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RELIGIOUS REFUSAL: ENDANGERING PREGNANT WOMEN AND PROFESSIONAL STANDARDS

Stephane P. Fabus*

There has recently been an upsurge in the attention paid to women's health issues and the viewpoints are often fiercely contested. One area has long been a hot spot for contention, the infamous "A" word—abortion. Where an individual or institution lands on the issue is often rooted deeply in religious, philosophical, and moral beliefs. Legislatures have tried to protect healthcare providers' personal beliefs by passing conscience clauses. As these clauses have expanded to include both individual and institutional providers, they appear to pose a real danger to the health of women suffering emergent medical conditions relating to pregnancy. Informed consent and medical standards of care may be in conflict with a provider's personal beliefs or the institution's policies, but such providers are protected from liability under conscience clauses when they violate these medical and legal principles based on their beliefs. In these instances, patients are left with no legal recourse when their care is negatively impacted. Catholic institutions in particular must follow the Catholic Church's Ethical and Religious Directives, without regard to what the individual provider or patient thinks is the best course of treatment. Health care,

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My seven years at Marquette University were the most inspiring and influential years of my life to date. I wish to extend sincerest gratitude to the faculty and students of Marquette University Law School who helped me to develop the tools and skills necessary to successfully pursue my passion of a career in health law. *Cura personalis*. I would also like to thank my parents who have always supported me, encouraging me to be well-informed and to never fear expressing my opinion.

however, has become a highly regulated industry, catering to people of all religions, philosophies, and moralities. The First Amendment can only reach so far, and where the line has been crossed into state action, even a religious corporation cannot violate the Constitution for the sake of enforcing religious principles.

This article explores the impact of the Catholic Ethical and Religious Directives ("ERDs") on medical treatment and decision-making in Catholic-affiliated hospitals in the United States. Its scope is restricted to the narrow issue of the treatment of emergent conditions in pregnant women, such as ectopic pregnancy, severe pulmonary hypertension, and miscarriage, where there is no chance of continued fetal life but extreme risk to the health and life of the mother. Its focus is on the harm caused by institutional, rather than individual, religious refusal to provide emergency abortion services. Specifically, this article discusses the inability of medical professionals working in Catholic-affiliated hospitals to follow standards of care in such cases because of the stringent interpretation of the ERDs. In these cases, transfer to a more accommodating hospital may not be possible; federal law prohibits hospital transfers when they increase the risk to the health and life of the patient. The quality of medical care in these situations is being compromised due to the conflict between policies imposed by the ERDs on providers and providers' attempts to comply with medical and legal standards of care. This tension endangers the lives of pregnant women who have these types of emergent conditions. The legal protection offered by conscience clauses exacerbates the issue by providing healthcare providers, both individually and institutionally, a right to elevate their beliefs above such medical and legal standards.

The first section of this article discusses recent cases motivating this author's investigation into this narrow issue, gives a description of the ERDs, and presents an overview of the current presence of Catholic hospitals in the health care industry. The second part discusses the medical risks to mothers that result from strict interpretation of the ERDs, the

professional standards medical providers breach in conforming to the requirements of the ERDs, and the likelihood that such acts might disqualify hospitals from public funding. It also discusses the vast protection offered by “conscience clauses” at the state and federal level, which limits the enforcement of current medical ethics, standards of medical practice, and legal standards such as medical malpractice and informed consent. The final section addresses constitutional issues surrounding the ERDs, such as the constitutional validity of conscience clauses generally under the First Amendment. Further it discusses how such clauses may be unconstitutional as applied under a state action theory recognizing Catholic-affiliated hospitals as state actors who, in enforcing the ERDs, infringe on the individual constitutional rights of patients. This article adds to the academic landscape a narrowly tailored argument that the best approach to protecting pregnant women suffering from life-threatening conditions is to view Catholic healthcare institutions as quasi-public actors who cannot deny treatment based on religious refusal.

I. BACKGROUND AND STATISTICAL OVERVIEW

In November 2009, a 27-year-old mother of four presented to the emergency room at St. Joseph’s Hospital, a Catholic hospital in Phoenix, Arizona.¹ She was eleven weeks pregnant with her fifth child and suffering from severe pulmonary hypertension, a condition that threatened her life.² There was no way to save the fetus, and without an immediate abortion the mother would die as well.³ The hospital’s ethics board convened and determined that, despite hospital policy, the mother should be advised of

1. Becky Garrison, *Playing Catholic Politics with U.S. Healthcare*, THE GUARDIAN (Dec. 31, 2010), <http://www.guardian.co.uk/commentisfree/belief/2010/dec/31/catholic-us-healthcare-abortion>.

2. Molly M. Ginty, *Treatment Denied*, MS. MAGAZINE BLOG (May 9, 2011), <http://msmagazine.com/blog/blog/2011/05/09/treatment-denied>.

3. *Catholic-Secular Hospital Mergers*, PBS (Mar. 25, 2011), <http://www.pbs.org/wnet/religionandethics/episodes/march-25-2011/catholic-secular-hospital-mergers/8431> [hereinafter PBS] (video and transcript).

her option to have an abortion and one could be performed, if the mother chose to have the procedure.⁴ Almost immediately, the local bishop, charged with interpretation and enforcement of the ERDs, excommunicated Sister Margaret McBride, a member of the hospital ethics board who had approved the abortion, and stripped the hospital of its 116-year-long Catholic affiliation.⁵

Bishop Olmstead stated in support of his decision: "In this case, the baby was healthy and there were no problems with the pregnancy. Rather, the mother had a disease that needed to be treated. But instead of treating the disease, St. Joseph's medical staff and ethics committee decided that the healthy eleven-week-old baby should be directly killed."⁶ Under the ERDs, an abortion is "the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus," and is never permissible,⁷ not even to save the life of the mother.

This is not the first instance where Catholic policy has interfered with a pregnant woman's treatment of an emergent condition. When Kathleen Prieskorn felt fluid running down her leg and realized she was miscarrying for the second time, she rushed to her doctor's office in Manchester, New Hampshire and was informed her amniotic sac had torn.⁸ Unfortunately, because his affiliated hospital had recently merged with a Catholic hospital and her doctor could still detect a fetal heartbeat, he was prohibited from performing a uterine evacuation there.⁹ The nearest hospital that would perform the procedure was eighty miles away, but Prieskorn had no car and could not afford the expensive ambulance ride.¹⁰ Complications during the miscarriage posed potential risks including loss of

4. Ginty, *supra* note 2.

5. *Id.*; PBS, *supra* note 3.

6. PBS, *supra* note 3.

7. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 26 (5th ed.2009) (Directive No. 45).

8. Ginty, *supra* note 2.

9. *Id.*

10. *Id.*

her uterus or even death.¹¹ To get her the necessary treatment, her doctor gave her \$400 of his own cash and put her in a taxi to the distant hospital.¹²

Judy Hummel, another pregnant woman, presented to a Catholic hospital and was diagnosed as suffering blood poisoning due to a uterine infection.¹³ She miscarried, delivering a stillborn fetus.¹⁴ However, when her placenta did not appear, the doctor realized she had actually been carrying twins.¹⁵ The doctor, in line with his and the hospital's Catholic beliefs, did not inform Hummel of her option to have an abortion even though her uterine infection steadily grew more severe to the point of endangering her life. While the second baby eventually was born alive, she weighed just over one pound, was in extreme distress, and would suffer severe permanent physical disability and mental retardation.¹⁶ The Hummels sued the hospital and the doctor on behalf of their daughter claiming they departed from standard medical practice by failing to inform Mrs. Hummel of the option of abortion or transfer to another facility that would allow the procedure. At the time, the court agreed,¹⁷ however under expanding conscience clause protections discussed in Part II, *infra*, many similarly situated plaintiffs' claims might not survive today.

The narratives above demonstrate ways in which strict interpretation and enforcement of the ERDs' prohibition on abortion may compromise treatment of pregnant women with emergent conditions in Catholic hospitals and those secular hospitals that merge with Catholic providers and contractually agree to abide by the ERDs.¹⁸ The ERDs present "the theological

11. *Id.*

12. *Id.*

13. Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 83 OR. L. REV. 625, 642 (2003).

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.* at 643.

18. Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care*

principles that guide the Church's vision of health care."¹⁹ They have a dual purpose: (1) "to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person;" and (2) "to provide authoritative guidance on certain moral issues that face Catholic health care today."²⁰ They are interpreted and enforced by the United States Conference of Catholic Bishops "in the light of authoritative church teaching."²¹

The ERDs are divided into six parts addressing different areas of health care practice, with each part divided into two subparts. The first subpart is expository, providing an introduction and a context for discussion.²² The second subpart, however, is prescriptive and issues the Directives, which are intended to govern practice in Catholic-affiliated health care institutions "to promote and protect the truths of the Catholic faith."²³ For purposes of this article, the focus is on certain Directives contained in Part 4 covering "Issues in Care for the Beginning of Life,"²⁴ specifically Directives 45, 47, and 48.

Directive 45 is the primary Directive governing abortion and virtually eliminates the possibility of ever performing an abortion in a Catholic hospital, without regard to considerations such as the viability of the fetus or health and life of the mother. It states:

Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every 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. Catholic health care institutions are not to provide abortion services, even based upon the

Providers' Beliefs and Patients' Rights, 51 STAN. L. REV. 1703, 1738 (1999).

19. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *supra* note 7, at 3.

20. *Id.* at 4.

21. *Id.*

22. *Id.*

23. *Id.* at 5.

24. *Id.* at 23–28.

principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.²⁵

Based on the strict interpretation of the principles of material cooperation and scandal, Directive 45 limits a provider's ability to inform a patient of abortion as a treatment option and the ability to transfer the patient to another facility willing to provide an abortion.²⁶

Directive 47 allows for "operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman" even if they will result in fetal death, so long as they cannot be safely postponed until the fetus is viable.²⁷ These types of procedures have been referred to as "indirect abortions."²⁸ However, Directive 48 states that, "[i]n case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion."²⁹ Under the bishops' new stricter interpretation of the ERDs, what essentially constitutes a direct abortion is not permitted for "treatment" purposes and cannot be framed as an indirect abortion intending to treat a proportionately serious pathological condition threatening the health or life of the mother.³⁰

To understand the potential impact of this strict interpretation of the ERDs on pregnant women with emergent conditions, one must first grasp the broad presence of Catholic and Catholic-affiliated hospitals in the United States healthcare

25. *Id.* at 26.

26. Martha S. Swartz, "Conscience Clauses" or "Unconscionable Clauses": *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL'Y, L. & ETHICS 269, 290-91 (2006).

27. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *supra* note 7, at 26.

28. William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455, 503 (2001).

29. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *supra* note 7, at 27.

30. See letter from Thomas J. Olmstead, Bishop of Phoenix, to Lloyd H. Dean, President of Catholic Healthcare West (Nov. 22, 2010), *available at* <http://www.azcentral.com/ic/community/pdf/bishopletter.pdf>.

marketplace. Catholic hospitals contain 20% of the hospital beds in the United States.³¹ With over 600 hospitals nationwide,³² Catholic-affiliated institutions are the leading non-profit providers of health services in the U.S. and run 18% of hospitals.³³ Seven of the ten largest non-profit hospitals are Catholic, as are five of the ten largest provider networks.³⁴ Further, in 1998 ninety-one Catholic hospitals were certified as sole providers, a number that encompassed a 65% increase over the previous three years.³⁵ The presence of Catholic governance in health care has been exacerbated in recent years with the increase of mergers that allow Catholic hospitals to impose the ERDs and the bishops' interpretation of them on secular facilities.³⁶ Catholic entities are involved in a majority of the healthcare mergers in the United States,³⁷ with 171 mergers occurring between 1990 and 2001.³⁸

The potential impact on pregnant women with emergent conditions is also not as slight as it may at first seem. Miscarriage occurs in 10–20% of pregnancies.³⁹ There are a multitude of complications that can arise and potentially become life threatening as the miscarriage progresses.⁴⁰ Ectopic pregnancy is the leading killer of first trimester mothers.⁴¹ The small percentage of abortions performed in hospitals are usually performed out of necessity for women who are medically fragile

31. Swartz, *supra* note 26, at 331.

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

33. Swartz, *supra* note 26, at 331.

34. *Id.*

35. Susan R. Fogel & Lourdes A. Rivera, *Saving Roe is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 734 (2004).

36. See Tena Jamison, *Should God Be Practicing Medicine?*, 22-SUM HUM. RTS. 10, 10 (1995).

37. Clark, *supra* note 13, at 639.

38. Swartz, *supra* note 26, at 331.

39. *Below the Radar: Health Care Providers' Religious Refusals Can Endanger Pregnant Women's Lives and Health*, NAT'L WOMEN'S L. CTR. (Jan. 20, 2011), available at <http://www.nwlc.org/sites/default/files/pdfs/nwlcbelowtheradar2011.pdf> [hereinafter *Below the Radar*].

40. *Id.*

41. *Id.*

or at risk for serious complications and who require the medical back-up systems a hospital can provide.⁴² Further, women suffering these conditions and needing an abortion to protect their health or life may already have difficulty obtaining treatment. As of 2000, 87% of counties in the United States had no abortion provider and one-third of American women resided in these counties.⁴³ If the nearest provider for these women refuses to perform the procedure, she might have to travel fifty miles or more to get to the next nearest provider who will perform the procedure.⁴⁴ This problem has the potential to severely impact women's health in the reproductive arena especially in the case of emergency complications.

II. THE ERDs' NEGATIVE IMPACT ON MEDICAL AND LEGAL STANDARDS OF CARE AND THE PROTECTION OF CONSCIENCE CLAUSES

Strict enforcement of the ERDs can negatively impact the quality of care provided to pregnant women with emergent conditions as well as violate their legal and medical rights. The expanding protection offered to Catholic hospitals and physicians through state and federal conscience clauses may shield providers from liability for their actions simply because those actions conform to a religious, moral, or ethical belief system. While such actions may have initially disqualified providers from participation in government funding programs, the conscience clauses protect Catholic providers from this consequence. Conscience clauses thereby restrict the ways in which the government and individual pregnant women can enforce their rights.

42. Fogel & Rivera, *supra* note 35, at 735.

43. Swartz, *supra* note 26, at 332–33. As this article goes to print, a Federal judge is deciding the fate of the last abortion clinic in the state of Mississippi. The clinic is being shut down based on a newly passed state law that requires Mississippi abortion providers "be certified obstetrician/gynecologists with privileges at local hospitals." Rich Phillips, *Federal judge to determine fate of Mississippi's last abortion clinic*, CNN, (Jul. 11, 2012), <http://www.cnn.com/2012/07/11/us/mississippi-abortion-clinic-hearing/index.html>.

44. *Id.* at 333.

The ERDs often conflict directly with medical guidelines and, with increased expansion in the size and influence of Catholic hospitals, the ERDs may impede patient access to comprehensive health services.⁴⁵ They may also impede patient access to information.⁴⁶ Decreased access to services and information negatively impacts patient autonomy and may be medical malpractice.

One article has discussed the multitude of ways in which the effects of strict enforcement of the ERDs can harm both patients and society as a whole. Morrison and Allekotte state that the types of harm inflicted by religious refusals can include physical, emotional, financial, public, and legal harm.⁴⁷ Physical harm includes the serious health consequences a woman may suffer when a necessary medical procedure is either not provided or its provision is delayed because of a religious refusal.⁴⁸ The loss of a pregnancy naturally causes emotional harm. However, this harm can be exacerbated by a refusal, which implies an external judgment "that these women are doing something wrong and invoke shame during a fragile time."⁴⁹ Refusals further "reduce efficiency in healthcare" and "impose additional costs because of insurance limitations," causing financial harm to the patient individually and increasing the costs of healthcare and insurance for the general public.⁵⁰ Refusals also harm the public by "reinforc[ing] and perpetuat[ing] the idea that medical professionals are morally judging the behaviors of their patients."⁵¹ This can make patients less forthcoming with their doctors or cause them to

45. Kimberly A. Parr, *Beyond Politics: A Social and Cultural History of Federal Healthcare Conscience Protections*, 35 AM. J. L. & MED. 620, 637 (2009).

46. Jill Morrison & Micole Allekotte, *Duty First: Towards Patient-Centered Care and Limitations on the Right To Refuse for Moral, Religious or Ethical Reasons*, 9 AVE MARIA L. REV. 141, 148–49 (2010).

47. *Id.* at 149–62.

48. *Id.* at 150.

49. *Id.* at 155.

50. *Id.* at 157–58.

51. *Id.* at 160.

avoid the healthcare system completely.⁵²

Refusals also threaten medical and legal standards of care and restrict patient autonomy. For example, under the informed consent doctrine the patient has the right to be presented with the full range of treatment options and have the risks and benefits of each treatment thoroughly explained before selecting a treatment plan.⁵³ Informed consent is a medical and legal standard of care, meaning providers can be held liable for failing to meet its requirements.⁵⁴ Informed consent is intended to protect patient autonomy by ensuring the patient has all information necessary to make a decision regarding medical treatment.⁵⁵ Providers governed by the ERDs, however, may not inform a patient of all possible treatment options, or may give inaccurate or misleading information to sway patient decision-making.⁵⁶ Regarding emergency abortions, some religious hospitals “forbid employees from providing information or counseling about abortion [or] referring patients to other facilities for abortions.”⁵⁷

Further, the medical standard of care may be violated where refusal of treatment is commanded by the ERDs. The medical profession establishes its own acceptable standards of competence and professional ethics.⁵⁸ These standards become the legal standard in medical malpractice cases, which require that the provider act with the same “degree of skill and care ordinarily possessed by a reasonable and prudent physician in the same medical specialty acting under the same or similar circumstances.”⁵⁹ Unfortunately for patients, the religious

52. *Id.* at 160–61.

53. *Id.* at 161.

54. *Id.*

55. *Id.*

56. *Id.* at 148–49, 161–62. Also *Below the Radar*, *supra* note 39, at 6–7; Fogel & Rivera, *supra* note 35, at 728.

57. Steph Sterling & Jessica L. Waters, *Beyond Religious Refusals: The Case for Protecting Health Care Workers’ Provision of Abortion Care*, 34 HARV. J. L. & GENDER 463, 465 (2011).

58. Swartz, *supra* note 26, at 342.

59. *Id.* (quoting Eric M. Levine, *A New Predicament for Physicians: The Concept of Medical Futility, the Physician’s Obligation to Render Inappropriate Treatment, and the*

principles controlling the availability of services can conflict with accepted medical standards of care.⁶⁰

In the cases of ectopic pregnancy and miscarriage, delay in treatment falls below the standard of care and threatens the life and health of the mother. There are four treatment methods for an ectopic pregnancy: to administer "a single shot of a drug, methotrexate, which dissolves the embryo; to surgically remove the embryo while keeping the fallopian tube intact . . .; to remove the entire section of the fallopian tube containing the embryo; or 'expectant management,' which postpones all treatment to observe how the condition evolves."⁶¹ Catholic hospitals governed by the ERDs view the use of methotrexate or surgical removal of the embryo as direct abortion.⁶² These providers will not perform either treatment even where indicated as the standard of care or best practice based on the patient's condition.⁶³ These procedures may be the only means of preserving future fertility, however they are not an option in a Catholic hospital following a strict interpretation of the ERDs.⁶⁴ One study found that in order to comply with the ERDs, treatment of ectopic pregnancy was delayed by unnecessary tests.⁶⁵ One provider stated such delay caused the patients' tubes to rupture, threatening the mothers' health and lives.⁶⁶ Further, the standard of care for patients suffering an emergency miscarriage at risk for complications is an immediate surgical uterine evacuation.⁶⁷ Some Catholic hospitals that refuse to perform the procedure may transfer the woman elsewhere or delay treatment until the fetal heartbeat has stopped, putting the woman at risk for unnecessary blood transfusions, infection,

Interplay of the Medical Standard of Care, 9 J. L. & HEALTH 69, 101 (1994-1995)).

60. Fogel & Rivera, *supra* note 35, at 727.

61. *Below the Radar*, *supra* note 39, at 5.

62. *Id.* Also Morrison & Allekotte, *supra* note 46, at 152-53.

63. *Below the Radar*, *supra* note 39, at 5.

64. *Id.* Also Morrison & Allekotte, *supra* note 46, at 153.

65. *Below the Radar*, *supra* note 39, at 5.

66. *Id.*

67. *Id.* at 4.

hysterectomy, or death.⁶⁸ Conformity with the requirements of the ERDs in these instances breaches the medical standard of care and places the providers in a position where they could be liable for medical malpractice. Most providers in these instances are protected from this consequence by conscience clauses discussed later in this section.

Further, health care providers have a special duty to treat pregnant women presenting to emergency rooms with serious conditions under the Emergency Medical Treatment and Active Labor Act (“EMTALA”). EMTALA requires that hospitals “provide stabilizing treatment to patients with emergency medical conditions who seek care at emergency rooms,” and treatment of severe symptoms must occur immediately; the hospital is not permitted to wait until the patient’s condition jeopardizes her health.⁶⁹ EMTALA also prohibits hospitals from transferring unstable patients to another hospital when those patients, within reasonable medical certainty, will experience a material deterioration of their condition during transfer.⁷⁰ EMTALA does not contain an exception for providers who are unwilling to provide care due to their religious objections.⁷¹ Providers who delay treatment or transfer a woman who presents to an emergency room with severe pregnancy complications rendering her condition unstable are in direct violation of this federal law.

Catholic hospitals may jeopardize their government funding when they refuse to provide the information necessary to obtain informed consent, fail to provide the standard of care in their treatment of pregnant women with emergent conditions, or transfer or delay care of such patients in violation of EMTALA. The Medicare Conditions for Participation require that providers receiving Medicare funding obtain informed

68. *Id.*

69. *Id.* at 10; Emergency Medical Treatment and Labor Act, 42 U.S.C. §§ 1395cc and 1395dd.

70. *Below the Radar*, *supra* note 39, at 10; 42 U.S.C. §§ 1395cc and 1395dd.

71. *Below the Radar*, *supra* note 39, at 10.

consent, respect patient autonomy in decision-making,⁷² treat patients in accordance with medically accepted standards of care, and abide by federal and state laws related to patient health and safety, such as EMTALA.⁷³ Hospitals that do not comply with these conditions can be deemed ineligible for Medicare funding. Conscience clauses, however, are protecting providers from this consequence as well.

Enforcement of the above-mentioned medical and legal standards, whether individually through use of the courts in medical malpractice cases or governmentally through restrictions on public funding, is becoming increasingly difficult as conscience clauses expand protections of religious providers against liability.

A conscience clause is a legislative provision that allows an individual or institutional provider to claim exemption from compliance with a legal standard or requirement, usually based on religious freedom grounds.⁷⁴ These clauses exist at both the state and federal level. Forty-seven states and the District of Columbia have at least one conscience clause, and of these only three states and the District of Columbia have an emergency exception requiring the provider to provide services in an emergency despite religious objection.⁷⁵ Further, twenty-seven of these states shift the responsibility for injury resulting from a religious refusal to the patient by shielding the provider from liability.⁷⁶

Since their emergence in the 1970s, federal conscience clauses have steadily expanded funding and liability protections for providers. After the landmark decision in *Roe v. Wade*, Congress enacted the first federal conscience clause, the Church Amendment, in 1973.⁷⁷ It "prohibited a court or public official

72. Hospital Conditions of Participation: Patients' Rights, 42 C.F.R. § 482.13(b) (2010).

73. See § 482.11(a) (2010).

74. Parr, *supra* note 45, at 622.

75. *Id.*

76. *Id.*

77. Fogel & Rivera, *supra* note 32, at 10.

from using certain federal funds to require any individual or institution to perform or assist in performing abortions or sterilization procedures, if doing so would violate the individual's or institution's religious or moral beliefs."⁷⁸ In 1997, Congress extended protections to cover Medicaid and Medicare managed care plans.⁷⁹ The Hyde-Weldon Amendment, enacted in 2004, further required that "federal funds be [] disbursed only to federal agencies that honor so-called conscience clauses; as a condition of federal funding, agencies must allow the institutions, insurers, health care facilities, and individual health care providers that they fund to refuse to provide, pay for, provide coverage for, or refer for abortions."⁸⁰ The Hyde-Weldon Amendment is drafted so broadly that the refusal need not be based on religious or moral beliefs, but for any reason whatsoever.⁸¹ It does not contain an emergency clause⁸² and allows providers to refuse to even inform patients of the availability of such procedures,⁸³ in violation of informed consent standards.

As a result of expanding conscience clause protections at both the state and federal level, pregnant women may not have legal recourse through medical malpractice actions for violations of informed consent or medical standards of care. Further, the government may be unable to enforce laws such as EMTALA and the Medicare Conditions of Participation through restrictions on funding. With religious providers reaping the benefit of such vast protections from liability, they are free to set their own standards of practice and care based on religious beliefs even though such standards may threaten the health of pregnant women suffering from emergent conditions.

This danger could be averted if conscience clauses are found generally to be constitutionally invalid or if hospitals are

78. Swartz, *supra* note 26, at 280.

79. *Id.* at 283.

80. *Id.* at 274.

81. *Id.*

82. *Id.*

83. *Id.* at 333–34.

viewed as state actors who cannot infringe on patients' constitutional rights.

III. CONSCIENCE CLAUSES AND CONSTITUTIONAL CONSIDERATIONS

Due to state and federal legislatures' support and increasing expansion of conscience clauses in recent years, it appears that patients may only be able to seek protection of their autonomy, rights, and health from the Constitution. Conscience clauses may be challenged generally under the First Amendment's establishment and free exercise clauses, but such challenges would likely prove unsuccessful. A better route would be to challenge the conscience clauses as applied to hospitals. Due to the development of the healthcare marketplace, courts are becoming more likely to find institutional healthcare providers to be quasi-public institutions that, as state actors, cannot infringe on patients' constitutionally protected rights. In these cases, conscience clauses are unconstitutional as applied to hospitals.

The First Amendment states in pertinent part: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."⁸⁴ This breaks down into the establishment and the free exercise clauses, both of which have their own line of United States Supreme Court precedent and are intended to address concerns regarding the entanglement of church and state.⁸⁵

The establishment clause protects the separation of church and state by prohibiting the government from privileging one religion over another or religion over non-religion.⁸⁶ Announced by the Supreme Court in *Lemon v. Kurtzman* and its progeny, the test for the validity of a statute challenged under the establishment clause requires that a statute have "'a secular

84. U.S. CONST. amend. I.

85. Parr, *supra* note 45, at 625.

86. *Id.*

legislative purpose,' that its principal or primary effect neither advance nor inhibit religion, and that it not foster an 'excessive entanglement with religion.'"⁸⁷ Courts may inquire into whether a certain religion is singled out for benefits under the statute, whether it applies equally to religious and secular groups, or whether the statute imposes an undue burden on non-beneficiaries.⁸⁸ A statute's mention of religion or incidental benefit to religion will not automatically be grounds for finding an unconstitutional endorsement of religion.⁸⁹

The Supreme Court has "warned that absolute accommodations for religion are constitutionally intolerable" and violate the establishment clause where they "provide[] no exceptions and fail[] to give any consideration to the burdens placed on . . . nonbeneficiaries."⁹⁰ Burdens to non-beneficiary patients as outlined above would support a finding that the absolute accommodation to religious providers without informed consent or emergency exceptions is unconstitutional under the establishment clause.⁹¹ However, First Amendment protection under the establishment clause is only available where a statute preferences religion.⁹² Because conscience clauses now almost uniformly offer protection to a broad range of personal beliefs—be they religious, moral, or ethical—it would be difficult to show that the clauses afford preferential treatment to a particular religion, or religion generally over non-religion.⁹³ They do not single out religion for special treatment or endorse particular religious beliefs, but allow secular beliefs to also qualify for protection.⁹⁴ Though unlikely, if a court were

87. *Id.* at 626 (quoting *Lemon v. Kurtzman*, 403 U.S. 602, 612, 613 (1971)). Also *White*, *supra* note 18, at 1730.

88. Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: the Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779, 828 (2007).

89. *Id.*

90. *Id.* at 829.

91. See Parr, *supra* note 45, at 628.

92. Harrington, *supra* note 88, at 829.

93. *Id.* at 828, 829.

94. See *id.* at 829.

to find that the statutes were intended to protect primarily beliefs arising out of religious tenets, they could be viewed as endorsing religion, even while also benefiting secular beliefs.⁹⁵ Under this interpretation, conscience clauses would be unconstitutional under the First Amendment's establishment clause by endorsing or giving preferential treatment to religion, or for offering an absolute accommodation to religious belief or behavior.

The free exercise clause protects the separation of church and state by prohibiting laws that overly inhibit the free exercise of religion, protecting both religious belief and religiously motivated conduct.⁹⁶ The United States Supreme Court in *Employment Division v. Smith* and its progeny has established that where a law is valid, neutral, and generally applicable it will not violate the free exercise prohibition by having the incidental effect of burdening religious action.⁹⁷ Most conscience clauses will survive a free exercise challenge because, as discussed above, they are phrased in such a way as to meet the valid, neutral and generally applicable standard by covering both religious and secular refusals. Further, because the free exercise clause targets discrimination against or burdens on religion by government action, conscience clauses that by their nature benefit religion may fall outside free exercise scrutiny.⁹⁸

However, the *Smith* holding cuts both directions because it extended only a qualified protection to religiously-motivated conduct. An individual or institution's freedom to perform religiously motivated conduct can be overridden by state interests in protecting against the potential harm or burden such conduct imposes on others.⁹⁹ Religious refusals by providers are religiously motivated conduct. Therefore, a state interest in the health or welfare of pregnant women with emergent conditions

95. *Id.* at 830.

96. Clark, *supra* note 13, at 628. Also, Parr, *supra* note 45, at 627.

97. Parr, *supra* note 45, at 627.

98. *Id.* Also Harrington, *supra* note 88, at 790.

99. Clark, *supra* note 13, at 650. Also, Harrington, *supra* note 88, at 789.

would be sufficient to override free exercise protection and support laws requiring the inclusion of emergency exceptions in conscience clauses. At least one commentator has stated that the government may have a compelling interest not only in ensuring medically necessary services but also in helping to counter gender discrimination in health care.¹⁰⁰ Gender discrimination arises because conscience clauses primarily impact female reproductive health care services. Laws mandating emergency exceptions in conscience clauses could help to combat the harm of religious refusals because post-*Smith* these laws would likely survive a First Amendment free exercise challenge.¹⁰¹

The best way to successfully challenge conscience clauses is to claim that they are unconstitutional as applied under a state action theory. A state actor is a person or institution that is acting under the color of state law and therefore cannot act in a way that violates an individual's civil rights.¹⁰² Based on the evolution of healthcare institutions, the modern religiously affiliated healthcare provider may be more likely to qualify as a state actor than in the past. If Catholic hospitals are found to be state actors, they could not seek conscience clause protection if enforcing the ERDs infringes on patients' constitutional rights.

Courts have generally been unsympathetic to institutional refusals, demonstrated by their willingness to characterize hospitals as public or quasi-public institutions.¹⁰³ The Church Amendment was enacted partly in response to *Taylor v. St. Vincent's Hospital*,¹⁰⁴ in which the court held that a Catholic hospital, found to be a state actor based on the substantial amount of government funding it received, violated the plaintiff's due process rights by refusing to perform a sterilization. Shortly after the enactment of the Church Amendment, the Fourth Circuit decided *Doe v. Charleston Area*

100. Swartz, *supra* note 26, at 329.

101. Clark, *supra* note 13, at 655–61.

102. See Swartz, *supra* note 26, at 298.

103. *Id.* at 297–98.

104. 369 F. Supp. 948 (D. Mont. 1973), *aff'd* 523 F.2d 75 (9th Cir. 1975).

Medical Center.¹⁰⁵ In *Doe*,¹⁰⁶ a suit brought under 42 U.S.C. § 1983, the plaintiff claimed a nonprofit private hospital acting under the color of state law violated her constitutional rights when it refused to perform an elective abortion.¹⁰⁷ The court determined the receipt of construction funds under the Hill Burton Act was a sufficient nexus to find the hospital was a state actor.¹⁰⁸

Other courts followed suit. In 1976, the New Jersey Supreme Court in *Doe v. Bridgeton Hospital Association*¹⁰⁹ held that several private, nonprofit, secular hospitals were quasi-public institutions. This categorization was based on evidence that the hospitals were "organized to serve the public, received substantial financial support from federal and local governments and the public, benefited from tax exemptions, were available to the public, and because their properties were 'devoted to a use in which the public has and are subject to control for the common good.'"¹¹⁰ As state actors, the hospitals could not refuse to permit first trimester abortions under a state refusal statute because it would be state action in violation of the federal constitutional right to a first trimester abortion.¹¹¹ The Alaska Supreme Court in *Valley Hospital Association v. Mat-Su Coalition for Choice*¹¹² also found a hospital to be a quasi-public institution and held the hospital could not abridge a patient's right to a constitutional abortion because "it had a special relationship with the state through the state's Certificate of Need program, received construction funds from state, local, and federal governments, and also received a significant portion of its operating funds from governmental sources."¹¹³ Further, the

105. *Id.* at 298.

106. 529 F.2d 638 (4th Cir. 1975).

107. Swartz, *supra* note 26, at 298.

108. *Id.*

109. 366 A.2d 641 (N.J. 1976).

110. *Id.* at 299 (quoting *Doe v. Bridgeton Hospital Association*, 366 A.2d 641, 645 (N.J. 1976)).

111. *Id.*

112. 948 P.2d 963 (Alaska 1997).

113. *Id.* at 299-300.

New Jersey Supreme Court in *Hummel v. Reiss*¹¹⁴ intimated, based on the duty to obtain informed consent, that “conscience clauses may not protect a religious hospital from liability for failure to inform a patient of otherwise generally acceptable medical practices,” even if those practices run contrary to the hospital’s religious policies.¹¹⁵

While the state actor cases following the Church Amendment considered only secular hospitals, the courts’ analyses could easily be applied to Catholic hospitals. Take for example the California Superior Court’s conclusion in *Catholic Charities of Sacramento, Inc. v. Superior Court*¹¹⁶ that the narrowly-interpreted term “religious employer” in a conscience clause did not exempt a Catholic charitable corporation “(1) for which the inculcation of religious values is not the purpose of the entity; (2) which serves people of all faiths; (3) which employs mainly non-Catholics; (4) which offers social services to the general public; and (5) which benefits from a federal tax exemption.”¹¹⁷

Originally, religiously affiliated hospitals were small, locally-owned institutions built by sectarian philanthropy and financed by non-governmental sources to perform religious ministries and serve, almost primarily, their own religious members.¹¹⁸ Modern Catholic hospitals have had to alter the way they do business to survive in the highly regulated and ever-changing health care industry, and are now often difficult to distinguish from their secular counterparts.¹¹⁹

Catholic hospitals are quasi-public institutions that qualify as state actors for the same reasons as the private secular hospitals in the cases above. Like secular hospitals, Catholic hospitals appear to be primarily government-funded. In 1998, combined Medicare and Medicaid funding accounted for nearly

114. 608 A.2d 1341 (1992) (discussed at n. 13, *infra*).

115. Bassett, *supra* note 28, at 558.

116. 85 P.3d 67 (Cal. 2004)

117. Swartz, *supra* note 26, at 301.

118. See Bassett, *supra* note 28, at 461

119. *Id.* at 461, 545, 558. Also Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 Hous. L. Rev. 1429, 1432 (1995).

half of revenues in religiously affiliated hospitals; the other half came from third-party payors and non-patient sources.¹²⁰ This percentage of governmental funding appears to have stayed consistent since 1989.¹²¹ Surprisingly, almost no funding for such hospitals comes from the religious entities with which they are affiliated.¹²² Further, Catholic hospitals hire and elect to their boards of directors members of the general public who often do not share their religious beliefs, and they are organized to treat members of the general public regardless of religious leaning.¹²³

As the number of mergers increase, even a hospital's name is no longer a reliable indicator of religious affiliation.¹²⁴ Consequently, prospective patients can recognize hospitals as religiously affiliated "only with great difficulty and after careful investigation."¹²⁵ Even the United States Supreme Court has put Catholic health care providers in a different class than other Catholic ministries, holding in *Bradfield v. Roberts*¹²⁶ that "church-related hospitals are public benefit corporations, unlike churches themselves, which are primarily religious in character," and they "fulfill a primarily secular purpose in serving the needs of society."¹²⁷ Due to the secularization of Catholic hospitals, they should be held to the same constitutional standards as their secular counterparts. They are state actors that violate the Constitution when they infringe on patients' constitutionally protected rights by refusing to perform procedures based on religious convictions.

CONCLUSION

Pregnant women suffering from emergent conditions should be able to count on medical treatment that conforms to legal and

120. Fogel & Rivera, *supra* note 35, at 742-43.

121. See White, *supra* note 18, at 1730.

122. Fogel & Rivera, *supra* note 35, at 743.

123. Basset, *supra* note 28, at 545, 548, 551.

124. *Id.* at 547.

125. *Id.* at 485.

126. 175 U.S. 291 (1899).

127. Basset, *supra* note 28, at 547, 548. Also, White, *supra* note 18, at 1731.

medical standards of care. In Catholic hospitals governed by the ERDs, the threat to patient health and safety is exacerbated by a refusal to perform life-saving abortions when complications in pregnancy arise. The ability to protect patient autonomy and enforce legal and ethical standards of care is steadily being limited by the expansion of state and federal conscience clauses that protect Catholic providers from liability.

To counter this effect, the expansion of conscience protection must be curtailed. This limitation is best attained through a constitutional analysis that recognizes religious hospitals as state actors, reducing their ability to seek conscience clause protection for actions motivated by religious policies when such actions infringe on patients' constitutional rights.

In the alternative, the First Amendment would permit a requirement that healthcare providers give patients all the information necessary to meet the informed consent standard, regardless of a provider's religious objection. Additionally, laws could be enacted requiring that all conscience clauses include an emergency exception. Mandating that necessary services be performed during a medical emergency could provide some protection to pregnant women suffering emergent conditions without running afoul of the First Amendment's establishment and free exercise clauses.