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Susan Berke Fogel

Lourdes A. Rivera

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Saving Roe is Not Enough: When Religion Controls Healthcare

Cover Page Footnote

Susan Berke Fogel, J.D., Law Offices of Susan Berke Fogel, Attorney in private practice focused on women's health and rights. Lourdes A. Rivera, J.D., is the Managing Attorney of the National Health Law Program Los Angeles office.

SAVING *ROE* IS NOT ENOUGH: WHEN RELIGION CONTROLS HEALTHCARE

*Susan Berke Fogel & Lourdes A. Rivera**

INTRODUCTION

Gilroy, California, is a small town about thirty-three miles south of San Jose—the heart of Silicon Valley.¹ Gilroy historically has been an agricultural community. It has the highest rates of poverty and teen pregnancy in Santa Clara County.² It has one hospital.³ There are five Ob/Gyns.⁴ The hospital is the only site in Gilroy with the appropriate facilities to perform inpatient and outpatient tubal ligations, as well as abortions.⁵ In 1999, Catholic Healthcare West purchased the hospital⁶ and immediately told the physicians that they must abide by Catholic teachings; they had to stop performing sterilizations and abortions, and family planning supplies and emergency contraception were no longer available at the hospital or in the emergency room.⁷

The impact on the community was immense. Physicians were outraged at the interference with their medical judgment and the doctor-patient relationship over providing sterilizations. They organized, wrote letters to the editor, voted as a hospital staff to preserve sterilizations, and even appealed directly to the Bishop—all to no avail.⁸

* Susan Berke Fogel, J.D., Law Offices of Susan Berke Fogel, Attorney in private practice focused on women's health and rights. Lourdes A. Rivera, J.D., is the Managing Attorney of the National Health Law Program Los Angeles office.

1. See Gilroy (2003), at <http://www.gilroy.org/> (last visited March 15, 2004) (noting that Gilroy is "the fastest growing city in the Silicon Valley" and that its growth is focused on high-tech industries).

2. Grantee Profile, Teenage Pregnancy Prevention Program (Feb. 2001), at <http://www.c.de.ca.gov/cyfsbranch/lsp/health/TPPGprofiles/Gilroy.html> (last visited Mar. 4, 2004).

3. Amy Pyle, *Collision of Medicine & Faith*, L.A. TIMES, Jan. 3, 2000, at A1.

4. Nadya Labi et al., *Holy Owned: Is it Fair for a Catholic Hospital to Impose its Morals on Patients*, TIME, Nov. 15, 1999, at 85.

5. See *id.*

6. Pyle, *supra* note 3.

7. See Labi et al., *supra* note 4.

8. See Pyle, *supra* note 3 (relating how the physicians and the local medical association wrote letters to the Bishop who responded that allowing tubal ligations would be "imprudent" in light of the Pope's comments that permitting the procedure would be a "grievous sin").

Women, who had the time and could afford transportation, traveled to San Jose to get the services they needed.⁹ The Gilroy doctors lost many insured patients, thereby reducing their incomes.¹⁰ Low-income women, who could not manage the thirty-five-mile-each-way bus trip, were left with no alternatives.¹¹ One woman, pregnant with her ninth child, could not get the voluntary sterilization even though she had already signed her consent form.¹² According to her doctor, another pregnancy would “drastically increase the chance of life-threatening complications.”¹³

January 22, 2004 marked the thirty-first anniversary of *Roe v. Wade*¹⁴ which gave women the Constitutional right to seek abortion services until the fetus is viable.¹⁵ Ever since *Roe*, many have been battling to keep that legal right. Access to abortion, however, and the broader scope of reproductive health services—from family planning to fertility services to HIV and AIDS prevention—also are threatened by an issue which receives much less public attention. This is the increased role in the health care marketplace of religiously-owned-and-operated hospitals and health care entities.

While our nation struggles with enormous issues of access to health care for millions of uninsured and underserved individuals, consumers of health care services nonetheless have developed reasonable expectations of certain “patient rights.” Health care professionals are held accountable to their patients including the paramount principle of the sanctity of the patient-doctor relationship and patient-doctor communication. Patients expect that they will receive full and medically accurate information that will enable them to control their health care choices.¹⁶ Individual health care providers have a reasonable expectation that they will be able to offer complete information to their patients and to make medical

9. *See id.*

10. *See id.*

11. *See* Labi et al., *supra* note 4, at 85-86.

12. *See* Pyle, *supra* note 3.

13. Leslie Laurence, *The Hidden Health Threat that Puts Every Woman at Risk*, REDBOOK, July 2000, at 112, 114.

14. 410 U.S. 113 (1973).

15. *Id.* at 164-65.

16. For example, forty-five percent of nationally-surveyed women said that “if they were treated at a Catholic hospital, they would expect to have access to medical services or procedures that are contrary to Catholic teaching.” CATHOLICS FOR A FREE CHOICE, CATHOLIC HEALTH CARE UPDATE: THE FACTS ABOUT CATHOLIC HEALTH CARE 2 (July 2002) [hereinafter CFFC UPDATE], available at <http://www.cath4choice.org/indexhealth.htm>.

decisions for treatment options based on medical research and generally accepted standards of practice.

When a woman decides that the child she is about to deliver is going to be her last, she expects her physician will be able to perform a sterilization; when a woman is raped, she expects that the emergency room to which she is taken will give her emergency contraception to prevent pregnancy; when a woman of child-bearing years is scheduled to undergo chemotherapy that may destroy her future fertility, she expects to be told that she can harvest her eggs for later implantation; when a physician faces a patient with an ectopic pregnancy, she expects to be free to choose the best treatment for the patient; when a dying patient writes advance directives, she expects that they will be honored; when a patient goes to a health care professional, she expects that she will get all of the medically accurate information she needs.

The expansion in size and influence of religiously-controlled health systems is impeding patient access to comprehensive health services, including reproductive health services, patients' end of life decisions, and patients' access to research involving emerging medical technologies. The scope of services available at religiously-controlled hospitals, health clinics, or HMOs is determined by the dictates and principles of that religion,¹⁷ even though these religious principles often conflict with accepted standards of medical practice and patients' right to self-determination.

The growing influence of these health systems has resulted in a proliferation of refusal clauses (also known as "religious exemptions" or "conscience clauses").¹⁸ These refusal clauses are statutory provisions that allow certain persons or entities to "opt out" of complying with laws and regulations based on their religious or moral objections.¹⁹ While refusal clauses recognize that certain medical procedures may be antithetical to the beliefs of some individual providers, broad-based refusal clauses also have the potential to significantly burden patients by creating obstacles and absolute impediments to patients' ability to make their own health care decisions. Further, they thwart physicians from exercising

17. See Labi et al., *supra* note 4, at 85-86 (stating that when a Catholic health provider purchased the local hospital, the hospital started to abide by regulations issued by Roman Catholic bishops).

18. See Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1481-82 (1995) (relating the history of the conscience clause).

19. *Id.*; see also Monica Sloboda, *High Cost of Merging With a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140, 144 (2001).

their best medical judgment in treating their patients by prohibiting them from providing wanted and needed health care services.²⁰

Refusal clauses also have been used to allow entities and individuals to opt out of providing medically accurate and relevant information to patients when the entity or health care professional has an objection.²¹ Withholding medical information from patients violates basic principles of informed consent. It potentially harms patients by preventing them from making fully informed decisions and obtaining the medical care they need.²² As the federal government proposes a greater public role and greater public funding for faith-based institutions,²³ it is critical to ensure that any group that provides medical care to the public and operates in the public sphere does not impose its religious beliefs on the recipients of those services, especially where such beliefs result in a denial of medical care to those who need it.

It is time for policymakers to act. They should guide government policies and facilitate the enactment of laws and regulations which will protect individual rights of both patients and individual health care professionals. Thoughtful policies should make a distinction between individual health professionals and their institutions. Entities that operate in the public sphere serving the general public, largely with public funds, should have to abide by generally accepted medical practice guidelines and to provide patients with full and medically accurate information, regardless of the beliefs of the health professional or institution.²⁴

In the reproductive health context, it is possible to accommodate individual—as opposed to institutional—refusals to provide certain health services without imposing inappropriate burdens on pa-

20. See Sloboda, *supra* note 19, at 144-45 (describing situations where merged hospitals, under strong pressure, have changed to more restrictive policies to accommodate the religious prohibitions of their partner hospital); see also Andis Robeznieks, *Wisconsin "Conscience Clause" Bill Gets Rapped as Bad Policy*, AMEDNEWS.COM (Aug. 4, 2003), at http://www.a-ma-assn.org/amednews/2003/08/04/prs_d0804.htm (last visited Mar. 5, 2004) (discussing the problems with refusal clauses).

21. Susan B. Fogel & Lourdes A. Rivera, *Religious Beliefs and Healthcare Necessities: Can They Coexist?*, 30 HUM. RTS. 8, 8 (2003).

22. See Christine Vargas, Note, *The Epic Quest for Prescription Contraceptive Insurance Coverage*, 28 AM. J.L. & MED. 455, 460 (2002) (noting that those who oppose refusal clauses consider them loopholes around principles of informed consent).

23. See *id.*; see also President George W. Bush, State of the Union Address (Jan. 20, 2004), available at <http://www.whitehouse.gov/news/releases/2004/01/20040120-7.html>.

24. These policy proposals do not address churches, temples, mosques and other institutions whose purpose is to practice and teach religious doctrine.

tients' rights.²⁵ There should be limits, however, even to an individual health professional's right to refuse. In particular, no health care professional should be exempt from providing complete and accurate medical information, from making appropriate referrals, or from providing urgent care.²⁶ In rural or otherwise isolated or medically underserved areas, there may be no alternate source of care. In cases where there is a direct conflict and there is no alternative that does not unreasonably burden the patient, the medical needs of the patient should prevail.²⁷

I. HEALTH CARE ENTITIES ABIDING BY RELIGIOUS RESTRICTIONS WIELD SIGNIFICANT CONTROL IN THE MARKETPLACE

Over the past several years, religiously-controlled hospital systems have been the fastest growing hospital systems in the United States.²⁸ In 1999, Catholic systems reported a 25.1% increase in the number of Catholic-owned acute care hospitals and a 22.8% increase in staffed beds.²⁹ At the same time, for-profit systems decreased both the number of acute-care hospitals and the number of staffed beds.³⁰ The number of staffed beds in Catholic hospitals continued to rise in 2000, although the total number of hospitals declined through consolidation.³¹

Religious restrictions are a significant obstacle for patients and physicians because of the size of religiously-controlled health systems. Five of the ten largest health care systems in the United States are Catholic.³² Catholic institutions control the largest sin-

25. Fogel & Rivera, *supra* note 21, at 22.

26. *Id.*

27. The ACLU Reproductive Freedom Project has proposed an analytic framework for assessing refusal clauses. Their analysis has two prongs: 1) Does the refusal place burdens on people who do not share the beliefs that motivate the refusal? The more the burdens fall on such people, the less acceptable any claimed right to refuse; 2) Is the objector a sectarian institution engaged in religious practices, or is it instead an entity—whether religiously affiliated or not—operating in a public, secular setting? The more public and secular the setting, the less acceptable an institution's claimed right to refuse. ACLU REPRODUCTIVE FREEDOM PROJECT, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 25 (2002).

28. Deanna Bellandi et al., *Profitability a Matter of Ownership Status*, MODERN HEALTHCARE, June 12, 2000, at 42.

29. *Id.*

30. *Id.*

31. Deanna Bellandi et al., *Overall, Not So Bad: Survey Finds Hospital Systems Posted a Modest Operating Profit in 2000*, MODERN HEALTHCARE, June 4, 2001, at 36.

32. Vince Galloro & Patrick Reilly, *Trickling Down*, MODERN HEALTHCARE, June 2, 2003, at 26. The ranking is based on net patient revenue.

gle group of non-profit hospitals in the United States.³³ Out of the top ten hospitals, seven were Catholic in 2002.³⁴ Ascension Health System is the largest non-profit system with net patient revenues of over \$7.2 billion.³⁵ Nearly eighteen percent of all hospitals and twenty percent of all hospital beds in the United States are controlled by Catholic systems.³⁶ From 1990-2001 there were 171 mergers or acquisitions of secular hospitals by Catholic health systems.³⁷

Religious restrictions have proliferated with the expansion of religiously-controlled managed care plans. A survey conducted by Catholics for a Free Choice found that in the year 2000, there were forty-eight Catholic managed care plans nationally in which nearly 2.5 million privately and publicly insured individuals were enrolled.³⁸ Of these, fifteen Catholic HMOs in fourteen states contract to serve Medicaid populations.³⁹ In New York, Fidelis is a Catholic-owned, Medicaid-managed care plan with 65,000 Medicaid enrollees, but it does not cover family planning or other Medicaid-covered reproductive health services that violate Catholic teachings.⁴⁰ Even though Fidelis has contracted to provide referral services, some plan enrollees have had little to no guidance when

33. *Id.*

34. *Id.* at 26, 28. The ranking is based on the number of staffed acute care beds. Another one of the hospitals was Adventist. Thus, only two out of ten of the top ten non-profits were secular. The ranking of non-profit systems was calculated by the authors.

35. *Id.*

36. CFFC UPDATE, *supra* note 16, at 1. Religious restrictions on access to care outlive Catholic ownership of the health facilities. When Catholic systems sell their hospitals to non-sectarian operators, they nevertheless require that the new owners continue to abide by the Catholic Church doctrine. Tenet Healthcare, for example, has purchased eight Catholic Hospitals and continues to restrict health care services in those facilities. The scope of these restrictions is sometimes time-limited, but at least one transaction, the Daniel Freeman Memorial and Marina hospitals in Los Angeles, requires that the restrictions are a covenant that runs with the land. CATHOLICS FOR A FREE CHOICE, CATHOLIC HEALTH CARE STATE REPORTS: CALIFORNIA 3 (Nov. 2002), available at <http://www.cath4choice.org/indexhealth.htm>.

37. CFFC UPDATE, *supra* note 16, at 2.

38. CATHOLICS FOR A FREE CHOICE, CATHOLIC HMOs & REPRODUCTIVE HEALTH CARE: EXECUTIVE SUMMARY 3, available at <http://www.cath4choice.org/catholicmos.pdf> (last visited Feb. 14, 2004).

39. These states are Arizona, California, Illinois, Kentucky, Missouri, Montana, New Jersey, New York, Ohio, Oregon, Pennsylvania, South Carolina, Texas, and Wisconsin. CATHOLICS FOR A FREE CHOICE, CATHOLIC HMOs AND REPRODUCTIVE HEALTH CARE 27 (2000).

40. Angela Bonavoglia, *Co-Opting Conscience*, PROCHOICE MATTERS, Jan. 1999, at 7, available at <http://www.prochoiceresource.org/about/CoopConsc.pdf>.

they have sought certain services.⁴¹ Access problems arise for women enrolled in non-sectarian health plans, whether Medicaid or private insurance, which contract with religiously-controlled hospitals and other entities that restrict access.

Catholic doctrine can continue to restrict the scope of health care services even after a hospital is sold to a non-sectarian buyer.⁴² As the market changes, Catholic systems have sold some of their low-performing hospitals to for-profit health care systems. The Catholic sellers insist, as a condition of sale, that the new buyers continue to abide by the Ethical Directives that restrict health care services and end of life decision making.⁴³ Some for-profit systems, such as Tenet Healthcare, actively market themselves to Catholic hospitals by agreeing to preserve and enhance the religious mission of formerly-Catholic hospitals.⁴⁴ There are at least twelve formerly-Catholic hospitals that continue to operate under Catholic doctrine.⁴⁵

As of January 1, 2004, California law prohibits the Attorney General from consenting to any transaction in which the sellers of non-profit health systems restrict the type and scope of medical services that the purchaser may offer.⁴⁶ This is the first statute in the country to effectively end the practice of perpetuating health care restrictions based on the religious doctrine of the former owners.

41. *Id.*

42. *See, e.g.*, Fogel & Rivera, *supra* note 21 (noting that after purchasing eight Catholic hospitals, Tenet Healthcare continued restructuring health care services).

43. *See, e.g.*, LEWIN GROUP, INC., & HEALTH CARE PLANNING & POL'Y, EFFECT OF PURCHASE OF DANIEL FREEMAN HOSPITALS BY TENET HEALTHCARE CORPORATION ON THE AVAILABILITY AND ACCESSIBILITY OF HEALTH CARE SERVICES 7 (2001), available at http://caag.state.ca.us/charities/publications/nonprofitosp/dfh_report.pdf.

44. In considering a merger, Catholic hospitals often mandate that their restrictions be followed. *See* CATHOLICS FOR A FREE CHOICE, MERGER TRENDS 2001: REPRODUCTIVE HEALTH CARE IN CATHOLIC SETTINGS 12 (2002), available at <http://www.cath4choic e.org/pdf/mergertrends2001.pdf>.

45. *See id.* (chronicling the hospitals that continue to follow the Directives even after the ownership is no longer Catholic).

46. CAL. CORP. CODE § 5917.5 (West 1990 & Supp. 2004).

II. RELIGIOUS RESTRICTIONS INTERFERE WITH THE RIGHTS OF PATIENTS AND HEALTH CARE PROFESSIONALS

Several religions restrict medical services to some extent.⁴⁷ Specifically some Seventh Day Adventist and Baptist hospitals do not provide abortion services, and stress “abstinence only” practices rather than contraception and condom distribution to prevent pregnancy and transmission of HIV/AIDS.⁴⁸ Deseret Mutual Benefit Administration’s HMO, a Latter Day Saint controlled managed care organization, does not cover sterilizations until a woman has five children or is forty-years old.⁴⁹ Jewish hospitals do not restrict medical services, but some orthodox Jewish nursing homes have restrictions on end of life care when it comes to honoring medical directives to discontinue life-sustaining treatment.⁵⁰

By far the largest systems with the greatest restrictions on health services are Catholic health systems.⁵¹ Catholic hospitals are governed by the Ethical and Religious Directives for Health Care Services, promulgated by the United States Conference of Catholic Bishops (“Ethical Directives”).⁵² These Directives promote prenatal care, but prohibit virtually all other reproductive health services. Contraceptive methods other than “natural family planning” (i.e. the rhythm method) are prohibited.⁵³ Other banned services include most infertility treatments,⁵⁴ sterilizations,⁵⁵ and abor-

47. Lisa C. Ikemoto, *Doctrine at the Gate: Religious Restrictions in Health Care*, 4 J. GENDER SPECIFIC MED. 8, 8 (2001), available at <http://www.mmhc.com/jgsm/archives/01oct.shtml>.

48. *Id.*

49. LOIS UTTLEY & RONNIE PAWELKO, NO STRINGS ATTACHED: PUBLIC-FUNDING OF RELIGIOUSLY-SPONSORED HOSPITALS IN THE UNITED STATES 24 (2002).

50. Elena Cohen, *Refusing and Forgoing Treatment*, in TREATISE ON HEALTH CARE LAW 18-113 n.43 (Alexander Capron & Irwin Birnbaum eds., 2002). For example a study of New York City nursing homes found that forty percent had so-called “conscience policies.” JEAN MURPHY & CYNTHIA HOSAY, FRIENDS & RELATIVES OF INSTITUTIONALIZED AGED, CONSCIENCE POLICIES IN NEW YORK CITY NURSING HOMES (2003), available at http://www.fria.org/publications_conscience_policies.html.

51. Ikemoto, *supra* note 47, at 8.

52. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed., 2001) [hereinafter ETHICAL DIRECTIVES], available at <http://www.nccbuscc.org/bishops/directives.htm>.

53. *Id.* at Directive 52.

54. *Id.* at Directive 38 (allowing “assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself” as the only permitted treatments for fertility problems”).

55. *Id.* at Directive 53. There is, however, an exception imbedded in the Directive that allows sterilization where the “direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.” In other words, sterilization may be allowed when the intent is not contraception. *Id.*

tions.⁵⁶ There are no exceptions for rape, incest, or to protect the life or health of the woman.⁵⁷ Treatment of ectopic pregnancy, which almost always endangers the health or life of the woman, may be limited.⁵⁸ For example, the least invasive medical interventions—pharmaceuticals in lieu of surgery—to end a tubal ectopic pregnancy may be prohibited by Catholic teachings because the treatment may include the use of abortifacients.⁵⁹ The Directives, however, permit medical treatment that may incidentally result in ending a pregnancy if it is necessary to treat a serious medical condition of a pregnant woman.⁶⁰ The Directives require that advance medical directives be honored only to the extent that they do not conflict with Catholic teachings.⁶¹ The Directives also render it impossible for hospitals to develop or engage in new technologies that employ embryonic stem cells for both research and potential treatment.⁶²

Religious restrictions on services affect everyone, but they particularly impact women's health. The greatest burden falls on low-income women who have neither the resources to pay for services out-of-pocket nor the ability to travel long distances to obtain services from an alternate provider.⁶³ When hospitals and clinics controlled by religious entities deny access to reproductive health services, the burden of providing those services to low-income and

56. *Id.* at Directive 45.

57. *But see* CFFC UPDATE, *supra* note 16, at 2 (noting that Directive 36 specifies that a woman "who has been raped should be able to defend herself against a potential conception" but only if there is "no evidence that conception has occurred").

58. ETHICAL DIRECTIVES, *supra* at 52, at Directive 48 (stating that "[i]n case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion").

59. *See id.* at Directive 45 (prohibiting "[e]very procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo").

60. *See id.* at Directive 47 (stating that "[o]perations, treatments, and medications . . . 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").

61. *See id.* at Directive 59 (stating that "[t]he free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching").

62. Although the Directives do not explicitly prohibit such research, the Introduction in Part Four says that the Church "witnesses to the sanctity of life 'from the moment of conception until death.' The Church's defense of life encompasses the unborn . . ." *Id.* (footnote omitted). This position is a *de facto* prohibition of such research.

63. Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1113 (1996).

uninsured women falls on other providers in the community. Sexual Assault Response Teams ("SART") run by county health departments may have difficulty meeting the needs of sexual assault survivors when local hospitals refuse to deliver emergency contraception to prevent a pregnancy after rape.⁶⁴ These restrictions are felt especially strongly in rural areas. In 1998, there were ninety-one Catholic hospitals were designated by Medicare to be eligible for enhanced reimbursement as "sole providers" because they are the only hospital in a geographic area.⁶⁵ This is an increase of sixty-five percent in just three years.⁶⁶

III. RELIGIOUS RESTRICTIONS OFTEN CONFLICT WITH GENERALLY ACCEPTED MEDICAL PRACTICE GUIDELINES

The politicization of women's reproductive health care has diverted public discussion away from the fact that the services at risk for elimination are part of a basic package of primary care and other necessary health care.⁶⁷ As a result of these restrictions, women's health services become bifurcated. Services that, according to generally accepted medical guidelines, should be provided concurrently ("linked-services") are fragmented, with potential serious health consequences. For example, the American College of Obstetricians and Gynecologists ("ACOG") recognizes that, unless counter-indicated in individual cases, an appropriate time to provide voluntary sterilizations is usually at the time of labor and de-

64. In one central California city, for example, Sexual Assault Response Team ("SART") members and other rape crisis staff were required to offer women emergency contraception in the parking lot of the hospital because the hospital would not allow it. Melanie Conklin, *Blocking Women's Health Care: Your Hospital May Have a Policy You Don't Know About*, PROGRESSIVE, Jan. 1998, at 23.

65. CATHOLICS FOR A FREE CHOICE, CAUTION: CATHOLIC HEALTH RESTRICTIONS MAY BE HAZARDOUS TO YOUR HEALTH 6 (1999).

66. *Id.*

67. For example, family planning plays a crucial role in reducing infant and maternal mortality and in improving women's and children's health. See, e.g., ALAN GUTTMACHER INST., FAMILY PLANNING CAN REDUCE HIGH INFANT MORTALITY LEVELS (2002), available at http://www.guttmacher.org/pubs/ib_2-02.html; ALAN GUTTMACHER INST., SUPPORT FOR FAMILY PLANNING IMPROVES WOMEN'S LIVES (1998), available at <http://www.guttmacher.org/pubs/ib23.html>; ALAN GUTTMACHER INST., WOMEN & SOCIETIES BENEFIT WHEN CHILDBEARING IS PLANNED (2002), available at http://www.guttmacher.org/pubs/ib_3-02.html. Provision of emergency contraception also has averted an estimated 51,000 unintended pregnancies in 2000, accounting for forty-three percent of the decrease in abortions since 1994. Lawrence B. Finer & Stanley K. Henshaw, *U.S. Abortion Incidence and Services*, 35 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 6, 14 (2003), available at <http://www.guttmacher.org/pubs/journals/3500603.pdf>.

livery.⁶⁸ The religious prohibition of sterilization, however, subjects women to an another operation, at another time, at another facility with an increased risk of infection, experiencing adverse side effects of anesthesia, additional costs, and the risk of another pregnancy.⁶⁹ This assumes that there is another facility that is accessible and that the second procedure is affordable and can be accessed in a timely manner.⁷⁰

While only a small percentage of abortions are provided in hospitals,⁷¹ the ones that are performed in hospitals are done there out of necessity for women who are medically fragile and at risk of complications.⁷² Women further into their pregnancies may also need the medical back-up systems that a hospital provides. For example, a woman in her third trimester who discovers she is carrying an anencephalic fetus (a fetus without a cranium) would be a prime candidate for an abortion performed in a hospital.⁷³ Denying access to these services subjects women to the difficulty and expense of obtaining services out of their areas, as well as exposing them to increased risk of harm.⁷⁴

Access problems also arise for women enrolled in secular health plans that contract with sectarian hospitals that restrict access. For example, most managed care plans cover both sterilization and delivery.⁷⁵ A woman desiring a tubal ligation at the time of labor and delivery, however, may need to obtain these services separately if the hospital covered by the health plan refuses to provide steriliza-

68. See Labi et al., *supra* note 4, at 85-86.

69. *Id.*

70. *Id.* (discussing one community's prohibition against sterilization and the hardships that the prohibition has caused).

71. Alan Guttmacher Institute, *Facts in Brief: Induced Abortion* (Dec. 1998), at http://www.guttmacher.org/pubs/fb_induced_abortion.pdf (last visited March 10, 2003).

72. See, e.g., ACLU REPRODUCTIVE FREEDOM PROJECT, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 15 (2002) (describing refusal of religious hospital to provide an abortion to a ten-week pregnant mother of a two year-old who was diagnosed with a blood clot in her lung), available at <http://www.aclu.org/ReproductiveRights/ReproductiveRights.cfm?ID=10946&c=224>. The clotting problem was a life-threatening condition that was exacerbated by the pregnancy. Her doctors told her that she had two alternatives: a) she could stay in the hospital on intravenous blood thinners for the remaining six and one half months of the pregnancy and undergo a procedure in which an umbrella-like device would be inserted in her veins in order to catch blood clots before reaching vital organs; or b) she could have a first trimester abortion, switch to oral blood thinners and be released from the hospital). *Id.*

73. See Julie Koenig, *Anencephalic Baby Theresa: A Prognosticator of Future Bioethics*, 17 NOVA L. REV. 445, 453 (1992).

74. ACLU REPRODUCTIVE FREEDOM PROJECT, *supra* note 72, at 17.

75. See Labi et al., *supra* note 4, at 85-86.

tion services, or she may have to pay more, either in higher out-of-pocket expenses or in the form of a higher co-pay or other additional charges in order to obtain the services concurrently.⁷⁶ Often, health care consumers are unaware of these access limitations until they need the services. Not only must they then contend with managed care gatekeepers, but they need to battle ideological ones as well.

The ACOG and the American Medical Association have adopted medical guidelines that require emergency contraception be offered to prevent unwanted pregnancy in rape survivors.⁷⁷ Yet, a recent national survey conducted by Catholics for a Free Choice found that only twenty-eight percent of Catholic hospitals provided emergency contraception in their emergency rooms to women who had been raped. Many of the hospitals that provided emergency contraception first required a pregnancy test.⁷⁸ Fifty-five percent refused to dispense emergency contraception under any circumstances⁷⁹ and only half of those provided referrals.⁸⁰ Two-thirds of the referrals proved to be dead-ends.⁸¹

This issue was addressed in a California Court of Appeal case, *Brownfield v. Daniel Freeman Marina Hospital*.⁸² Kathleen Brownfield was a young woman taken to the emergency room of a religiously-controlled hospital after being raped. She was not offered emergency contraception.⁸³ Ms. Brownfield sought declaratory and injunctive relief that would require the hospital to either provide rape victims with information and access to the service or to discontinue treatment of rape victims.⁸⁴

76. See MergerWatch, *Religious Provider Exemptions* (2004), at <http://www.mergerwat.ch.org/conscience/conscience.html> (outlining the Balanced Budget Act of 1997 which allows managed care plans to refuse to provide certain services if the plan objects to them on moral grounds).

77. American Medical Association, *Statement of The American College Of Obstetricians and Gynecologists Supporting the Availability of Over-the-Counter Emergency Contraception*, ACOG NEWS RELEASE (Feb. 14, 2001), at http://www.acog.org/from_home/publications/press_releases/nr02-14-01.cfm.

78. CATHOLICS FOR A FREE CHOICE, *SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS 5-6* (Dec. 2002), available at <http://www.cath4choice.org/lowbandwidth/indexhealth.htm>.

79. *Id.*

80. *Id.* at 6.

81. *Id.*

82. 256 Cal. Rptr. 240 (Ct. App. 1989); see also Boozang, *supra* note 18, at 1451-53 (1995) (analyzing the Brownfield case).

83. *Brownfield*, 256 Cal. Rptr. at 242.

84. *Id.*

The court found that, absent a statutory refusal clause, the patient maintains a common law right to self-determination in her treatment, and this right prevails over an entity's moral or religious convictions.⁸⁵ In addition, the court held a failure to offer emergency contraception to a rape victim who then becomes pregnant would be grounds for a medical malpractice action.⁸⁶

Imposition of the Ethical Directives has other health consequences. For example, it is becoming a usual practice to offer women of child-bearing age, who require cancer treatments that could destroy their ability to produce eggs, the opportunity to harvest their eggs prior to treatment,⁸⁷ so that the harvested eggs can be implanted at a later date thereby preserving future fertility. Such treatments are prohibited at Catholic facilities.⁸⁸

End of life care also may be adversely affected by religious restrictions. While the Ethical Directives recognize the right of patients to forgo extraordinary means to forestall death,⁸⁹ Directive 59 explicitly reserves the right of a Catholic facility to override a patient's decision: "The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, *unless it is contrary to Catholic moral teaching.*"⁹⁰ A New Jersey appellate court held in *In re Beverly Requena*⁹¹ that a Catholic hospital could not evict a patient who refused to accept artificial feeding, thus upholding the patient's right to make her own uncoerced health care decisions.⁹² The court was particularly concerned that the patient had no notice of the hospital's religious

85. *Id.* at 244.

86. *Id.* at 245. The court found that a malpractice action would stand if; 1) a skilled practitioner of good standing would have provided her with information on and access to emergency contraception; 2) that she would have elected such treatment if the information had been provided; and 3) that damages (i.e. pregnancy) had proximately resulted from the failure to provide her with information concerning this treatment option. The court found that this particular plaintiff did not state a cause of action for declaratory or injunctive relief, and that she had not demonstrated that she had suffered damages (in other words, she had not become pregnant as a result of the rape). *Id.*

87. Fogel & Rivera, *supra* note 21, at 10.

88. See ETHICAL DIRECTIVES, *supra* at 52, at Directive 41 (forbidding the use of artificial insemination or "any technique used to achieve extra-corporeal conception").

89. *Id.* at Directive 57.

90. *Id.* at Directive 59 (emphasis added).

91. *In re Beverly Requena*, 517 A.2d 869 (N.J. Sup. Ct. App. Div. 1986).

92. *Id.* at 870.

objection to allow a patient to refuse food and hydration.⁹³ The court stated that the hospital's policy could be valid "only if it does not conflict with a patient's right to die decision and other protected interests."⁹⁴ The court further required the hospital to provide a reasonable and convenient alternate facility.⁹⁵ In the particular case of Beverly Requena, the court determined that it was not reasonable to move her, and therefore ordered the hospital to comply with her wishes.⁹⁶

There are few other recorded cases involving institutional religious healthcare providers and refusal clauses outside of the employment context. In *Bartling v. Superior Court*,⁹⁷ a California appellate court held that, despite the Adventist hospital's and physicians' religious objections, a competent adult patient had the right to refuse unwanted medical treatment. In this case, the patient no longer wished to be kept on a ventilator that was necessary to sustain the patient's breathing. In so holding, the court stated that "if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors."⁹⁸ For example, in addition to *Brownfield* and *Requena* cited above, a Washington state court found that the refusal clause permitting providers to opt out of performing abortions did not exempt physicians from the duty to provide genetic counseling including the option of abortion.⁹⁹ In *St. Agnes Hospital v. Riddick*,¹⁰⁰ the court held that a Catholic hospital was not exempt from providing or arranging for abortion, contraception, and sterilization training in its medical training program in compliance with the Accreditation

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Bartling v. Superior Ct.*, 209 Cal. Rptr. 220 (Ct. App. 1984).

98. *Id.* at 225.

99. *Harbeson v. Parke-Davis*, 656 P.2d 483 (Wash. 1983).

100. *St. Agnes Hospital v. Riddick*, 748 F. Supp 319 (D. Md. 1990). Congress acted in response to the *St. Agnes Hospital* case, however, requiring that residency programs refusing to require, provide, refer for, or arrange for abortion training, to be treated as accredited by the federal government, and state and local governments receiving federal funds, for purposes such as certification, licensing and funding. The Omnibus Budget Reconciliation Act of 1996, Pub. L. No. 104-134, § 515, 110 Stat. 1321-245, *codified at* 42 U.S.C. § 238n (1996).

Council for Graduate Medical Education.¹⁰¹ In *Doe v. Bridgton Memorial Hosp. Ass'n*,¹⁰² the court stated:

The [hospitals] are non-profit corporations organized to serve the public by operating medical facilities. Each receives substantial financial support from federal and local governments and the public. Each is the beneficiary of tax exemptions. Each is an institution whose medical facilities are available to the public, particularly those who live in their primary service areas. The properties of these hospitals are devoted to a use in which the public has an interest and are subject to control for the common good. As quasi-public institutions, their actions must not contravene the public interest. They must serve the public without discrimination.¹⁰³

Health and Medical Associations have already adopted policy in this area. The American Public Health Association (“APHA”) has adopted a resolution and a policy statement to address religious restrictions in hospital mergers and specifically addresses the issue in which public funding is involved.¹⁰⁴ Among other things, the APHA adopted the policy to “[u]rge that health care facilities receiving public funding assure the availability of comprehensive reproductive health services and end-of life [sic] choices.”¹⁰⁵ APHA also has adopted two other resolutions, one calling on policy makers and medical professional organizations to require all hospital emergency rooms, without exception, to provide emergency contraception to sexual assault survivors who request it.¹⁰⁶ The other

101. The Accrediting Council for Graduate Medical Education (“ACGME”) requires that obstetric and gynecology programs offer clinical training in contraception and sterilization. ACGME also requires that clinical training in abortion be provided unless the individual resident or the residency program has a “religious or moral objection.” In such case, the program must ensure that all residents receive training in managing abortion complications. If the residency program has a religious, moral or legal restriction prohibiting the residents from performing abortions within the institution, the program must also publicize the restrictions to all residency applicants, and allow residents to receive abortion training outside of the program. ACCREDITING COUNCIL FOR GRADUATE MED. EDUC., REQUIREMENTS FOR RESIDENCY EDUCATION IN OBSTETRICS AND GYNECOLOGY § V.C.4, 5 (2003), available at http://www.acgme.org/downloads/RRC_progReq/220pr703.pdf.

102. 366 A.2d 641 (N.J. 1976).

103. *Id.* at 645 (citation omitted).

104. Am. Pub. Health Ass’n, *Preserving Consumer Choice in an Era of Religious/Secular Health Industry Mergers*, Policy 20003 (Jan. 1, 2000), at <http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=view&id=209> (last visited Mar. 5, 2004).

105. *Id.*

106. Am. Pub. Health Ass’n, *Providing Access to Emergency Contraception for Survivors of Sexual Assault*, Policy 200316 (Nov. 18, 2003), at <http://www.apha.org/>

resolution opposes broad-based religious exemptions in health care and urges policy makers to protect access to reproductive health services for low-income women on Medicaid.¹⁰⁷ The American Medical Association and the American College of Obstetricians and Gynecologists medical guidelines particularly recognize the requirements to offer and provide emergency contraception to survivors of sexual assault¹⁰⁸—a treatment that, unless compelled by law,¹⁰⁹ some religiously-controlled hospitals refuse to provide.

Last, the public believes that hospitals operating in the public sphere should provide a full range of health care services.¹¹⁰ A nationwide poll in 2000 found that three out of four women were opposed to giving hospitals religious exemptions that overruled doctor's decisions about medical treatment.¹¹¹

IV. PATIENTS LACK INFORMATION ON RELIGIOUS RESTRICTIONS ON HEALTH ACCESS

Religious restrictions on access to care are rarely disclosed to consumers before the time of service, creating significant barriers to fully-informed consent and effective decision making. A nationwide poll in 2000 found that almost half of the women surveyed believed that if they were admitted to a Catholic hospital, they would be able to get the medical services they needed, even if those services were contrary to Catholic teachings.¹¹² While many members of the public are aware of Catholic restrictions on abor-

legislative/policy/policysearch/index.cfm?fuseaction=view&id=1253 (last visited Mar. 5, 2004).

107. Am. Pub. Health Ass'n, *Access to Reproductive Health Care in Medicaid Managed Care*, Policy 200313 (Nov. 18, 2003), at <http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=view&id=1250> (last visited Mar. 5, 2004) (specifically calling on Congress to repeal the refusal clauses in the Balanced Budget Act of 1997 that pertain to Medicaid managed care, to protect providers' right to provide full information to patients, and to prevent auto-assignment of Medicaid beneficiaries into managed care plans that refuse services).

108. AM. MED. ASS'N, *STRATEGIES FOR THE TREATMENT & PREVENTION OF SEXUAL ASSAULT* 15-16 (2nd ed. 2002), available at <http://www.ama-assn.org/ama/pub/category/3548.html>.

109. Two states, California and New York, require that hospital emergency rooms offer emergency contraceptives to survivors of sexual assault regardless of the religious affiliation of the hospital, and several states are considering such legislation. See CAL. PENAL CODE § 13823.11(g)(4) (West 2000 & Supp. 2004); N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2001 & Supp. 2004).

110. Belden, et al., *Religion, Reproductive Health and Access to Services: A National Survey of Women Conducted for Catholics for a Free Choice* (Apr. 2000), at <http://www.cath4choice.org/lowbandwidth/indexhealth.htm> (last visited Mar. 5, 2004).

111. *Id.*

112. *Id.*

tion, few know that a broad range of services is restricted.¹¹³ Only three percent of women surveyed knew that sterilization was not available and only six percent knew that there was no access to emergency contraception.¹¹⁴

Without strong requirements that hospitals and health providers disclose in advance any restrictions on provision of care, a sexual assault survivor may find herself in an emergency room that does not offer emergency contraception, a pregnant woman may find out, too late, that her obstetrician cannot offer her a voluntary sterilization, and women on Medicaid may be automatically enrolled in a managed care plan that does not offer family planning. California is the first state to require managed care organizations and insurance companies to warn consumers that some physicians and hospitals restrict access to covered reproductive health services and to offer consumers information about those restrictions.¹¹⁵ The California law, AB 525, requires that health insurers, including managed care organizations, post information in their provider directories (both paper and electronic formats) informing their members that some providers do not offer a full range of reproductive health services, listing the specific services that may not be available, and providing a toll-free number where consumers can call to obtain more information about how to access the services they need.¹¹⁶ AB 525 is unique in that it requires the posting of a list of specific services that may not be available, educating consumers about the breadth of health care restrictions they may encounter.¹¹⁷ In *In re Beverly Requena*,¹¹⁸ the fact that Requena had no notice of a restrictive hospital policy that did not allow her to refuse food

113. *Id.*

114. *Id.*

115. AB525, 1999-2000 Assemb. Reg. Sess. (Cal. 2000), codified at CAL. HEALTH & SAFETY CODE §1363.02 (West 2000 & Supp. 2004), CAL. INS. CODE § 10604.1 (West 1988 & Supp. 2004), and CAL. WELF. & INST. CODE § 14016.8 (West 2001).

116. *Id.*

117. *Id.* AB 525 requires the following specific language:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at (insert the health plan's membership services number or other appropriate number that individuals can call for assistance) to ensure that you can obtain the health care services that you need.

118. *In re Beverly Requena*, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986).

and hydration was a significant factor in the Court of Appeal's decision that, regardless of the religious beliefs of the institution, the institution was ordered to honor her directives.¹¹⁹

Access to information is a critical problem for low-income women on Medicaid. The Balanced Budget Act of 1997¹²⁰ contains a broad refusal clause that allows managed care organizations to serve the Medicaid population, but to opt out of "provid[ing], reimburs[ing] for, or provid[ing] coverage of, a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds."¹²¹ As a result, many women of childbearing age are mandatorily enrolled in Medicaid plans that refuse to provide Medicaid-covered services that are central to their health care, and most importantly, they are not given information or referrals on how to obtain these services. They have the right to go out-of-plan to obtain these services, but that assumes that there are out-of-plan geographically-accessible services and that the women know how to access them.¹²²

V. RELIGIOUSLY-CONTROLLED HOSPITALS DELIVER RESTRICTED HEALTH CARE LARGELY WITH PUBLIC FUNDS

Religiously-controlled hospitals operate in the public sphere and they do so largely with public funding.¹²³ In fact, revenue sources of religious controlled health systems are not significantly different from those of any other private corporate interests in the health care industry.¹²⁴ For example, in 1998, the combined Medicare and Medicaid funding for religiously-controlled hospital accounted for roughly half of their revenues.¹²⁵ Religiously-controlled hospitals nationwide in 1999 received \$41.3 billion in Medicare funding which alone accounted for thirty-six percent of their funding, a

119. *Id.* at 870.

120. 42 U.S.C. § 1396u-2(b)(3)(B) (2000).

121. *Id.*; see also 42 C.F.R. § 438.102(a)(2) (2002). In order for health plans to implement this provision, they must provide the state, potential enrollees and enrollees with certain notice of the exclusion; however, the health plans are not required to provide enrollees with information on how to access excluded services. The state must provide that information to Medicaid beneficiaries. 42 U.S.C. § 1396u-2(b)(3)(B)(ii); 42 C.F.R. § 438.102(b).

122. Lourdes A. Rivera, *Helping Low-Income Women Clients Access Reproductive Health Services*, 36 CLEARINGHOUSE REV. 488, 493 (2003).

123. UTTLEY & PAWELKO, *supra* note 49, at 2.

124. *Id.* at 4.

125. *Id.*

larger percentage than for other types of hospitals.¹²⁶ In addition, religiously-controlled hospitals received a disproportionate share of \$760 million in federal hospital funds in 1999.¹²⁷ Other types of government appropriations (e.g. State-sponsored bonds) for these hospitals in 1998 approached \$700 million.¹²⁸

In fact, almost no funding for religiously-controlled hospitals comes from religious entities. A case study of religiously-controlled hospitals in California in 1999 found that forty-six percent of all revenue came from Medicaid and Medicare, fifty-one percent came from third-party payors, and three percent came from non-patient sources.¹²⁹ Of the three percent, thirty-one percent came from county government, thirty percent came from income on investments, and five percent came from charitable contributions.¹³⁰

The current Administration's "Faith-Based Initiative" has the potential of increasing financial support by tax payers of these entities, while the institutions refuse to provide services needed by the public.

VI. BROAD REFUSAL CLAUSES PROTECT INSTITUTIONAL INTERESTS OVER PATIENTS' RIGHTS

Refusal clauses have expanded beyond exempting individual beliefs to exempting entire corporate health systems by allowing these systems to opt out of providing certain services and also relieving them from offering referrals or counseling about how to obtain services elsewhere.¹³¹ The Medicaid Managed Care Balanced Budget Act of 1997 provision discussed above is such an example.¹³²

Another example is the Abortion Non-Discrimination Act ("ANDA") introduced in the last session of Congress.¹³³ The extremely broad refusal clause would have permitted not only individual providers, but also hospitals, provider-sponsored organizations, health maintenance organizations, health insurance plans, or any other kind of health care facility, organization, or plan to opt out of performing, providing coverage of, paying, or making referrals for induced abortions without any exceptions to

126. *Id.* at 12.

127. *Id.* at 15.

128. *Id.* at 4.

129. *Id.* at 15.

130. *Id.*

131. See *supra* Part II and accompanying text.

132. See *supra* notes 120-23 and accompanying text.

133. Abortion Non-Discrimination Act of 2002, H.R. 4691, 107th Cong. (2002).

save the life or health of the mother or for cases of rape or incest.¹³⁴ Hospitals would have been able to legally turn away women who need emergency abortions because they are hemorrhaging or experiencing heart failure, despite federal and state laws that generally require hospitals to treat patients in medical emergencies.¹³⁵ Also, while women on Medicaid have the right to abortion coverage in cases of rape, incest, or to save the life of the mother, institutions and providers can refuse to provide an abortion or even tell the women how to access the service.¹³⁶ In addition, this refusal clause would pre-empt state and local regulation in this area. The bill will likely be reintroduced in the current Congressional session. Without overturning *Roe v. Wade*, ANDA would, in effect, potentially leave women with no way to obtain or pay for an abortion.¹³⁷

Recently, several state legislatures have enacted requirements that employers provide contraceptive coverage as part of their prescription drug benefits. The Equal Employment Opportunity Commission has recognized that the failure to provide coverage for prescription contraceptives when an employer provides coverage for other prescriptions is a form of gender discrimination and an unlawful employment practice because it fails to cover a treatment used only by women.¹³⁸ Some of these state statutes contain no refusal clauses, some have very broad exemptions, and some, like California and New York, have narrow clauses that exempt only

134. *Id.*

135. *See, e.g.*, The Emergency Medical Treatment and Active Labor Act ("EMTALA"), codified at 42 U.S.C. § 1395dd (requiring hospitals receiving Medicare funds to screen, stabilize, treat, and transfer, only with informed consent, those individuals coming to the emergency room seeking emergency services).

136. *See* 42 U.S.C. § 238(n) (2003).

137. Access to abortion and other reproductive health services is already an issue for many women, especially women living in low-income and/or rural areas or areas in which religious entities are the sole providers. *See supra* notes 63-65 and accompanying text. The Medicaid program, while covering family planning and other services, restricts coverage of abortion to cases of rape, incest and to save the life of the mother due to the Hyde Amendment, a restriction placed on annual appropriations for the program. *See, e.g.*, Hyde Amendment, Pub. L. No. 95-480, § 210 (1978); *see also* Consolidated Appropriations—FY 2001, Pub. L. No. 106-554, §§ 508, 509 (2000), reprinted in 2000 U.S.C.A.N., 114 Stat. 2763A-69 to 70. Seventeen states, however, cover all abortions for low-income women using state funds. Alan Guttmacher Inst., *State Funding of Abortion Under Medicaid: State Policies in Brief* (2004), at http://www.guttmacher.org/pubs/spib_SFAM.pdf (updated monthly).

138. U.S. Equal Employment Opportunity Commission, *Decision* (Dec. 14, 2000), at <http://www.eeoc.gov/policy/docs/decision-contraception.html> (last visited Apr. 23, 2004); *see also* *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1271-72 (W.D. Wash. 2001).

religious entities that primarily serve and employ people of a particular faith from providing contraceptive coverage.¹³⁹ In *Catholic Charities v. Superior Court*,¹⁴⁰ Catholic Charities claimed that the California statute, which requires employers who offer health plans with prescription drug coverage to also include prescription contraceptives, interferes with the establishment and free exercise clauses of the federal and state constitutions.¹⁴¹ Catholic Charities conceded that it did not provide a religious service and did not meet the definition of religious employer as set forth in the statute, but that, among other things, the statute impermissibly burdened its religious freedom.¹⁴² The California Supreme Court rejected that claim and found that the statute “serves the compelling state interest of eliminating gender discrimination”¹⁴³ and is narrowly tailored to achieve that purpose.¹⁴⁴

A similar case was filed in New York, and the lower court decision was in concert with the California courts. The New York lower court dismissed a challenge by Catholic Charities and other organizations to the Women’s Health and Wellness Act (“WHWA”) stating, “WHWA constitutes a comprehensive approach to ending discrimination against women”¹⁴⁵ and that “the narrow exemption serves to protect the rights and health of large numbers of employees who do not share their employer’s religious views, while exempting those employers whose employees do share their employers religious views.”¹⁴⁶

State Attorneys General are also relying on charitable trust doctrine and their authority to oversee non-profit entities to protect access to reproductive and end of life medical care.¹⁴⁷ First, state common and statutory laws require and/or provide the state Attorney General authority to protect the charitable assets of non-profit

139. See, e.g., CAL. HEALTH & SAFETY CODE §1367.25(b) (West 2000 & Supp. 2004); CAL. INS. CODE §10123.196(d) (West 1993 & Supp. 2004).

140. *Catholic Charities of Sacramento v. Superior Court*, 10 Cal. Rptr. 3d 283 (Ct. App. 2004).

141. *Id.* at 293.

142. *Id.* at 299-301.

143. *Id.* at 313.

144. *Id.* at 315.

145. *Catholic Charities of the Diocese of Albany v. Serio*, No. 8229-02, at 4 (N.Y. Sup. Ct., Nov. 25, 2003).

146. *Id.* at 17.

147. ELENA COHEN & JILL MORRISON, NAT’L WOMEN’S LAW CTR., HOSPITAL RESTRICTIONS ON REPRODUCTIVE & OTHER HEALTH CARE: USING CHARITABLE ASSETS LAWS TO FIGHT BACK, NATIONAL WOMEN’S LAW CENTER (2001); see also NAT’L WOMEN’S LAW CTR., CONSUMER PROTECTION LAWS TO FIGHT BACK (forthcoming publication 2004).

corporations, including health care entities.¹⁴⁸ Under such laws, charitable assets generally must be used for purposes which are consistent with the original mission of the entity. Thus, where transactions between non-sectarian non-profit health entities and religious entities entails the imposition of religious doctrine and the reduction or elimination of reproductive health services, some Attorneys General have argued that such transactions are inconsistent with the mission of the secular hospital. For example, in 1998 the New Hampshire Attorney General, relying on state common and statutory law providing authority to oversee charitable trusts and responding to community pressure, required both a Catholic and a non-sectarian hospital that had previously merged to examine how the transaction affected the mission of each entity.¹⁴⁹ The Attorney General determined that the imposition of the Ethical and Religious Directives on the non-sectarian hospital to prohibit abortion services “sacrificed [the hospital’s] ‘traditionally secular approach to medicine.’”¹⁵⁰ The Attorney General’s inquiry ultimately resulted in a dissolution of the merger after the hospitals failed to determine how they could maintain separate identifies that would not go afoul of their respective charitable missions.¹⁵¹

A. A Proposed Analysis of Refusal Clauses

Refusal clauses first emerged in a significant manner at the time of *Roe v. Wade*. The Church Amendment, passed in 1973 and named after Senator Frank Church, allowed health care providers to opt out of providing abortions or sterilizations, and also provided that those practitioners could not be discriminated against in the workplace for either performing or refusing to perform those medical services.¹⁵²

Recently, however, refusal clauses have been expanded beyond issues of individual beliefs to apply to entire corporate health systems.¹⁵³ These refusals allow these systems to opt out of providing certain services but also relieve them from offering referrals or

148. See, e.g., CAL. CORP. CODE § 5914 *et. seq.* (West 1990 & Supp. 2004). See generally, COHEN & MORRISON, *supra* note 147.

149. COHEN & MORRISON, *supra* note 147, at 25.

150. *Id.*

151. *Id.* at 25-26.

152. 42 U.S.C. § 300a-7 (1973). The Church Amendment prohibits courts and public officials from requiring the recipients of governmental funding to perform sterilizations or abortions.

153. See *supra* Part II and accompanying text.

counseling about how to obtain services elsewhere.¹⁵⁴ The Medicaid Managed Care Balanced Budget Act of 1997 provision, and potentially ANDA, discussed above are such examples.¹⁵⁵

There are several examples in which the application of refusal clauses or the practice of religious health care providers have compromised or resulted in creative solutions to preserve some range of access to otherwise prohibited health services. In the case of health system mergers and takeovers, one compromise in California resulted in Catholic Healthcare West establishing the "Community Model"¹⁵⁶ in which sterilizations and all forms of contraception were preserved, while abortion and fertility treatments were banned.¹⁵⁷ This model has been used to date in eighteen hospitals.¹⁵⁸ In Port Jefferson, New York, Catholic St. Charles Hospital and non-sectarian John Mather Hospital have a joint venture agreement in which all reproductive and maternity services are provided at the non-sectarian hospital.¹⁵⁹ These solutions are limited, however, in that the Directives caution Catholic hospitals about affiliation or association with institutions that provide abortions: "Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers."¹⁶⁰ And, as with many compromises, not everyone is always happy with the results. The California statute discussed above requiring contraceptive coverage to be included in employer drug benefit packages contains a refusal clause that is very narrow.¹⁶¹ It essentially comports with the ACLU analysis and exempts religious entities that primarily serve and employ people of that religion but does not exempt entities that generally serve and employ the general public.

In another compromise achieved through litigation, the religious entity prevailed in its ability to eliminate services, but was required

154. See *supra* notes 21-22 and accompanying text.

155. See *supra* notes 120-122 and 133-137 and accompanying text.

156. CATHOLIC HEALTHCARE WEST, COMMON VALUES FOR COMMUNITY SPONSORSHIP 14 (rev. ed. 1998). This type of compromise may no longer be possible as the 2001 revision of the Ethical Directives has equated sterilization with abortion. There is a very narrow exception allowing sterilization if it is needed to cure a present serious pathology and a simpler treatment is not available. ETHICAL DIRECTIVES, *supra* at 52, at Directive 53. Community advocates report that, to date, sterilization services nevertheless have been retained in the Community Model hospitals.

157. CATHOLIC HEALTHCARE WEST, *supra* note 156, at 14.

158. Pyle, *supra* note 3.

159. Stuart Vincent, *Port Jeff Hospitals in Alliance*, NEWSDAY, May 9, 1996, at A25.

160. ETHICAL DIRECTIVES, *supra* at 52, at Directive 45.

161. See *supra* note 139 and accompanying text.

to disclose its restrictions and provide information to consumers about how to access those services.¹⁶²

Past compromises and accommodations, however, have often been less than satisfactory, in some cases undone, and ultimately the burden has most heavily fallen on the patient rather than on the religious health system.

I recommend that policymakers adopt the following principles:

- **Respect for individual conscience:** The conscience of patients, the conscience of individual health care professionals who want to provide a full range of health care services to their patients, and the conscience of individual health care professionals who do not want to provide certain health care services.
- **Informed Consent:** In order to exercise their right to provide fully informed consent, all patients are entitled to thorough and complete information about their treatment choices, including all relevant and medically accurate information necessary for them to make fully informed health care decisions and to access needed services in a timely manner.
- **Medical Standards of Care:** Health care entities that operate in the public sphere and serve the general public should not be able to refuse, on religious or “moral” grounds, to honor patients’ informed health care decisions, or to provide medically appropriate services (including drugs, devices and procedures), as defined by the applicable standard of care.
- **Urgent Healthcare Needs:** When there is a conflict between the urgent or emergent needs of the patient and the objections of the individual health care professional, and there is no reasonable alternative, the medical needs of the patient should prevail.

Adoption of these principles will strengthen individual rights, the rights of women, and freedom of speech.

CONCLUSION

Religious restrictions on health care services are based on religious beliefs and doctrine, not on scientific research, medical trials, or health outcomes. While it is appropriate for individuals to decide what role religion will play in their personal health care decisions, it is not appropriate for corporate health care entities to

162. Settlement Agreement filed in *Amelia E. v. Pub. Health Council, Inc.*, No. 7062-94 (N.Y. Sup. Ct. filed Dec. 2, 1994).

impose those beliefs on physicians and patients and the communities they serve in a manner that supplants sound medical decision making and patients' rights.

