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11.
From Catholic Healthcare West to Dignity Health

Conflicts of Conscience in American Catholic Health Care

By Carol Bayley

The formation or our conscience comes about through the constant struggle to become good. We may first experience this as we learn our parents' ideas of good and naughty and then internalize those ideas as the superego develops. But gradually the formation of the moral conscience takes place,distinct from the voice of the subconscious, as we enter the complicating challenges of adulthood and find that moral problems worth the name are rarely black or white; as we live our lives of real moral choices: as we confront the systemic failures of our society to bear forward the kingdom of God. In the Catholic tradition the formation or one's conscience must also include a careful listening to the accumulated wisdom of the church, as the Holy Spirit guides it in love to the union with God that is humanity's end.

But knowing each and every word of magisterial teaching from the last thousand years, even if that were possible, does not equip a person to exercise his or her conscience in any given situation. Such a situation would be full of contingent particulars, requiring the prudential application of the principles to the actual case in all its human grit, messiness, and uncertainty. Although far from the insights of *Gaudium et Spes* in other ways. the manualist tradition, in which confessors had lists of the many ways persons can offend God and used them to calculate relative culpability, gravity, and punishment, recognized the importance or the complexity and near-uniqueness of any situation.[1] Simply knowing the principles is not enough. One cannot read oneself into a well-formed conscience.

In the years following the Second Vatican Council, theologians explored the implications of the council's understanding of the interiority or conscience and its relation to and distinction from psychological concepts such as the "self' and

the “superego." One such theologian, John W. Glaser, writes that while in the superego there is the subconscious drive of the person to reestablish belonging in the community from which he has become isolated by his bad action, conscience is an entirely different reality. Glaser writes that while a "good conscience" may be described as harmony between God and the self-co-created by a person's free act, conscience can also well call one to an extremely isolated position. He writes that conscience is an insight into love and a "call issued by the ultimate value and promise of love."[2]

In this essay I describe two contemporary situations, full of contingent particulars, in which the decision of conscience was relatively straight-forward.[3] If conscience is like a muscle, getting stronger with use, these decisions were like the muscles the mother needs to throw the truck off her child to save its life--it is a muscle far stronger than anyone knew, and the decision is made almost without thought, because the requirements of con-science, the response to the call of love, arc so absolutely and immediately clear. In both situations, one individual and one institutional, the challenge was not in the conscience determining the requirements of love, but in accepting the consequences of acting on them. In Glaser's framework, the harmony was there, but so was the isolation.

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1 Albert R. Jansen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Los Angeles and Fkrkcley: University of California Press, 1988): sec also James F. Keenan, --"Vatican II and Theological Ethics." *Theological Studies* 74 (2013): 162--90.

2 John W. Glaser, S.J., “Conscience and Superego: A Key Distinction,” *Theological Studies* 32 (1971): 31.

3 I was the system ethicist at the time the events in these stories occurred. I was part of the original conversations with the bishops when non-Catholic hospitals joined Catholic Healthcare West (CHW) and at the time CHW became Dignity Health; l wrote the revised "Statement of Common Values": and in the first story. l was the person who dealt directly with the sister and her canon lawyer. wrote 1hc initial opinion for the bishop, secured an independent theologian's formal moral opinion, consulted with our board and other system ethicists to assess the moral appropriateness of our position, and worked with our communications team in order both to honestly represent our position as well as to preserve what might be left of a relationship with the bishop.

Two Cases

This is the story of two decisions of conscience, two acts of love, both very much resembling the mother and the truck. The first involved a hospital's approval or a life-saving termination of pregnancy for a woman in pregnancy-induced heart failure and the acceptance of the consequences of that when the local bishop, after the fact, disagreed. The second involved a Catholic organization's decision to maintain its integrity in the face or changing ecclesial priorities. Both decisions, and the actions subsequent to them, sprang from deeply held convictions, informed by fidelity to Catholic teaching, to manifest the healing love of God in the context of twenty-first- century healthcare in the United States.

Healthcare and the Limits of Magisterial Authority: Conscience within the Catholic Church

This case illustrates the question of exactly what sort of discernment the Catholic engages in when he or she invokes conscience. Is conscience, in the language of *Gaudium et Spes*. "the most secret core and sanctuary of a man" (no. 16)? ls it a listening in faith to the law in one's heart written by God? Or must a Catholic, in order to be Catholic, submit to a hierarchical authority outside of self'? Does conscience manifest primarily in obedience or in love?

In October 2010, a woman with primary pulmonary hypertension discovered that her birth control had failed, and she was seven weeks pregnant. Pulmonary hypertension presents on a continuum of severity. The condition in pregnancy carries a 25 percent risk of death overall, but in those with milder disease the risk is lower and in those with severe disease the risk is much higher. To understand pulmonary hypertension in pregnancy, think of a defective sump pump in a damp basement. For the ordinary rainstorm, the debilitated pump works hard and manages the job. But when the hundred-year flood comes, the pump is inadequate to the task. It burns out and stops.

A woman before she is pregnant has a certain volume of blood; by the end of her pregnancy that volume has increased by 50 percent--for awoman with severe pulmonary disease, the hundred-year flood. The heart of someone with pulmonary hypertension may manage with the standard volume of blood, but when the volume increases, the heart may be over- whelmed, inadequate to the task-and it simply fails. This is why her doctor, knowing the severity of the woman's disease before pregnancy, counseled her, at seven weeks, to end the pregnancy. She did not.

Four weeks later her blood volume had predictably increased and, despite medication, her heart had begun to fail. She was admitted to the ICU of the local Catholic hospital, where her physicians now warned her that if she did not end the pregnancy immediately, she would die. With four other children at home and her own mother encouraging her to terminate the pregnancy, she finally agreed.

Because this was a Catholic hospital, its ethics committee was consultedabout the permissibility of terminating this pregnancy. Abortion is not permitted in a Catholic hospital, according to the *Ethical and ReligiousDirectives for Catholic Health Care Services (ERDs). ERDs* defines abortion as the directly intended termination of pregnancy before viability, or the directly intended

destruction of a viable fetus, and further specify that "every procedure whose sole immediate effect is the termination of pregnancy before viability" is an abortion. [4] However, according to Directive 47, "Operations, treatments and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child." The ethics committee decided that the termination of pregnancy was justified under Directive 47. At eleven weeks the only procedure to end a pregnancy is a dilation and curettage (D&C). The aim of the procedure in this case was to save the mother's life by removing the placenta, which was producing the blood-volume-increasing hormone. The intention was not to end the fetus's life, but it was an inevitable and foreseen side effect. The termination occurred and the woman survived.

After the fact, during the moral theological analysis, categories such as the "intention," "the object of the act," and "what they were really doing" became relevant.[5] In the practical world of emergency medicine, those theological points are not the focus. If one had asked those on the woman's medical team what they were doing, they would have said they were saving the one life they could save. They were not performing an abortion. terminating a pregnancy, removing the placenta, or even performing "an operation that has as its direct purpose the proportionately serious pathological condition" of the woman. They were saving a life.

Several months later the hospital administrator and the Sister of Mercy who had communicated the ethics committee's decision to the physician were summoned to the local bishop's office. Having heard (from a priest whose mother worked at the hospital) of the termination, the bishop accused the two or authorizing an abortion. No amount of explanation, even after the bishop's version of the medically relevant facts had been corrected, dissuaded him from the position that the hospital had acted contrary to the *ERDs* and that by authorizing an abortion that she knew was against church teaching. the sister had excommunicated herself. The administrator was told that unless the hospital and the system that sponsored it publicly admitted its wrongdoing and promised never to do it again, the bishop would cease to recognize the hospital as a Catholic hospital. After sustained conversation with the bishop and meetings at the highest level of the Catholic organization that owns the hospital where the case

4 United States Conference of Catholic Bishops, *The Ethical and Religious Directives for Catholic Health Care Services,* 5th ed. (Washington, DC: USCCB, 2009), 26.

5 See Cathleen Kaveny, "What ss 'Abortion.' Anyway," *dotCommonweal* (May 20,2010), http://www.commonwealmagazinc.org; see also Therese Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital," *Origins* 40/33 (January 27. 2011): 537-47.

occurred-and four days before Christmas-the bishop publicly announced that he had withdrawn his recognition of the Catholic identity of the hospital and refused to allow mass to be celebrated in its chapel.

During negotiations with the bishop as the board and the Sister of Mercy sponsors evaluated their options, I consulted a number of moral theologians by telephone and email. They included theologians in universities and seminaries as well as those working for Catholic health systems in the role of ethicist. I cast a very wide net, consulting those with whom I have disagreed professionally in the past on a range of ethical issues in Catholic healthcare, although never on this subject. I also discussed the issue with several bishops.

Every bishop or theologian I consulted agreed that the hospital had done the only reasonable thing it could have done. When I asked them why that was so. their responses fell into three categories. One theologian said that the church's position is "cruel but it's clear." By this he meant that, regardless of intention to do good, the act to end a pregnancy necessitating the destruction of a fetus counts as an unjustified abortion and is deemed immoral in Catholic teaching. He also believed that under the circumstances, saving the woman's life was a stronger requirement than following the church's (cruel) teaching.

The second view, by far the most widely held among theologians employed as ethicists in Catholic healthcare systems, was that under the rule of double effect, the termination of the woman's pregnancy was entirely justified. In the traditional formulation, to be justified by double effect an action must satisfy four conditions: (1) the act itself must be good or at least neutral, (2) the good effect (and not the evil one) must be intended, (3) the good effect must not be attained by means of the evil effect, and (4) there must be a proportionate reason for permitting the evil effect.

These theologians held that the single act or ending the pregnancy had two effects, to save the woman's life and to end the fetus's, and it was only the first that was actually intended as the object or the act. They argued that the act was not wrong in itself; ending a pregnancy by removing a cancerous, though gravid, uterus, for example, is one of the standard cases in the teaching about double effect. The third requirement in the traditional application of the rule of double effect is that the bad effect may not be the means by which the good effect is attained. Satisfying this third condition, the good effect was not secured by means of the ending of the fetus's life; if there had been a way to end the production of the hormone by the placenta without damaging the fetus, it would have been done. The destruction of the fetus was not necessary, but it was inevitable. Finally, the

gravity necessary to the calculus of double effect was certainly present. If the termination were not performed, the woman and her fetus would both die. In fact, fetal death was assured in any case.

The third response was from a theologian who said cases like this one show the limits of Catholic teaching. The *ERDs* itself recognizes that it does not address in detail all the complex issues that face Catholic healthcare today.[6] In such cases prudential decisions must be made in light of the whole of Catholic teaching.

These opinions were rendered in the immediate aftermath of the bishop's pronouncement in the case. Afterward. because the case drew so much attention in both the secular press and the theological literature, several theologians. including Kevin O'Rourke, Bernard Prusak, and Gerald Magill, used the case both to opine on the case itself and to explore the limits of those theological doctrines used to analyze it.[7] Good arguments were made for looking at the case not simply through the lens of double effect, to which medical ethics often defaults, but also through the lens of choosing the lesser of two evils and the right to self-defense.

This case, and the decisions of conscience it required took place at several levels. At the most basic this Catholic woman resisted ending her pregnancy because she was Catholic. until the time when her own life was at stake. She did not rely on the likelihood, which was high, that her own life would *become* threatened. It was only when it was *actually* threatened that she agreed to end the pregnancy. Clearly her conscience was at work, first in resisting the abortion and then, in light of her responsibilities to her other children, agreeing to it.

At the level of the administrator and the sister who headed the ethics committee, the requirements of conscience were somewhat different. As a Catholic hospital. identified as a formal ministry or the Catholic Church, the hospital had a responsibility to uphold Catholic teaching. This is why, rather than just approving a life-saving abortion for a pregnant woman, the ethics committee reviewed the case and concluded that Catholic teaching, explicitly in the *ERDs* and more generally in the moral tradition of the rule of

6 United States Conference of Catholic Bishops, *The Ethical and Religious Directives for Catholic Health Care Services, 4.*
7 Sec Kevin O'Rourke, 0.P., "What Happened in Phoenix? The Complicated Reasons behind an Abortion at a Catholic Hospital:· *America* (.lune 21, 2010)idem, "Complications: A Catholic Hospital. a Pregnant Mother. and a Questionable Excommunication," *America* (August 2, 2010)idem, "From Intuition to Moral Principle: Examining the Phoenix Case in Light of Church Tradition:· *America* (November 15, 2010) idem, "Rights of Conscience Responding to a Bishop's Disciplinary Decisions," *America*(August 1, 2010); Bernard Prusak, "Double Effect, All Over Again: The Case of Sister Margaret McBride, "*Theoretical Medicine and Bioethics* 32/4 (August 2011): 271-83; and Gerald Magill. "Threat of Imminent Death in Pregnancy: A Role for Double-Effect Reasoning," *Theological Studies* 72/4 (December 2011): 848-78.

double effect would support the ending of the pregnancy for the proportionate good or saving the woman's life.

As the consequences of that decision played out -- after the bishop's ultimatum-the administrator and the board and the sister-sponsors of the parent organization looked not only at Catholic teaching, which they believed justified their action, but also at the requirements of conducting a healthcare enterprise in a pluralistic society with its own standards and regulations for operating in the public interest. In order to continue to provide the services to all the people in their local community who relied on them, the parent company refused to tell women that if the only way to save their life was to end their pregnancy, Catholic teaching required the woman's death.

This case illustrates the exercise of conscience, at all three levels, that has been formed in light of the requirements of love and in fidelity to Catholic teaching. The woman knew that abortion was wrong. Leadership at the hospital understood the implications of the *ERDs*. The parent company's reason for being--to continue to be the healing ministry of Jesus in a broken world-was precisely why it lost recognition by the bishop of the hospital as Catholic. These decisions were not the exercise of conscience requiring departure from Catholic teaching. These were decisions requiring the interpretation of that teaching to the contingent circumstances of an actual case.

Healthcare and the Limits of Magisterial Authority: Conscience, Church, and the Pluralist World

To understand the second case, some background is necessary. Established in 1986, Catholic Healthcare West (CHW) began as a small, twelve-hospital organization formed for the mutual support and effective stewardship or resources by two communities of Sisters of Mercy. Although a majority or the hospitals owned by these sisters were actually named Mercy Hospital, when they named the new system. they chose what they thought would be a more inclusive name: Catholic Healthcare West. In the twenty-first century, multi-hospital systems are the norm. In 1986, the hope was that other religious congregations whose numbers were becoming too small to sustain their Catholic hospitals would join CHW when local conditions began to threaten hospitals as stand-alone, community-based, not-for-profit ventures. Sisters were, and continue to be, deployed as board members, mission leaders, chaplains, and in some cases as nurses and patient advocates. but functions such as administration, finance, planning, purchasing, and legal (where few sisters traditionally served) were entrusted to lay people. These collaborators were professionals who understood both the business of healthcare as well as its identity as a social responsibility and human right. Indeed, the vision of the Mercy founders became a reality, and the system attracted the sponsorship of five more religious congregations, who contributed their hospitals to the system and their

leadership to the governance of the organization.

By the mid-1990s, CHW was strong enough to attract even non-Catholic hospitals, whose boards and leadership shared the values fundamental to the mission, especially in geographies where CHW already had a presence. In the face of shrinking reimbursement and capital challenges that were difficult to meet as an isolated borrower on Wall Street, these hospitals looked for a way to preserve both their not-for-profit status and their responsibilities to their local communities. Their choices were few, particularly as this was also a time of great consolidation and acquisition among for-profit healthcare systems like Tenet and HCA Columbia. As a way to preserve and strengthen Catholic healthcare and advance the mission of the organization to serve the healthcare needs of all, CHW undertook a process to bring these hospitals in as full members. That process resulted in the development of the "Statement of Common Values," a kind or a moral bottom line for partnership. Its first iteration was a reflection of the ERDs with an important difference. Whereas the ERDs forbid sterilization, this document was silent on the issue of permanent or temporary contraception, since it was not a value that CHW held in common with these hospitals.

Some of the hospitals had performed abortions in the past, and the "'Statement of Common Values" assured that this would stop. Nor would a hospital in the network ever perform physician-assisted suicide or euthanasia, in the event that those became legal in CHW jurisdictions. Furthermore, the hospitals agreed to meet CHW's very high standards for community benefit; to implement standards for palliative care that were among the strongest in the nation; to attend to the care or the whole person by hiring professional, not volunteer, chaplains; and to give employees a voice in the conditions of their work. The bishops seemed to agree that being part of CHW was a way for these non-Catholic hospitals to advance the mission of Catholic healthcare without actually becoming a ministry of the church.

In every case, in every area where the non-Catholic hospital asked CHW for membership, the local bishop was consulted, and the "Statement of Common Values" was discussed, with the provision that the hospital would continue to provide sterilization services made explicit. Since the hospitals were not going to become Catholic, the threat of scandal was minimal. The bishops who approved these mergers never did so in writing and never issued a *nihil obstat*. But they did make clear to CHW their thinking in meetings with system representatives in anticipation of the mergers. They were convinced by what the non-Catholic hospitals agreed positively to do (in the "Statement of Common Values"); the evil of sterilization, in the prudential judgment of the bishops, seemed to be outweighed by the good these hospitals would do. One bishop called it an "opportunity for evangelization."

CHW ls Dissolved

That was the state of affairs in 2010, some years after the last acquisition of a non-Catholic hospital by CHW. Several years before, a bishop new to a diocese in which CHW had a non-Catholic hospital (and therefore, not the bishop who understood and agreed to the arrangement) told CHW that he did not approve of the relationship and said it must discontinue. For seven years CHW's administrators, sister-sponsors, and their legal department met with the bishop to explain the contractual relationship with the hospital, that it was not a Catholic hospital, that the prior bishop and many other bishops in CHW had agreed to such arrangements, and that it was not possible to force the hospital to stop performing contraceptive sterilization without breaking CHW's word, violating its contract, and being liable for it in court. Important in the original negotiations-during which the non-Catholic hospitals agreed, among other things, to stop performing abortions-was the recognition by CHW that the provision of contraceptive services to their communities was, in a very real if not theologically nuanced sense, a matter of conscience for them. They considered it a fundamental part of their responsibility to their communities to maintain a service that many women, in conscience, believe is the appropriate moral choice for themselves and their families.

Unable to accomplish his goal directly with CHW, in 2010 the bishop contacted the United States Conference of Catholic Bishops (USCCB) and asked a simple question: Should a hospital in a Catholic system abide by every provision in the *ERDs?* Sometime later all the Catholic bishops in the United States received a three-paragraph letter, answering in the affirmative.

Not only was this letter prepared and sent without answering the mail or telephone calls of CHW to explain how it had arrived at the arrangements or what motivated them, but the USCCB also reached its conclusion without the benefit of any consultation with other bishops who had agreed to the inclusion or non-Catholic hospitals in CHW's ministry in the first place. Certainly the USCCB bishops must have talked among themselves, but their action displayed a profound disrespect for any outside dialogue, including the seven years of dialogue CHW had with the bishop who brought his question to them. There was no conversation with CHW leadership, none with any member or a community in which these hospitals operate, none with anyone about the legal requirements involved in the making of a secular hospital into a Catholic one, and no dialogue at all about the impact of such a decision, not only on CHW, but on the future of the Catholic healthcare apostolate in the United States. There seems to have been a complete absence of the kind of dialogue with the modern world for which

Vatican II called.

Clearly, the ecclesial landscape had changed. Now concerned more with purity of Catholic teaching and clarity of witness than with what prior bishops saw as evangelization and preservation of Catholic values in secular American healthcare, the bishops of California, Arizona, and Nevada gathered and gave CHW three choices. The first was to make all the non-Catholic hospitals Catholic. This was not possible, for all the reasons described above; by legal contract, the hospitals abided by the "Statement or Common Values," preserving their non-Catholic status, and were not prepared to "convert." The second choice offered by the bishops was that CHW should simply sell off the non-Catholic hospitals. CHW by then had forty hospitals; thirteen of them were not Catholic. These forty hospitals relied on one another for favorable contract with third-party payers, for borrowing money for capital improvements, and for shared services at the system level; they were entwined with one another in many other ways. Selling off more than one-third of them, if buyers could even be found, would leave the rest of the system in a state of collapse. This option displayed ethically a profound ignorance of the economy and operations of healthcare or a profound apathy toward it.

The last option, and the one that the sister sponsors and governance of CHW eventually chose, was to stop using the: name Catholic and to reorganize the governance so that the pontifical religious congregations were no longer at the head of the organization that they had founded.[8] Especiallyfor the sisters, but also for the lay members of the governing board, it was painful to realize that in order to preserve a ministry with fifty-five thousand employees and forty hospitals, many of which are the medical safety net in their communities, they would have to give up that ministry's association with the Catholic Church, in which they were founded, on the basis of the bishops' desire to be faithful to Catholic teaching on sterilization.

One is reminded of the story of the wise King Solomon in the Old Testament. Two women come before him with a baby, each claiming to be the baby's mother. The king calls for his sword- one baby and two mothers is a math problem that he purports to solve by slicing the baby in two and giving half to each woman. What happens, of course, is precisely what Solomon counted on to reveal the true mother. The one whose child it is cries, "Give the baby to her!"

8 Agbonkhianmeghc E. Orobator, S.J., notes that the same perverse threat experienced by the sponsoring congregations of CHW is felt by religious sisters in Uganda, Tanzania. and Kenya, who, trying to stem the spread of HIV/AIDS, feel the tension between the church's official leaching against the use of condoms and their compassionate duty to educate people and advise their use. The religious communities "of pontifical right" arc recognized by Rome; the withdrawal of this recognition effectively destroys the religious community ("'To Pardon What Conscience Dreads': Navigating the Contours and the Context of Life," chap. 12 in this volume).

In the CHW story the sister-sponsors and the bishops each claimed to be the "real" parent. The sisters gave birth to CHW, but the bishops insisted, in a way, that it was named after them. When the proposal was to split the baby, the true mothers did what was necessary to save CHW. Painful as it was, they let CHW go.

Especially in the case of the sisters. steeped in Catholic teachings and having lived lives where many choices have been voluntarily constrained by their vows and by their commitment to church and community, it would be absurd to say that their consciences were not well formed. Their decision to "save the baby" was the result of a deep and thorough understanding of the healthcare reality in the United States today, where millions of people still have no access to healthcare other than an emergency room and where the business values of efficiency and cost containment often undermine the human values of compassion and service.

The end of these stories completes the picture. The woman whose abortion saved her life is raising her four children. The sister who had "excommunicated herself" remains in good standing in her religious community and continues in a leadership role in the administration of the hospital. The hospital, although not recognized by the bishop as Catholic, is in fact recognized by everyone else as such--it still abides by the *ERDs,* it is still dedicated ecclesial properly that has not been alienated by Rome, and it is still sponsored by its religious founders. It walks like a duck and quacks like a duck.

Although it is still painful to its religious founders that CHW was dissolved as a corporation and its successor is no longer a formal ministry of the Catholic Church, that successor organization, Dignity Health, continues to educate its leaders in the tradition of Catholic social thought, continues the ministry of healing the whole person, continues to lift up the importance of the worker's voice in the workplace, and continues to dedicate millions of dollars in charity care and services for the benefit of the community. The consequences of these decisions of conscience were heavy, but in Glaser's words they were an answer to the call of love.

Conclusion

Taken together, these two cases prompt an interesting observation about the Catholic view of conscience. Brian Patrick Green suggests that there is a tension in Catholic teaching between the necessity to follow one's conscience, on the one hand, and the expectation that a rightly formed conscience will concur with the teachings of the church, on the other.[9]

9 Brian Patrick Green. "Catholicism and Conscience," Santa Clara University, Markula Center for Applied Ethics (May 2013) http://www.scu.edu

That tension is witnessed by the number of Catholics who, for example, believe that using birth control is morally appropriate. ls that what is going on here? As we have seen above, it strains credibility to suggest that the sisters-- the individual who approved the pregnancy termination and those who founded CHW-have consciences that are not well formed. Certainly in the first case both the sister and the hospital thought that they were abiding by a careful interpretation of the *ERDs*. as did many commentators afterward. In the second case, in founding CHW and engaging in the negotiation with the world that Vatican II invited, the sister-sponsors and the bishops who approved of the original deals also believed they were concurring with the teachings or the church. Although I agree with Green that this tension exists, it does not explain what happened in the first case.

There may be another way to view the tension, one that recognizes that just as an individual person (or institution) must listen to the voice of God within as well as the teachings of the church, no one bishop's opinion exhaustively represents the magisterium. Perhaps a bishop, or a group or bishops, can be wrong at a given time in history about what the church teaches, as can any individual. Like the rest of the faithful, a bishop may follow his conscience and still be in error. His conscience, like all others, is formed by family, politics, religious experience, the law and his own previous moral choices. This may explain the clash that occurred in the first case.

The clash in the second case is more concerned with the interpretation of church teaching, and here Green's dichotomy may explain more. It cannot be ignored that the subject of the teaching in question is one that has plagued the church since the early 1960s: contraception (in this case permanent contraception for women as it is practiced in an institutional ministry of the church). The institutional ministry is held by the hierarchy to stricter standards than any individual person might be because it is seen as part of the teaching function or the church. That question--whether an apostolic work *should* be characterized as part of the teaching function of the church-is one currently being debated, but the parties to the debate are unequally matched. Catholic hospitals in the United States were founded and run mainly by women religious. But the owners of the Catholic brand, so to speak, are the ordained and consecrated bishops. They hold the power to allow an organization to call itself Catholic. This is the same tension that Orobator identifies as the pull between rhetoric and practice. [10]

This does not contradict the view that over time the Holy Spirit will get it right. As John Noonan writes: "Development [of moral doctrine] proceeds directed by this rule. The love of God generates, reinforces, and seals the love of neighbor. What is required is found in the community's experience as it tests what is vital. On the surface, contradictions appear. At the deepest level, the course is clear."[11]

The wisdom of the church is the wisdom of a community in dialogue, persons who come together as moral equals even if they come from different perspectives or different positions or no position in the hierarchy. This sort of dialogue was missing in the cases above.

This is the fundamental reorienting insight of Vatican II, that the church is, in a real way, the whole people of God

10 Orobator, "To Pardon What Conscience Dreads."

11 John T. Noonan, Jr., *A Church than Can and Cannot Change: The Development of Catholic Moral Theology* (Notre Dame, IN: University of Notre Dame Press, 2005). 222.