to conscience rights from the standpoint of accommodation: to what extent can a doctor's conscience be accommodated without compromising patient care? If we proceed from the premise that conscience requires complete accommodation, the conversation revolves around the question: why restrict conscientious objection at all? Here, the primary reason to restrict becomes the patient's *negative* right to not be obstructed from legal medical care.

But what if we proceed from the premise that conscience requires no protection? Within this framing, the guiding question shifts: to what extent can conscience be denied while still preserving the ethical integrity and moral well-being of doctors? Here, the primary reason to expand conscience rights becomes the doctor's *negative* right to not be compelled to act in ways that violate their conscience. Both extremes emphasize negative rights—freedom from obstruction or freedom from coercion. This project has explored the American extreme, where conscience is broadly protected due to the doctor's freedom *from* coercion. Sweden embodies the other extreme with its focus on the patient's freedom *from* obstruction. A brief exploration of the foundation of the Swedish approach clarifies how the U.S. can accommodate conscience in a more pluralistic and proportionate way.

The Swedish Approach to Conscience

In Sweden, there is no conscientious objection in healthcare. For those familiar with European rights law and its freedom of conscience rights, the lack of conscience accommodation might seem at odds with the European Convention on Human Rights (ECHR), which Sweden

signed into Swedish law in 1995.[246] However, a closer reading of Article 9 of the ECHR—titled "Freedom of thought, conscience and religion"—reveals a distinction between the internal right to believe and the external right to act on those beliefs. Article 9 begins with the assertive statement that "everyone has the right to freedom of thought, conscience and religion."[247] The freedom of an individual to hold beliefs freely is absolute. However, as Article 9 continues,

> [T]his right includes the freedom to…manifest his religion or belief, in worship, teaching, practice and observance. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.[248]

Unlike the absolute freedom that comes with the right to hold a belief, the freedom to express and "manifest" a belief is conditional and subject to restrictions. While the state cannot dictate what one believes, it can regulate how those beliefs are acted upon in the public sphere—especially when those manifestations affect others. In the healthcare context, a doctor's actions frequently affect others, making manifestations of belief subject to more rigorous scrutiny. Taken as a whole, Article 9 distinguishes between two components of freedom of belief and conscience: *forum internum* and *forum externum*.[249] While *forum internum* describes the right to form, hold, and change an *internal* belief, *forum externum* describes the outward *manifestation* of that belief.[250]

This distinction is central to how Swedish law approaches conscience in healthcare. As Stockholm University Professor Kavot Zillén describes in *Hälso- och sjukvårdspersonalens*

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[246] Kavot Zillén, *Hälso- och sjukvårdspersonalens religions- och samvetsfrihet: En rättsvetenskaplig studie om samvetsgrundad vägran och kravet på god vård* (Uppsala: Uppsala Universitet, 2016), https://uu.diva-portal.org/smash/get/diva2:889301/INSIDE01.pdf, 125.
[247] Council of Europe, *European Convention on Human Rights* (Strasbourg: European Court of Human Rights), https://www.echr.coe.int/documents/d/echr/convention_ENG, 11.
[248] Ibid.
[249] Zillén, *Religions- och samvetsfrihet*, 125–6.
[250] Ibid.

religions- och samvetsfrihet, Swedish law draws a firm line between *forum internum* and *forum externum*. While the law protects the *forum internum* component completely, it subjects the *forum externum* component to strict limitations. In practice, these limitations result in a relatively narrow scope where individuals can exercise their right to freedom of belief and conscience.[251] In the healthcare context, a doctor's objection to provide, inform, or refer for certain procedures is seen as a harmful interference of the rights of the patient and, therefore, cannot be protected as an expression of conscience. This restrictive legal philosophy has not gone unchallenged. Two cases stand out.

In November 2013, Ellinor Grimmark, a Swedish national, informed her employer at a midwife training program at Höglandssjukhuset "that she did not wish to perform abortions due to her personal religious convictions."[252] Following her objection, she was "denied an extension of her contract" and was told that she "'was no longer welcome to work with them.'" She was also told that a person with pro-life views probably could not become a midwife.[253] Her student funding was canceled, and she was unable to find employment in other midwife training programs. In March 2015, Linda Steen, a Norwegian national entering midwifery studies in Nyköping, Sweden, "informed her employer that she would be unable to assist in carrying out abortions."[254] In response, she was told that she could not work at the clinic or receive the training unless she agreed to perform abortions. Although Steen received a midwifery certificate in 2015, she sought compensation.[255]

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[251] Ibid., 125
[252] Melisa Vazquez, "Abortion Inside Swedish Democracy: The Case of Ellinor Grimmark," *Verfassungsblog*, June 23, 2015, https://verfassungsblog.de/abortion-inside-swedish-democracy-the-case-of-ellinor-grimmark/.
[253] Ibid.
[254] Ibid.
[255] European Court of Human Rights, *Steen v. Sweden*, no. 62309/17, 2 November 2020, https://hudoc.echr.coe.int/eng?i=001-201732.

After unsuccessfully raising their cases in Swedish courts, the two nurses brought their cases to the European Court of Human Rights in 2017. They claimed that "by not letting them work as midwives because of their sincerely held religious beliefs regarding the sanctity of human life," the Swedish government had violated Article 9 of ECHR. Swedish law "interfered with their freedom of religion and belief…and their freedom of expression" and "discriminated against [them] on the grounds of their convictions."[256] To the surprise of many, the Court "unanimously rejected" the cases.[257] The Court's rejection was met with a wide array of criticism. While some of this criticism was outcome based, coming from those "endorsing an extensive understanding of the right to conscientious objection," the majority of the criticism was procedural. These critics argued that by rejecting the cases outright, "the Cour[t failed] to provide adequate reasoning" to support their stance on these freedoms. Notably, the ECHR "has not yet ruled on the issue of conscientious objection to performing healthcare."[258] In turn, their 2020 rejection of the Swedish cases perpetuates the "uncertainty regarding the Court's views on the right to conscientious objection."[259]

The outcome of the Grimmark and Steen cases reveals the practical effect of Sweden's approach. By enforcing uniform professional standards that include participation in abortion services, the healthcare system sets functional limits on who may participate in certain medical roles. In addition to the clear line between *forum internum* and *forum externum*, Article 10 of the ECHR has also informed the approach.[260] While Article 9 formally protects freedom of religion and conscience, Article 10 protects freedom of expression.[261] In theory, these rights of

[256] Wojciech Brzozowski, "The Midwife's Tale: Conscientious Objection to Abortion after Grimmark and Steen," *Oxford Journal of Law and Religion* 10, no. 2 (June 2021), https://doi.org/10.1093/ojlr/rwab016, 299.
[257] Ibid.
[258] Ibid., 302.
[259] Ibid.
[260] Zillén, *Religions- och samvetsfrihet*, 124.
[261] Council of Europe, *European Convention on Human Rights*, 12.

expression under Article 10 legitimize the narrow reading of Article 9 conscience rights. In guaranteeing rights of expression, governments can justify limiting the *forum externum*—the manifestation of belief. However, in practice, this deferral to Article 10 has produced a legal framework that does not view the protection of the expression of one's conscience in healthcare as necessary. Since a doctor has the Article 10 rights to express their convictions elsewhere, expression can justifiably be restricted in healthcare. From the perspective of choice, since the doctor has the freedom to choose to express elsewhere, they should not demand the freedom to choose when that choice can have consequences.

The Illusion of Voluntary Choice

The questions raised at the beginning of this chapter—questions regarding the level of choice and autonomy granted to doctors—reflect the broad resonance of the Swedish approach. In the U.S., those arguing against all accommodation of conscience in healthcare ground their arguments on the premise of voluntary choice. Since a doctor *voluntarily* entered the healthcare profession, it is unethical to deny patients care that is standard within that profession. From this perspective, the doctor's choice is preserved—in the form of the initial choice of profession or specialization—and patient care is guaranteed. In this space of "voluntary professional choice," doctors accept the obligation to place the well-being of the patient at the center of the professional practice.[262]

This project challenges the underlying assumptions of this "voluntary professional choice" argument. The argument assumes that professional standards, as well as the legal, medical, and cultural context, remain consistent over time. But as Chapters 1 and 2

[262] Crystal Gwizdala, "When Personal and Professional Morals Clash: Conscientious Objection in Medicine," webinar, Yale School of Medicine, July 18, 2022, https://medicine.yale.edu/news-article/when-personal-and-professional-morals-clash-conscientious-objection-in-medicine/.

demonstrated, the healthcare landscape is changing: laws change, technologies evolve, medical norms develop, and theories of morality are debated, revised, and entrenched. A doctor who made a choice to become an OB-GYN in a state like Montana twenty years ago may have made a very different choice today. The suggestion that objecting physicians should just change specialization if they cannot comply with evolving norms disregards the significant time and financial investment of the doctors whose beliefs have stayed consistent in a changing legal and institutional environment. After twenty years, choosing another field is, most often, incredibly difficult. More fundamentally, suggesting that a doctor must decide between performing a procedure against their conscience or leaving the specialization that asks them to perform it disregards the moral complexity of the doctor's position. As described in Chapter 3, conscientious objections often occur in morally ambiguous and tough situations. These situations are dilemmas—serious ones—and to assume that doctors do not bring moral and ethical seriousness to these decisions disregards their professional and personal integrity. By assuming a static moral, legal, and medical landscape, the voluntarist argument fails to account for past, present, and future change. In this sense, the voluntarist argument—expressed most clearly in Swedish law—treats professional obligation as absolute. Ultimately, it fails to recognize that for some, conscience is essential to navigating moral complexity.

Though they present opposing arguments, both the Swedish and the dominant American model reflect absolutist tendencies—the Swedish one in its refusal to accommodate conscience and the American one by accommodating it unqualifiedly. This project traced the historical, theological, and political roots of American absolutism, describing how absolutist interpretations of natural law shaped the introduction and expansion of conscientious objection rights after *Roe v. Wade*. But as the comparison with Sweden reveals, absolutism can exist on the opposite end,

as well. By excluding doctors who dissent from institutional norms, Sweden enforces a kind of moral conformity and undermines moral pluralism in healthcare and society at large. These two absolutes—located toward the extremes of the question of conscientious objection—challenge us to find a more sustainable and pluralistic middle way. As this project has demonstrated, proportionalism can provide an example for one such middle way that respects both patients and professionals in a shifting moral and legal landscape.

Value Democracy and the Promise of a Middle Way

Chapters 2 and 3 of this project explored the promise of proportionalism as a framework for prudential moral discernment. Proportionalism can provide a theologically grounded moral theory of action that justifies, and even mandates, a Catholic doctor to refer a patient for an abortion. Although this theological exploration is essential to any consideration of conscientious objection protections, it is only a piece of the story. The right to conscientious objection is enshrined in American law and must, therefore, be publicly justified in the secular realm.

Corey Brettschneider's theory of "value democracy" provides one way toward such public justification. In his 2012 book *When the State Speaks, What Should It Say? How Democracies Can Protect Expression and Promote Equality*, Brettschneider explores the question of how to approach hate speech. He begins the book by introducing the two traditional responses to hate speech. The first is the "neutralist approach," which "upholds free speech and protects hateful viewpoints from coercive sanction, despite their discriminatory content."[263] The state is "neutral" in the sense that it does not endorse any values. In contrast, the "prohibitionist approach" argues that "free speech rights should not protect viewpoints that are hostile to the

[263] Corey Brettschneider, *When the State Speaks, What Should It Say? How Democracies Can Protect Expression and Promote Equality* (Princeton, NJ: Princeton University Press, 2012), https://ebookcentral.proquest.com/lib/merc/home.action, 1.

values of a liberal democratic society."[264] The state is "prohibitionist" in the sense that it sets legal limits on the expression of certain values. Brettschneider "find[s] both of these approaches problematic."[265] He argues that the neutralism that has defined the American approach to hate speech "fails to answer the challenge that hateful viewpoints pose to the values of freedom and equality," and in doing so actually "threaten[s]...the very freedom and equality that justify protecting the rights of free speech for hate groups in the first place."[266] But the prohibitionist alternative "has its own drawbacks," most notably that it "overlooks the fact that the core democratic values of freedom and equality require the state to allow citizens to develop and affirm their own political views."[267] In other words, the prohibitionists fail to acknowledge that "citizens cannot endorse democracy itself" without "debat[ing] arguments, even those that challenge the foundations of liberal democracy."[268]

Brettschneider presents his theory of value democracy as an alternative to both these extremes. Value democracy does two things. First, it "defends robust rights of free speech, religion, and association," which requires the state to refrain from "banning political viewpoints, religious groups, or civil associations."[269] Second, value democracy simultaneously "articulate[s] the reasons that justify why rights should be respected in the first place" and it does so by "attempt[ing] to convince citizens to adopt the democratic values of freedom and equality as their own."[270] By distinguishing between the state's coercive power—its power to restrict, which it should exercise sparingly—and the state's expressive power—its power to persuade, which it

[264] Ibid.
[265] Ibid., 3.
[266] Ibid.
[267] Ibid.
[268] Ibid.
[269] Ibid., 4.
[270] Ibid.

should view as its democratic duty—value democracy protects the expressive rights of citizens while affirming the state's role in shaping a public culture grounded in democratic values.

Brettschneider's framework helps illuminate the shortcomings of both the Swedish and American models of conscience protection in healthcare. Like the prohibitionist approach toward hate speech, Sweden's approach to conscience relies heavily on the coercive power of the state to enforce a particular moral view. The approach legally excludes individuals whose religious or moral views conflict with institutional norms, thereby limiting public dissent. While this approach aims to enforce equality, it risks undermining the pluralism that a democracy is meant to protect. At the other extreme, the dominant American model resembles the neutralist approach. When conscientious objection includes objections to refer or inform patients, it expands without requiring public justification or accountability. The government claims neutrality by allowing objections to patient care and thereby fails to engage with the effects of that neutrality, including how objections disrupt patient care and access.

Value democracy offers a way out of this binary. Rather than choosing between two absolutes—prohibition and neutrality—value democracy encourages the state to protect rights while also expressing the values that justify the limits of that protection. In the healthcare context, this means preserving space for conscience while arguing for reasonable limits out of a commitment to equal access. By publicly justifying the importance of preserving moral pluralism, value democracy parallels the logic of proportionalism. They both advocate for contextual discernment, prudential moral reasoning, and the consideration of acts in their totality. Both frameworks reject absolutism—whether in the secular or religious context—and insist that coexistence in a democracy requires principled debate and compromise.

Responsible Exercise of Positive Liberty

As the comparison between the Swedish and dominant American models reveals, both systems rely primarily on a conception of negative liberty. The Swedish approach emphasizes the patient's negative right to not face obstruction when seeking an abortion while the American approach emphasizes the provider's negative right not to be compelled to act against one's conscience. Each model treats liberty as freedom *from* interference. But what happens if we recognize liberty as the freedom *to* act? When proceeding from complete accommodation, restriction doesn't just come from the patient's negative right to not be obstructed from medical care. Restriction also comes from the *positive* rights of the patient to receive legal medical care. When proceeding from the other extreme—no accommodation—expansion doesn't just come from the doctor's negative right to not be compelled to perform. Expansion also comes from the *positive* rights of the doctor to be affirmatively supported in their moral integrity. In both cases, rights involve not just freedom from interference, but the active fulfillment of one's rights as a patient or a provider.[271]

Within patients' rights, the positive rights framing is widely recognized and frequently discussed in both legal and bioethical discourse. In fact, patient rights are often presented as a combination of both negative and positive claims: patients have the negative right not to be obstructed or discriminated against in seeking care, and they also have the positive right to

[271] In recent years, especially since the *Dobbs* ruling, there have been substantial arguments in favor of protecting *conscientious provision* in healthcare. This refers to doctors acting in accordance with their moral or religious convictions by affirmatively offering care, such as an abortion, because their conscience compels them to. Conscientious provision reframes conscience as a positive right: the right to fulfill one's moral obligations through action. It has gained traction as a way of addressing the asymmetry in conscience laws, which protects objections but rarely provisions. In this project, I chose not to address conscientious provision for two reasons. First, it lacks an established legal tradition. Since I trace how Catholic moral theology has impacted and continues to impact American healthcare, the extensive jurisprudence behind conscientious objection rights provided the necessary legal and theological history. Second, conscientious provision raises very distinct institutional, professional, and ethical problems in need of a separate analysis. However, in general, protecting doctors' rights to provide care reflects the shift toward understanding conscience as an important tool for moral discernment.

access that care. Laws such as the Emergency Medical Treatment and Labor Act (EMTALA), which codify a patient's positive right to emergency medical treatment, reflect this combined framing. What's discussed far less, however, is the combination of positive and negative rights of the doctor.

In *Two Concepts of Liberty*, Isaiah Berlin famously warns against the coercive dangers of positive liberty:

> This is the positive doctrine of liberation by reason. Socialised forms of it, widely disparate and opposed to each other as they are, are at the heart of many of the nationalist, Communist, authoritarian, and totalitarian creeds of our day. It may, in the course of its evolution, have wandered far from its rationalist moorings. Nevertheless, it is this freedom that, in democracies and in dictatorships, is argued about, and fought for, in many parts of the earth today.[272]

The danger of positive liberty lies in its capacity to be misused—not in the concept itself. This misuse can occur in both authoritarian and democratic regimes. While an authoritarian regime involves the misuse of the ruler's positive freedom to rule, Mill pointed out that the absolute "sovereignty of the people" could misuse its positive freedom by mandating conformity to the majority.[273] Berlin's critique, then, concerns the *absolutizing* of any moral or political framework. The danger of positive liberty lies in its capacity to justify coercion by claiming to know what is best for all citizens.

But since it can be misused, it must also be able to be used responsibly because rights come with responsibility. Toward the end of his book, Berlin comments on the productive capacity of positive liberty:

> Indeed, I have tried to show that…the notion of freedom in its 'positive' sense…is at the heart of the demands for national or social self-direction which animate the most

[272] Isaiah Berlin, *Liberty: Incorporating Four Essays on Liberty*, ed. Henry Hardy (Oxford: Oxford University Press, 2002), 191.
[273] Ibid., 208.

> powerful and morally just public movements of our time, and that not to recognise this is to misunderstand the most vital facts and ideas of our age.[274]

Although he warns of its dangers, Berlin asserts that arguments for positive liberty can carry demands for justice, agency, and dignity. Yet this power requires caution. To ensure these arguments for positive liberty do not constitute coercion, they must be grounded in a commitment to moral pluralism. Since "the ends of men are many" and further since "not all of them are in principle compatible," Berlin concedes that "the possibility of conflict…can never wholly be eliminated from human life."[275] The belief in the existence of a "single formula" that can harmoniously accommodate every individual's ends is, in Berlin's assessment, "demonstrably false."[276] It would seem, therefore, that a responsible argument for positive liberty requires, most fundamentally, humility. No one person, church, or government can claim to know—absolutely—what is best for all. To preserve freedom and dignity in a pluralistic society, positive liberty must be exercised with an awareness of its limits and a respect for the diverse moral ends of others.

Proportionalism provides a workable framework for Catholic doctors to exercise their positive rights responsibly and humbly. Its community-based evaluation of morality redefines conscience not merely as a negative right, but as a morally formative practice that binds the doctor to act in light of their responsibilities to others. It recognizes the relevance of, in Berlin's words, the "facts and ideas of our age."[277] It sees the theological relevance of observing the contemporary world and the ethical imperative to respect what it observes. Proportionalism's

[274] Ibid., 214.
[275] Ibid.
[276] Ibid.
[277] Ibid.

positive right to conscience calls doctors to actively do good—good for themselves and their patients.

Proportionalism, and its potential to allow doctors to responsibly exercise their *positive* right to conscientious objection, can also inform attempts at moral compromise more generally. In the introduction, I described the abortion debate as stuck in a stalemate. Americans deeply disagree on the morality of abortion. While the two sides address the same core question, they are not speaking to one another. This breakdown in communication stems from their fundamentally different ways of engaging with the moral question of abortion. But as this final chapter reveals, this lack of thoughtful and effective communication also stems from a societal framing that pits negative and positive liberty claims against each other. Berlin speaks to this point:

> [T]he 'positive' and 'negative' notions of freedom historically developed in divergent directions, not always by logically reputable steps, until, in the end, they came into direct conflict with each other.[278]

Berlin's insight reveals that the two concepts of liberty are bound to come into direct conflict. While arguments for patients' rights draw on both negative rights (freedom from obstruction to care) and positive rights (freedom to access care), arguments for doctors' rights are most often articulated in terms of negative rights alone (freedom from compulsory performance). This asymmetry flattens the moral and professional complexity of the doctor's dual commitment to their religious and professional identities. Recognizing this deeper asymmetry uncovers a hidden explanation in the moral disagreement. Although Berlin cautions about the eventual tension between the concepts of liberty, that very insight could also hint at the impermanence of that conflict. Since their divergence occurred in the course of history, it is historically contingent. Its

[278] Ibid., 178-9.

historical contingency suggests potential for revision. Recognizing the existing asymmetry, as well as the historical contingency of that asymmetry, illuminates how a framework like proportionalism, which grounds the right to conscientious objection as a doctor's positive obligation to community, offers a promising foundation for moral compromise.

On January 29th, 2025, Robert F. Kennedy Jr. underwent his Senate Confirmation Hearing for Secretary of Health and Human Services. An hour and eight minutes into the hearing, Senator James Lankford asked RFK Jr. to answer the following question: "Will you step in and say that healthcare individuals have the right to conscience again as the federal law allows?"[279] RFK Jr. answered: "I don't know anybody who would want to have a doctor performing a surgery that the doctor is morally opposed to."[280] His response is revealing. Most patients do not want their providers to act against their most deeply held moral convictions, just as doctors fear the consequences of being forced to act in ways they cannot morally justify. This intuition, I argue, must be the starting point for any serious conversation about conscience rights in a pluralistic democracy. It acknowledges that healthcare is not a morally neutral enterprise and that doctors should not be asked to leave their moral frameworks behind when they enter the professional realm. Respecting conscience encourages those who care for us to practice with moral depth and thoughtful deliberation. At its core, it affirms that doctors are members of the very community they care for.

The Ethical Function of Religion

This project affirms the ethical relevance of studying religion. Although it highlights the relevance of a closer examination of the intra-Catholic debate, it also encourages a broader

[279] *Senate Confirmation Hearing: Robert F. Kennedy Jr., Day One*, July 20, 2023, video, 1:08, Rev.com, https://www.rev.com/transcripts/rfk-jr-confiramation-hearing-day-one.
[280] Ibid., 1:09.

engagement with religious debates. Religious traditions rarely contain a single, uncontested moral framework. All religions grapple with internal disagreement as they negotiate how to position themselves in relation to a changing world. This requires them to slow down, to find perspective and depth, all with the aim of providing meaning. To do this, they must be able to sustain principled disagreement for centuries. In this sense, religions offer lived examples of how to engage with disagreement. Politics can often appear void of value and meaning. This project acknowledges that certain actors within religious debates can effectively translate their specific moral visions into policy, with the healthcare space emerging as a central battleground for Catholics. At the same time, it also recognizes the importance of making space in the secular for alternative voices within these religious traditions. As citizens of a democracy, our commitment to pluralism compels us to recognize religions as models for principled moral compromise.

EPILOGUE

Moments ago, Catholics around the world watched as white smoke billowed from the chimney of the Sistine Chapel, signaling the election of the 267th pontiff of the Roman Catholic Church. As I write this epilogue, I'm watching Robert Francis Prevost—now Pope Leo XIV—deliver the Urbi et Orbi blessing on the balcony of St. Peter's Basilica.

On April 21, just over two weeks ago, Pope Francis passed away. The conclave to elect the next pope began yesterday. It has been nothing short of surreal to finish up this project in the midst of these profound changes in the Catholic Church. The election of the first American, and first North American, pope marks a symbolic shift within global Catholicism. Although Pope Leo was born in Chicago, he has spent much of his life as a missionary in South America. He speaks five languages and is a citizen of Peru. Pope Leo may be American, but his experience suggests that he will be a pope for all 1.4 billion Catholics in the world.

Much of my project centered on disentangling various Catholic interpretations of Thomistic natural law. In addition to earning a bachelor's degree in mathematics from Villanova University, Pope Leo received a Doctorate of Canon of Law from the Pontifical University of Saint Thomas Aquinas in Rome. It's at this school that Aquinas began writing *Summa Theologicae* to help guide students. For centuries, the Pontifical University has remained a place where Thomistic doctrine is reworked, reinterpreted, and debated. That the new pope attended the very institution where Thomistic natural law originated and has been most rigorously studied and debated raises the question: how will Pope Leo XIV interpret and apply Thomistic natural law? Whether he will follow in Pope Francis' footsteps and leave space for proportionalist reasoning remains an open question—one that will define a new chapter in Catholic moral theology.

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