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ARTICLES

PRIVATE RELIGIOUS HOSPITALS: LIMITATIONS UPON AUTONOMOUS MORAL CHOICES IN REPRODUCTIVE MEDICINE

*William W. Bassett**

INTRODUCTION

Patients' rights to free and informed choice of their own health care providers is severely limited by contemporary managed care imperatives. Most persons covered by employer-related health insurance plans, for example, have very little meaningful right to select either physicians or hospitals for their health care needs. Because of the loss of patient autonomy in coping with highly technologized medical systems, the author believes the federal and state legislation that provides statutory rights to private, religiously affiliated hospitals to refuse patient requests for health care services must be now reconsidered, especially where those services are legally permissible, medically indicated and reasonably expected by insurance purchasers. This is particularly important in the area of reproductive medicine, where the ethical exemptions protecting private religious hospitals are virtually unlimited.

The result of rapidly changing hospital corporate transformations and competitively negotiated managed health care contracts is that patients are so collectivized, that they no longer enjoy the decisional freedom that traditionally served as the foundation of the distinctive pluralism characterizing American organized health care. In the balance of hospital exemptions and diminished patient rights, institutional privileges cannot remain absolute. Private hospital exemptions should be re-written, with clear limitations conditioned upon newly evolving public policy imperatives for informed choice in comprehensive patient health care plans.¹

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This article will address the problem of health care delivery where reproductive services indicated are the most sensitive and controversial, that is, abortion, sterilization, prescription of contraceptive drugs and treatments, AIDS counseling, and various types of fertilization procedures. Religious hospitals serving as contract providers, ethically bound to limit their own participation in the provision of these health care services, should be free to refuse limited medical procedures only where patient choices of hospitals for their acute care needs are free. Otherwise, not.

This is not a new or undebated problem; it comes now, however, in a new scientific, social and managerial context. Until now the legislative focus has been upon the protection of hospital and provider choices; today, however, I believe the public policy focus must be shifted to patients' rights.² While the rights of conscience of each and every health care professional must be securely safeguarded at law, institutional ambiguities should be resolved in favor of the individual patient.

If patients could freely choose the hospitals they want for all their acute care needs, as, indeed, historically was the case, there would be no

friends and colleagues. Thanks to Richard Weinblatt and Carrie O'Neill for their exacting editorial work. Brooke Gillardi, Tim Ahearn and Sean Broderick provided me valuable research support in recovering and checking sources for this study.

1. Federal and state freedom of conscience statutes for health care providers are found in Section V.C., *infra*.

2. At its annual meeting in Chicago, June 12-16, 2000, the American Medical Association's House of Delegates, by a 247-184 vote, adopted a very cautious resolution to ensure patient access to reproductive services when private hospitals merge with or acquire other hospitals. The resolution also affirms a policy that physicians, hospitals and hospital personnel, should not be forced to do anything that violates their moral principles. Resolution 218, brought by the Committee on Legislation, reads, in part, as follows:

Resolved: That in the case of mergers and/or acquisitions of health care systems, our AMA support action to ensure continued patient access to pregnancy prevention services within the community, including tubal sterilization and vasectomy . . .

Resolved: That our AMA reaffirm its policy that neither physician, hospital, nor hospital personnel shall be required to perform any act which violates personally held moral principles.

See AMERICAN MEDICAL ASSOCIATION, HOUSE OF DELEGATES, REPORT OF REFERENCE COMMITTEE B (June 16, 2000) available at <http://www.ama.assn.org/meetings/public/annual00/reports/hodactions/rcbannot.doc> (last visited May 5, 2001).

problem of institutional autonomies in the balance of public policy requirements for comprehensive health care. The free exercise rights of medical service organizations and patients both could be protected. Where patients can no longer choose acute care providers, however, or are deceived by insufficient disclosures of restricted services, religious hospitals serving large, mixed patient bases and paid for services by health maintenance organizations or insurance carriers cannot alone be privileged by law to limit the services they are willing to provide. The modern imperative of personal autonomy as well as the public policy goal of comprehensive, quality medical services to meet the fundamental civic right to health care demand some restrictions in balancing public/private spheres of interest in the delivery of health care services.

I. THE LOSS OF INDIVIDUAL PATIENT CHOICE OF HOSPITAL SERVICE PROVIDERS

The corporate transformation of hospitals and acute care medical facilities under the impetus of managed care imperatives, as we know, has serious legal repercussions upon patients' rights to choose the medical service options they desire. Rights to competent medical care, prices, and availability, are negotiated in employee benefit plans now, for the most part, collectively, sometimes annually, for persons forming patient bases often numbering tens of thousands of participants. There are both private and governmental subscriber groups of enrollees serviced by tiers of separate corporate entities. The majority of covered participants today deal, not individually, but in groups, through their employers, professional or union administrators,³ with insurance and health maintenance

3. The number of people served by health management organizations (HMO's) has doubled in this decade to about 160,000,000 in 1999. Nearly three-fourths of American workers with health insurance, 48,000,000, receive their coverage in HMO's or other managed care plans. <http://www.aahp.org> (last visited July 15, 1999). The remaining with health insurance are privately insured by state-regulated insurance plans. The Census Bureau reported that in 1997 43,448,000 Americans, i.e., 16.1%, were without health care insurance of any kind. U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES: 1999 HEALTH AND NUTRITION, NOS. 185 & 190 (2000). Since most employer-sponsored benefit plans including HMO's are regulated by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461 (1994), federal standards are essential to secure patient rights where ERISA is preemptive of the states' traditional role in regulating insurance. These standards, however, are meager. See Jack K. Kilcullen, *Groping For the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J. L. & MED. 7 (1996). The significant tax advantages to employer-based health insurance make other forms of private insurance

organizations. These intermediaries, in turn, utilize care providers that themselves are institutional members of labyrinthine systems of medical facilities formed by mergers, consolidations, acquisitions, joint ventures and other legal forms of resource-sharing. With time, only a diminishing minority of patients using the services of religious hospitals will carry private medical insurance. The problems of individual, informed choice for patients caught in the cost-conscious and often profit-driven world of medicine may be so intractable that federal or state patients' bills of rights legislation at the present time may be no more than palliative.⁴

The issue of hospital provider choice is central to the balance of patient

economically unattractive. Federal preemption also precludes or blunts state legislative attempts to regulate or reform employment-related health care plans. Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case For Managed Federalism*, 23 AM. J. LAW & MED. 251 (1997). Exemption from general state regulation under ERISA combines with very few federal restrictions to provide enormous impetus to the growth of very large employer-based group health plans. See *Pegram v. Herdrich*, 520 U.S. 211 (2000) (holding that mixed eligibility and treatment decisions made by HMO, acting through its physician employees, were not fiduciary acts within meaning of ERISA and, thus, could not form basis for breach of fiduciary duty claim under ERISA - 29 U.S.C. §§ 1002(21), 1109(a)); *Christiantielli v. Kaiser Foundation Plan of Texas*, 113 F. Supp. 2d 1055 (N.D. Tex. 2000) (finding that ERISA preempts state medical malpractice claim against insurance coverage denial); *Rutledge v. Seyforth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212 (9th Cir. 2000) (deciding that ERISA preempts state law claim that law firm overcharged for services to employee benefit plan).

4. Patients' Bill of Rights legislation has failed in every session of Congress, notwithstanding strong support from the Democratic Administration. President Clinton announced its reintroduction in his State of the Union address, January 19, 1999. The most recent bill contained no provisions directly ameliorating the difficulties of patient informed choice we address here. On June 11, 2000, the Senate rejected the Democratic bill, sponsored by Sen. Edward Kennedy, by vote of fifty-one to forty-eight, a more narrow margin than the fifty-three to forty-seven vote in favor of a Republican alternative last July. Jonathan Gardner, *Senate Again Rejects Patient-Protection Bill*, MOD. HEALTHCARE, June 12, 2000, at 4. Patients' bills of rights have been enacted, at least partially, in thirty-four states as of this writing. In none of these statutes, however, is there clear protection of patients' rights to full disclosure of services offered, or restricted, by health care providers, enabling them to make a free choice of hospital providers. For a very insightful analysis of the difficulties in drafting and enforcing patients' bills of rights statutes to regulate managed care, see David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221 (2000); Alycia C. Regan, *Regulating the Business of Medicine: Models For Integrating Ethics and Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635 (1997).

rights and organizational imperatives where religiously affiliated hospitals enter into participatory contractual arrangements with general service HMOs as medical service providers. In this area patient medical choices that become limited as a result of private religious hospital-HMO contracts and corporate transformations through mergers and acquisitions should be protected over institutional autonomies as a matter of principle, if not from the prudential viewpoint of public policy approbation and licensing. Statutory privileges protecting organizational moral choices, the so-called federal and state “conscience clauses,” should be revisited by courts and legislative bodies in an entirely new context in these cases, from a perspective that, in many ways, is far different from that originally justifying the legislation. Changes in contemporary health care financing and delivery compel this reevaluation.

A growing body of legal literature frames the parameters of choice protected under the religious freedom safeguards of the First Amendment⁵ for medical-moral decisions made by administrators of

5. “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; . . .” U.S. CONST. amend. I. In the free exercise jurisprudence of the Supreme Court limitations upon religiously-motivated conduct, not belief, struck the fundamental parameter of choice as early as *Reynolds v. United States*, 98 U.S. 145, 166 (1878) and *Davis v. Beason*, 133 U.S. 398, 402 (1890) (enforcing federal anti-polygamy statutes). Too much should not be made of the distinction, however, in view of the First Amendment’s express protection of religious “exercise,” denoting religious practice or religious observance. This seems to have been the case in *Braunfeld v. Brown*, 366 U.S. 599, 603-04 (1961), in which the Court rather cavalierly played down the significance of religiously-motivated conduct in upholding Sunday closing laws, which proved to be extremely onerous to Orthodox Jews and other sabbatarians. That jurisprudence concerns criminal activities that may be religiously motivated, and was summarized by the Supreme Court in *Employment Div., Dep’t of Human Res. of Ore. v. Smith*, 494 U.S. 872 (1990) (upholding state criminalization of the sacramental use of peyote), affirmed in *City of Boerne, Texas v. Flores*, 521 U.S. 507 (1997) (upholding municipal historical preservation ordinance that prohibited expansion of a church and striking down the Religious Freedom Restoration Act of 1993). The jurisprudence of the Supreme Court that mandates conduct that is religiously prohibited, however, is uneven. See e.g., *West Virginia Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943) (finding that pledge of allegiance in public schools cannot be forced on students contrary to religious belief); *Wooley v. Maynard*, 430 U.S. 705 (1977) (holding that forced government speech violates free exercise); cf. *Bowen v. Roy*, 476 U.S. 693 (1986) (forcing payment of tax withholding and Social Security assessments even against employers’ religious beliefs); *United States v. Lee*, 455 U.S. 252 (1982) (requiring submission of Social Security numbers). In *Wisconsin v. Yoder*, 406 U.S. 205, 220 (1972), the Court acknowledged that religious practices are, indeed, protected, and that it is wrong to emphasize a

private, church-related hospitals when these hospitals form cooperative ventures with non-profit public or community hospitals.⁶ A smaller number of studies analyze the problem where private religious hospitals are sold to for-profit corporations.⁷ Several studies propose helpful public policy considerations to ground legislative initiatives.⁸

distinction clearly contrary to the text of the Amendment (“belief and action cannot be neatly confined in logic-tight compartments”). In *Smith*, Justice O’Connor, concurring, said “Because the First Amendment does not distinguish between religious belief and religious conduct, conduct motivated by sincere religious belief, like the belief itself, must therefore be at least presumptively protected by the Free Exercise Clause.” 494 U.S. 872, 893 (1990). The faith/conduct dichotomy continues in use, however, as a practical decisional standard notwithstanding sustained criticism by jurists and theoreticians of the sociology of religion. See, e.g. *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 526 (1993); Fred P. Bosselman, *Extinction and the Law: Protection of Religiously-Motivated Conduct* 68 CHI.-KENT L. REV. 15 (1992); Christopher L. Eisgruber & Lawrence G. Sager, *The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct*, 61 U. CHI. L. REV. 1245 (1994).

6. In *Deciding the Fate of Religious Hospitals In the Emerging Health Care Market*, 31 HOUS. L. REV. 1429 (1995), Kathleen M. Boozang focussed a study on the ethical directives of the Catholic Health Association and constitutional dilemmas caused in cases of monopolized provision for healthcare. See also, Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control In A Consolidating Market*, 72 TUL. L. REV. 159 (1997) (examining the issue of free exercise and public interest); Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177 (1993) (providing a helpful survey of the so-called “conscience clauses” in federal and state statutes and urging legislative extension of these to all religiously affiliated hospitals); Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087 (1996) (a symposium on rural health care outlining legal support for the concerns of the public for reproductive health services where local general service hospitals become affiliated with Catholic hospital systems).

7. See, e.g., Phillip P. Bisesi, *Conversion of Nonprofit Health Care Entities to For-Profit Status*, 26 CAP. U. L. REV. 805 (1997); Shannon M. Hernandez, *Conversions of Nonprofit Hospitals to For-Profit Status: The Tennessee Experience*, 28 U. MEM. L. REV. 1077 (1998); Shelley A. Sackett, *Conversion of Not-for-Profit Health Care Providers: A Proposal for Federal Guidelines on Mandated Charitable Foundations*, 10 STAN. L. & POL’Y REV. 247 (1999); Eric S. Tower, *Directors’ Duty to Obtain a Fair Price in the Conversion of Nonprofit Hospitals*, 6 ANNALS HEALTH L. 157 (1997).

8. See Kathleen M. Boozang, *Developing Public Policy for Sectarian Providers: Accommodating Religious Beliefs and Obtaining Access to Care*, 24 J. MED. & ETHICS 90 (1996); Kathleen A. White, *Crisis of Conscience: Reconciling Religious Healthcare Providers’ Beliefs and Patients’ Rights*, 51 STAN. L. REV. 1703

In today's rapidly changing health services market the independent private hospitals that formed the paradigm for largely-unrestricted religious privilege, locally-owned institutions that were obviously performing religious ministries, serving, for the most part, their own co-religionists, built by sectarian philanthropy and financed by privately insured or uninsured fee-based services, are almost anachronisms.⁹

In addition to changes in the formulation of group benefit policies and the look of competing corporate technologies, publicly-funded contract services, Medicare, Medicaid and parallel state programs, administered by private, religious hospitals, alter the legal nature of funds financially supporting the work of religious hospitals.¹⁰ These new, permanent transformations of institutionalized health care occasion the need for ongoing legal analysis and public policy reconsideration.

A. Restructuring Health Care Realigns the Balance of Public Values

The restructuring of the non-profit sector of the health care industry, hospital mergers, joint ventures and shared resources is now creating huge conglomerates to be used as cost-cutting and market-maximizing devices for hospitals to compete in managed care markets. As for-profit organizations, insurance companies, and other health maintenance groups race to obtain market share, they do so at the expense of not-for-profit providers.¹¹ To remain financially viable, non-profit hospital systems¹²

(1998).

9. Frank Cerne, *The Fading Stand-Alone Hospital*, HOSP. & HEALTH NETWORKS, June 20, 1994, at 28.

10. See Carl H. Esbeck, *A Constitutional Case for Government Cooperation With Faith-Based Social Service Providers*, 46 EMORY L.J. 1 (1997). Esbeck provided two earlier studies of the effect of government financing and regulation of public benefit services provided by religious charities upon the churches' free exercise of religion in *Government Regulation of Religiously-Based Social Services: The First Amendment Considerations*, 19 HASTINGS CONST. L.Q. 343 (1992), and *State Regulation of Social Services Ministries of Religious Organizations*. 16 VAL. U. L. REV. 1 (1991). These and further research were published separately as *The Regulation of Religious Organizations As Recipients of Governmental Assistance* (1996).

11. Deanna Bellandi, *Profitability a Matter of Ownership Status: For-Profit Systems See Earnings Rise, While Not-for-profits Lag*, MOD. HEALTHCARE, June 12, 2000, at 26, lists the top for-profit health care systems as:

		Hospitals	
		1999	1998
1.	Columbia/HCA Healthcare Corp.	203	299
2.	Tenet Healthcare Corp.	130	122
3.	Universal Health Services	21	21

must bid successfully for patient bases to pay for delivery of service packages.¹³ This necessarily entails at least two major factors in the

4.	Triad Hospitals	29	-
5.	Health Mgmt. Assoc.	32	28
6.	Quorum Health Group	21	18
7.	Cnty. Health Systems	46	43
8.	LifePoint Hospitals	23	23
9.	New Am. Healthcare Corp.	11	8
10.	Province Healthcare Corp.	15	10

12. The leading non-profit health care systems, as reported in Bellandi, *supra* note 11, are:

		Hospitals	
		1999	1998
1.	U.S. Dept. of Veterans Aff.	172	172
2.	Ascension Health*	60	-
3.	Catholic Health Initiatives	71	65
4.	Christus Health**	27	-
5.	Catholic Health East	32	31
6.	Catholic Healthcare West	48	36
7.	Mercy Health Services	17	17
8.	Sutter Health	25	24
9.	NY Presbyterian Healthcare Sys.***	16	16
10.	Catholic Healthcare Partners	27	22

* In Nov. 1999, Daughters of Charity National Health System, St. Louis, and Sisters of St. Joseph Health System, Ann Arbor, Mich., merged to form Ascension Health, St. Louis.

** Christus Health was formed through the merger of Sisters of Charity, Houston, and Incarnate Word Health System, San Antonio.

*** Previously known as New York Presbyterian Health Network.

13. The American Hospital Association listed 195 mergers involving 404 hospitals between 1980 and 1991. All but 14 of these involved nonprofit hospitals. Howard J. Anderson, *AHA Lists Hospital Merger Activity for 12-Year Period*, HOSPITALS, June 20, 1992, at 62 (quoting American Hosp. Ass'n, *Hospital Mergers and Consolidations, 1980-1991* (1992)). In 1996, there were 595 merger and acquisition deals involving HMOs, hospitals and physician groups, up forty-five percent since 1994. Between 1994 and 1996 the value of those transactions jumped thirty-eight percent to \$29 billion in 1998. The rapid expansion of for-profit corporations into the feverish merger and consolidation market with non-profit hospitals and HMOs is also being driven by the growing push to put Medicare and Medicaid beneficiaries into HMOs. Shorter inpatient stays and declining admissions are a result of Medicare's Diagnosis-Related Group (DRG) reimbursement scheme, which pays providers on a per-patient basis based on

negotiations: (1) the quality, kind, comprehensiveness and cost of medical services; and (2) the needs, demands and expectations of employers, union leaders and other kinds of group service administrators for health benefit packages satisfying to their employees and members. Group service negotiators must be able, in turn, to offer attractive benefits packages to prospective applicants to be competitive within their own industry, union or profession. In other words, private religious hospitals today compete in a fiercely tough financial market where the array of quality, cost-effective services provided is the key to success to all the organizational players in the system.¹⁴ If medical services are curtailed by religious hospitals for ethical reasons, that fact must be known not only by the health plan negotiators, but also clearly and unmistakably by the persons comprising their prospective patient subscribers. A limitation upon services provided entails the corollary that the religious hospitals must offer strong alternative values of quality and attractiveness to remain financially viable and competitive.

Today, the other side of the negotiating table from employers, professional and employee group agents, insurance carriers and HMO administrators is occupied, not by the individual religious hospital struggling to stay alive financially, but rather by representatives of the combined resources of increasingly large and strong non-profit hospital systems. Individual hospitals cannot compete in this market. Large systems, however, combining both religious and community, or non-profit hospitals of other religious sponsorship affiliations, strive to match the commercial HMOs in both quality and range of services provided. What individual hospitals are reluctant to provide, the plurocratic systems supply by way of contracting out and referrals, often within the systems themselves, increasingly less often to facilities outside the systems. Thus, the religious non-profit hospital systems can match the commercial giants in the array of services offered, avoid contractual disclosure of restricted services, and capitalize on their strengths of community and physician loyalties. As non-profit corporations, they also have cost savings, of course, in property, sales and excise tax exemptions. In the large systems,

diagnosis, not on the actual cost of treating the patient. JOHN J. MILES, 2 HEALTH CARE AND ANTITRUST LAW: PRINCIPLES AND PRACTICE § 12-2 (1994).

14. Total profits of for-profit hospital systems rose to 3.5% in 1999, up from 2.8% of the year before, while the total profits for the private, not-for-profit sector sank to 2.2% last year from 3.4% in 1998, according to the 24th annual Hospital Systems Survey, formerly the Multi-unit Providers Survey. A total of 193 systems reported data for both years, including nine for-profits, 165 private non-profits and 19 public systems. The biggest non-governmental system is Columbia/HCA with \$16.7 billion in net patient revenue in 1999. See, Bellandi, *supra*, note 11 .

therefore, in theory, services need not be absolutely restricted, as patients can be triaged to different facilities using less restrictive ethical norms in the area of reproductive medicine.

Religiously affiliated hospital systems are major corporate players in the non-profit health care market.¹⁵

Adding to the transformation of non-profit hospitals and long-term care facilities is the creation of for-profit subsidiaries, joint ventures, acquisitions, mergers or other contractual affiliations with for-profit hospital systems, and/or mergers involving public and community hospitals.

Complete absorption of formerly independent religious hospitals into for-profit systems tilts the edge of secularity, leaving some protection for

15. MODERN HEALTHCARE (June 12, 2000) listed the top 20 health care systems ranked by net patient income as follows:

	Net Patient Total Revenue		Total Hospitals
	(millions)		
	1999	1998	1999
1. U.S. Dept. of Veterans Affairs	20,709.0	20,027.1	172
2. Columbia/HCA Healthcare Corp.	16,700.1	18,700.0	207
3. Tenet Healthcare Corp.	9,958.0	8,997.0	130
4. Ascension Health	5,485.5	-	70
5. Catholic Health Initiatives	4,756.1	4,787.3	71
6. Catholic Healthcare West	3,963.5	3,301.3	48
7. NY City Health & Hosp. Corp.	3,691.7	3,834.5	11
8. NY Presbyterian Health Sys.	3,038.5	3,121.7	16
9. Mayo Foundation	2,775.1	2,417.0	18
10. N. Shore Long Island Jewish Health System	2,331.3	2,174.7	13
11. Sisters of Mercy Health System, St. Louis	2,291.1	2,341.4	24
12. L.A. City Dept. of Health Services	2,239.1	2,341.4	6
13. Sutter Health System	2,128.0	2,010.0	27
14. Catholic Health East	2,063.2	1,683.8	33
15. Adventist Health System	2,044.8	1,740.4	29
16. St. Joseph Health System	2,016.7	1,345.7	15
17. Marian Health System	2,010.0	2,106.0	35
18. Catholic Healthcare Partners	1,984.1	1,833.4	30
19. Providence Health System	1,970.0	1,712.0	21
20. Mercy Health Services	1,969.4	1,943.9	20

personal faith-based options by medical staff, but hardly any for the administrators of commercial organizations as such.¹⁶ Federal and state statutory “conscience clauses” do not protect commercial, for-profit health care providers. Thus, in the commercial health care sector the religious mission of private hospitals may be temporarily preserved, perhaps, on a voluntary and individual basis; the institutional mission of disinterested charity, with its public interest exemptions, however, is no longer viable where hospital services are sold for shareholders’ profit.

Prospective patients who buy into private or company plans managed by health insurance corporations using managed care networks have limited choices among professional and institutional providers.¹⁷ Individuals, with families and enrolled dependents, form patient bases, numbering in the thousands, or tens of thousands, assigned by corporate health care purchasers to contract delivery systems evaluated by capitated costs, classification and quality of services offered.¹⁸ Physicians, nurses,

16. See Section VI.B.4, *infra*.

17. Limited, that is, by services provided by carriers or contract bases for private or company plans measured by cost-efficiency analyses.

18. See, generally, *Symposium: Health Care Capitated Payment Systems*, 22 AM. J.L. & MED. 167 (1996). Freedom to choose one’s caregivers is universally agreed-upon as a necessary part of a desirable health plan. See THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 179 (1994). Patients, on the other hand, the consumers of services in the health care sector, generally lack the expertise to make informed choices among acute care hospitals when they purchase healthcare services. Furthermore, when the need arises patients not only lack specialized knowledge of complicated and, perhaps, protracted medical treatments, but are too sick, too old or lack the energy necessary for such decisions. Patient bases also lack the organized clout to override or change employer, provider and physician choices. Physicians typically control the course of treatment and the choice of hospital. See GEORGE ANDERS, HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST (1996). Though physician autonomy is being diminished by the pressure of managed care, one of the major risks hospital corporations run is not only disaffection of referring physicians, but conflicts with insurers with close ties to physician associations. In the 1980’s, for example, Humana, Inc., ran into conflicts when doctors in some cities boycotted Humana Hospitals. Humana then split off its hospitals as a separate company that later joined with Columbia/HCA. See James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1470-71 (1994). Physicians in New York, New Jersey, California, Connecticut and at least ten other states are forming unions rapidly now to gain collective strength to counterbalance HMO/hospital bargaining power. Most of the union activity is among salaried staff doctors at hospitals, both public and private. The AMA endorsed physician unionization at its July, 1999, annual meeting. See, Steven

pharmacists, hospital administrators, in this narrowing world of patient choice, determine quality and comprehensiveness of services, availability, costs, and, in some cases, referral support.

Rapidly evolving health care systems created by private non-profit hospitals to share resources are increasingly coming under government scrutiny, not only by the Federal Trade Commission and the Anti-Trust Division of the Department of Justice,¹⁹ but also by state legislatures alarmed at the growing economic power of managed health care corporations to set prices, as well as coerce and restrict medical

Greenhouse, *Angered By HMOs Treatment, More Doctors Are Joining Unions*, N.Y. TIMES, Feb. 4, 1999, A-1; Frances H. Miller, *Capitation and Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma*, 6 HEALTH MATRIX 89 (1996).

19. Section 7 of the Clayton Act prohibits proposed mergers involving any acquisition of another firm's ("person's") assets, stock, or share capital that "may substantially lessen competition, or tend to create a monopoly." 15 U.S.C. § 18-21 (1988 & Supp. V 1993). Challenges to mergers are filed also pursuant to the Federal Trade Commission Act, 15 U.S.C. §§ 44-58 (1988 & Supp. V 1993). *United States v. Rockford Mem. Corp.*, 898 F. 2d 1278 (7th Cir. 1990); *FTC v. University HealthInc.*, 938 F.2d 1206 (11th Cir. 1991); *Adventist Health System/West*, 114 F.T.C. 458 (1991). HEALTH, EDUC. & HUMAN SERV. DIV., GENERAL ACCOUNTING OFFICE, GAO/HEHS-94-220, *HEALTH CARE: FEDERAL & STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY* 3 (1994). The 1992 Department of Justice/Federal Trade Commission Merger Guidelines contain government enforcement policy concerning horizontal mergers and acquisitions. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *MERGER GUIDELINES* (1992). Most hospital mergers require Hart-Scott-Rodino filings. See 18 U.S.C. § 18A (1988 & Sup. V 1993)(requiring that the FTC receive prior notice of most mergers in which the value of the acquired entity is over \$10 million). See Symposium: Antitrust Policy and Health Care Reform, 1995 UTAH L. REV. 365-559; Laura L. Stephens, *Nonprofit Hospital Mergers and Section 7 of the Clayton Act: Closing An Antitrust Loophole*, 75 B.U. L. REV. 477 (1995); Gordon H. Copland & Pamela E. Hepp, *Government Antitrust Enforcement In the Health Care Markets: The Regulators Need An Update*, 99 W. VA. L. REV. 101 (1996); Michael D. Belsley, *The Vatican Merger Defense--Should Two Catholic Hospitals Seeking to Merge Be Considered A Single Entity For Purposes of the Antitrust Merger Analysis?* 90 NW. U. L. REV. 720 (1996); William M. Stelwagon, *Does a Healthy Patient Need a Cure? A Response to Health Care Industry Proposals to Reform Antitrust Analysis of Horizontal Hospital Mergers*, 69 ST. JOHN'S L. REV. 553 (1995); Edward Hirschfield, *Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks*, 6 ANNALS HEALTH L. 1 (1997); Amanda J. Vaughn, *The Use of the Nonprofit Defense under Section 7 of the Clayton Act*, 52 VAND. L. REV. 557 (1999).

decisions.²⁰

As community-based non-profit hospitals are sold off, merged or enter into joint ventures with for-profit providers, government agencies fear for loss of the non-profit sector or are concerned for the recoupment of taxes foregone by years of exemption.²¹ Similarly, where community and

20. For example, under California law any foreign corporation or state-chartered public benefit corporation owning or controlling health facilities is required to provide notice to and seek the consent of the State Attorney General before disposing of assets or transferring control, responsibility or governance to any other entity. CAL. CORP. CODE §§ 5914, 5917, 5959 (West 1999).

21. Nonprofit hospitals are organized and operated for federal tax exemption purposes under Internal Revenue Code § 501(c)(3). Health Maintenance Organizations are § 501(c)(4) "social welfare" organizations. While both are required under federal tax regulations, Treas. Reg. § 1.501(c)(3)-1(b)(4) (see Rev. Proc. 82-2, 1982-1, CB 367), as well as mirroring state law, e.g. see, Cal. Corp. Code §§ 5130, 6719 (West 1990) and Cal. Rev. & Tax Code § 23701f (West 1992), to contain in their articles of incorporation provision that upon liquidation, dissolution, or abandonment, the assets of the public benefit corporation will be distributed exclusively to another charitable organization. 501(c)(4) organizations are not prohibited from engaging in interested-party transactions, per se, such as for-profit conversions involving private inurement. See Lee A. Sheppard, "HMO Conversion and Self-Dealing," Tax Analysis, Oct. 6, 1993 [LEXIS, Fedtax Library, TNT File]. Self-dealing transactions, such as HMO conversions, may be authorized by the Department of Corporations in California under Corp. Code § 5233(d) (West 1990). Contributions to §501 (c)(4) organizations are not tax-deductible, though the organizations are tax exempt. I.R.C. § 501(a). In California, conversion of nonprofit corporations to for-profit status is governed generally under supervision of the Department of Corporations by Cal. Corp. Code § 5813.5, which permits conversion to for-profit status under certain conditions, among which is the dedication of their current asset value to charity: "A public benefit corporation may amend its articles to change its status to that of . . . a business corporation . . . by complying with this section. . . . If the public benefit corporation has any assets, an amendment to change its status. . . shall be approved in writing by the [Commissioner of Corporations]." A converting public benefit corporation must prepay its minimum tax liability and set aside the fair market value of its assets for charitable purposes. See also CAL. HEALTH & SAFETY CODE § 1399.72(c)(1) (West Supp. 1999). Valuation of corporation assets generally follows accepted Valuation Methods under IRS Revenue Ruling 59-60 (Rev. Rul. 59-60, 1959-1, C.B. 237). Conversion of health maintenance organizations is specifically regulated by rules set forth by Cal. Health & Safety Code §§ 1399.70-1399.76 (West Supp. 1999). For-profit conversions have been permitted, or even encouraged, by both federal and state government agencies in the past in the thought that the public may better be served by allowing these organizations access to capital markets, ensuring their financial viability and the continued availability of health care to the public. See Health Maintenance

religious hospitals are sold off to become parts of commercial for-profit conglomerates there is concern for assets, which are dedicated to public service charities and are required by law to be re-distributed for similar charitable purposes upon termination or liquidation.²²

The same serious public policy concerns have marked the states' attempts to regulate for-profit conversion of non-profit health maintenance and insurance organizations.²³

State legislatures are being pressured by special interest groups to mandate ever-more comprehensive coverage in health services to the public by a licensed and closely-regulated industry.²⁴ These mandates come in packages with more stringent disclosure requirements and restricted participatory rights in state-subsidized medical programs and tax and employment policy exemptions.

Private, non-profit religious hospitals, thus, play on financial fields of increasingly competitive markets, growing patient demands and closer governmental scrutiny.²⁵ State mandated patient services, as well as

Organization Act of 1973, 42 U.S.C. §§ 300e-300e-14a (1974).

22. I.R.C. 501(c)(3). IRS Publication 557. Revised Model Nonprofit Corporation Act, § 14.06 (ABA, 1988); *Holden Hosp. Corp. v. Southern Ill. Hosp. Corp.*, 174 N.E. 2d 793 (Ill. 1961). See Theresa McMahon, *Fair Value? The Conversion of Nonprofit HMOs*, 30 U.S.F. L. REV. 355 (1996).

23. IRS Guidelines require that joint ventures between for-profit and nonprofit hospitals give the "charitable purpose" priority over "maximizing profits", that the nonprofit needs to hold a majority of seats on the hospital's board, and there must be evidence of ongoing charitable commitments. See Health Care News Servers, www.healthcareserver.com/stories, Mar. 5, 1998. See also, Milt Freudenheim, *As Blue Cross Plans Seek Profit, States Ask a Share of the Riches*, N. Y. TIMES, March 25, 1996, p. A-1 (detailing New York's legislative response after Empire Blue Cross and Blue Shield received state approval to establish a for-profit subsidiary).

24. Where state Medicaid programs, for example, have converted to managed care, some states have been unwilling to award contracts to hospitals which do not provide, or arrange for the provision, of contraceptive drugs, devices and sterilization services. For an limited overview of state-mandated health coverage and their projected economic effects, see Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994). See also Katie C. Morgan, *Leaving the Management of 'Managed Care' Up to the States: The Health Insurance Industry and the Need for Regulation of the Regulators*, 65 U. CIN. L. REV. 225 (1996); William J. Barr, *Although Offering More Freedom to Choose, 'Any Willing Provider' Legislation is the Wrong Choice*, 45 U. KAN. L. REV. 557 (1997).

25. The growth of private accreditation agencies monitoring and evaluating hospital and physician services to provide information for administrators buying

training programs,²⁶ add to the mix of public forces pushing against the envelope of private hospital ethical autonomy.

To date attacks on acute-care provider-HMO contracts, particularly under the so-called "exclusivity" clauses commonly employed restricting enrolled physicians to choice of hospitals within the circle of HMO

into health maintenance insurance contracts and healthcare organizations adds to the mix of pressures to multiply comprehensive service packages and better quality/price ratios. For example, the National Committee for Quality Assurance, NCQA, is a growing power source providing accreditation information on hundreds of HMOs to employers, unions and interested parties. NCQA, of course, exerts great pressure on religious hospitals and health-care organizations to get high ratings to enhance their bargaining position in getting contracts for patient bases. The National Board of NCQA includes leaders of business, the HMO industry, and consumer organizations. To date it has no representation of religious ministries in health-care. See www.ncqa.org. Three new players in the information supply business providing consumer reports about the performance of hospitals and physicians should also be mentioned: America's Health Network, a cable TV network that provides health-related programming, is developing hospital report cards for 15 cities in conjunction with the health information company HCIA (<http://www.ahn.com>); Healthcare Report Cards, Inc., a division of a Colorado physician practice management company, in fall, 1997, put its hospital report cards on the internet (<http://www.healthcarereportcards.com>); and Patient Watch, a New York company, started selling hospital and physician reports in 1998 as part of a patient advocacy service (<http://www.patientwatch.com>). Patient Watch, for example, gives each hospital an overall rating based on staffing ratios and other criteria. Consumers pay \$35 per hospital or per doctor report. The cost for a patient advocate who visits the patient in the hospital is \$200 per day.

26. The Accreditation Council for Graduate Medical Education (ACGME) in February, 1995, issued a directive that ob/gyn training programs include a mandated abortion training component as a condition for accreditation. This directive was to take effect on January 1, 1996, but was withdrawn due to opposition in Congress. The effect of accreditation requirements, however, it should be noted, is to set standards that teaching programs must obey to qualify for government-conferred benefits. Loss of ACGME accreditation, for example, may adversely effect a teaching hospital's ability to receive Medicare payments. Only residents enrolled in ACGME-accredited programs can defer payment of their federally subsidized Health Education Assistance loans. Most states, moreover, will license only doctors who have graduated from a program of ACGME accreditation. Thus, as a nation-wide accreditation agency ACGME exerts quasi-governmental power over hospitals and state public health licensing agencies to conform to their standards. See *St. Agnes Hosp. of Baltimore v. Riddick*, 748 F. Supp. 319 (D. Md. 1990). See footnotes 274-75 *infra*. See Barry R. Furrow, *Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos*, 43 VILL. L. REV. 361 (1998).

contract providers, have served largely to litigate physician-hospital staffing rights, employment termination, gag rules and appeals.²⁷ It should be emphasized here, however, that these same contractual provisions binding enrolled physicians limit even more drastically the choices their patients are allowed to make.²⁸ The recent spate of cases challenging the enforceability of the “exclusivity” clauses on anti-trust bases, indeed, punctuates the loss of patient rights to make meaningful hospital choices for their medical needs.²⁹

If patients are restricted in their right to chose a hospital of preference because of insurance or physician limitations, or achieve an adequate understanding of quality and range of services offered antecedently to execution of health insurance contracts in a thoughtful way, how can they be said to participate meaningfully and freely in the religious restriction of medical choices for their care? In this context patients are constrained by the pertinent markets to purchase medical services that they may never be able to receive.

One must emphasize that the choices hospital administrators make to enter into arrangements to serve as contract health care providers for insured patient bases directly affect the hospitals’ own rights of ethical autonomy. If patients have little or no choice of hospitals, hospitals cannot retain a distinctive ethical autonomy to deny patients their rights to comprehensive medical care.

The interest of churches and religious organizations who have built and sponsored the hospitals that are now major participants in this emerging

27. See generally, *Summit Health v. Pinhas*, 500 U.S. 322 (1991) (termination of a ophthalmologist’s staff privileges); *BCB Anesthesia Care v. Passavant Mem. Area Hosp. Ass’n.*, 36 F. 3d 664 (7th Cir. 1994) (no antitrust violation in hospital staffing decisions). Also the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-52, providing qualified immunity from money damages for persons involved in decisions to deny staff privileges to physicians based on competence or professional conduct. Following expressions of concern by the AMA, at least 16 states passed laws in 1996 prohibiting HMOs from including in their contracts so-called gag clauses intended to prevent physician-patient discussions of treatment options or cost-cutting measures by the insurer. In December, 1996, the Department of Health and Human Services added a federal regulation stating that any contract that limits a doctor’s ability to advise and counsel a Medicare beneficiary violates Medicare rules. Bryan A. Liang, *An Overview and Analysis of Challenges to Medical Exclusive Contracts*, 18 J. LEG. MED. 1 (1997).

28. Rebekah K. Campbell, *Hospital Collaboration Laws, Antitrust, and State Action Immunity: Will These Statutes Pass Muster?* 47 EMORY L.J. 1003 (1998).

29. See *supra* note 17.

market is to accentuate the religious ministry traditionally linked to health care services as a core manifestation of belief broadly protected by the First Amendment.³⁰ The very success of the voluntary religious sector in creating vast philanthropies to serve the general public, however, serves to undercut the force of the free exercise argument. Private philanthropies, however large, serve the general public, not only the faithful of the individual denominational sponsors.

Currently acceptable market strategies enable non-profit hospital systems to underwrite medical technology and spread costs in enviable competition with the for-profit sector and government-sponsored or community-based secular providers.³¹ The more successful religious health care systems become as quasi-businesses and the more they monopolize local health care accessible to the public the less compelling is their claim to religious exemption.³² Exemption runs in tandem with the preservation of free choice for patients, as well as the disinterested service of public charity.³³ Religious exemption as a public policy issue runs both to the substance of freely-conferred ministries and to their evident

30. Peter Campbell, *Evolving Sponsorship and Corporate Structures: Canon Law Considerations For Changing Organizations*, HEALTH PROGRESS, July-August 1995, at 35.

31. What Paul Starr noted in 1982 as the growing tendency of nonprofit hospitals to reorganize to add profit-making subsidiaries as a source of revenue, e.g., for-profit laboratories, rehabilitation centers, retirement homes, hospices, stress management centers, etc., has continued unabated by the accountancy demands of the unrelated income taxation regulations of the Internal Revenue Service. See I.R.C. §§ 511-514 PAUL STARR, *supra* note 31, at 437. A recommended overview of hospital development is V. CLAYTON SHERMAN, *CREATING THE NEW AMERICAN HOSPITAL: A TIME FOR GREATNESS* (1993).

32. See *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (4th Cir. 1963); *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550 (S.D. N.Y. 1974); *Simon v. Eastern Ky. Welfare Rights Org.*, 426 U.S. 26 (1976). A major component of the movement to remove property tax exemption from nonprofit hospitals is the perception of their similarity to businesses, and thus, their competitive advantage over the for-profit health care sector, as well as a general lack of sustained unpaid service to the indigent. See Bruce R. Hopkins & Thomas Hyatt, *The Law of Tax-Exempt Healthcare Organizations*, Ch. 6 (1996 and Supp.); see also Bruce R. Hopkins, *The Law of Tax Exempt Organizations*, § 25.1(f) (7th ed. 1998).

33. Jennifer Preston reports on state efforts to reimburse hospitals for revenue losses in providing below cost treatment for uninsured patients, mostly the working poor, and numbering nationally close to 50 million persons, in *Hospitals Look On Charity Care As Unaffordable Option Of the Past: Squeezed By Managed Care and Reduced Aid*, N.Y. TIMES, April 14, 1996.

appearance to the legislative agents of the taxpaying public.

Public pressures outside the denominational context of voluntary adherence to religious belief, most notably, from competitive economic needs, further constrain limitations upon religiously-based moral choices in monopolized provision for public health care. Market factors forcing down costs and sharpening competition for patients tend to level the playing field with for-profit counterparts.³⁴ This competition plays out in the need to offer more attractive and more comprehensive service plans.

Modern medicine, thus, provides valuable services to the public in a fiercely complex First Amendment zephyr. The law must bridle the admittedly core exercise of religious freedom and ministry that is institutional care of the acutely-sick and dying to three principled limitations: 1) the right of the public to accessible, licensed and accredited health care; 2) the right of patients to informed choice and freedom from coercion in the delivery of health care services; and 3) the accepted jurisprudential balance between custodial religious choice and the paramount public interest in safeguarding the health and wellbeing of children, disabled persons, and emergency patients whose lives may be saved by alternative, medically acceptable procedures even within religiously-operated facilities.

These limitations form the content of compelling state interests under the jurisprudence of the Free Exercise clause allowing states to place some limits upon church-related hospitals' free exercise of religion. Religious exemption goes hand in hand with maintenance of the integrity of free patient choice of services and providers.

When non-profit religious hospitals are sold to commercial health care organizations local communities have expressed two pressing concerns: (1) Will medical services continue to be provided for the poor and the uninsured on a below-cost or cost-free basis; and (2) will the institutions retain their historical religious identity so that religious ministries, not only chaplaincies, but ethical medical-moral choices, may be made by the institutions as such?³⁵

34. See Donna Bellandi et al., *Profitability A Matter of Ownership Status*, MODERN HEALTHCARE, June 12, 2000; Bradford H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals* (1991).

35. For example, on November 23, 1998 the boards of two Alexian Brothers Hospitals in Santa Clara County, California, announced a sale/exchange with Columbia/HCA. In exchange for 2 Chicago-area Columbia hospitals, the Catholic hospitals would leave San Jose, California, and receive in turn two for-profit hospitals owned by Columbia in the Chicago area, converting them to private, nonprofit Catholic hospitals. The sale was completed and the hospital exchange

Market forces, continued governmental financing and its compliance demands, and expansion of mandated covered services, will hedge the parameters of religious choice. While the First Amendment affords maximum protection for the free exercise of core religious beliefs, countervailing patient rights may supply compelling state interests in setting peripheral limitations upon institutional providers' choices in individual cases. This article will attempt an orderly examination of the balancing forces in institutional and personal choice, with some tentative suggestions for future development.

We must make a distinction between the delivery of elective health services and emergency life-sustaining care; between hospitals that are obviously recognizable as religious and those that appear, to all intents and purposes, the same as their secular non-profit or for-profit counterparts; and between monopolized and alternative delivery systems of health care. The current scenario in the national movement of health care reform is so complex, so much in flux, and so locally differentiated that there is no simple answer to fit all cases.³⁶ Religiously affiliated hospitals cannot be squeezed into a single box. What is needed, and, I believe, possible now, however, is the outline of a principled statement of policy.

B. Religious Health Care Ministries Exercised in Varied Corporate Configurations

To set the discussion into a practical context, let us take the example of ten private hospitals. Each is a religiously affiliated hospital, built and operated with faith-based motivation and dedication. Each hospital has a generational dedication to public service in the community it serves. Each hospital was built by the labor and risk capital of committed women and men of religious faith who gave an essential part of their lives to the spiritual ideals of ministry to the sick and dying.³⁷ Each of these hospitals

became final January 15, 1999. Note also the sale of Catholic university medical centers to Tenet Healthcare by Creighton in Omaha, Nebraska, and St. Louis Universities, two Jesuit universities. Michael Place, *Planned Sale of St. Louis University Hospital to For-Profit Chain*, 27 ORIGINS 497 (Jan. 14, 1998).

36. Paul M. Ellwood, Jr., and George D. Lundberg, *Managed Care: A Work In Progress*, 276 J.A.M.A. 1083, 1083 (Oct. 2, 1996).

37. In addition to Paul Starr's work, *supra*, note 31, see the remarkable new work of Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (1999); Odin Anderson, *Health Services In the United States: A Growth Enterprise Since 1875* (1985); Charles E. Rosenberg, *The Care of Strangers: the Rise of America's Hospital System* (1987); and Eli Ginzberg, *The Medical Triangle: Physicians, Politicians and the Public* (1990). See also Catholic Health Association, *Inventorying Church Property and Other Administrative Matters*

makes available to its patients chaplaincy and religious services of choice on a noncoercive, ecumenical and cooperative basis. Each hospital has teaching programs as well as community outreach services for the sick and chronically ill. Each of these hospitals was originally founded by private religious philanthropy to minister as an institution to the particular bodily and spiritual needs of the sick and dying of the church or denomination that sponsored it, though today a major component of its patient services is to the general public. Each hospital retains specialists in medical ethics to assist patients and professional staff with difficult moral choices in treatment and care.

Revenue and financial support, for the most part, come from government-funded programs, insured and contract services with health maintenance organizations, though each hospital has an endowment created over the years by investment of private philanthropies and surplus revenues.³⁸ None of these hospitals discriminates among persons in any way in provision of licensed services of the highest professional quality. All are or were organized and operated as tax-exempt charities under the provisions of Section 501(c)(3) of the Internal Revenue Code.³⁹

Currently, there are at least four different kinds of corporate configurations used by private religious hospitals: (1) As autonomous, self-standing religious or non-profit public benefit corporations; (2) as hospitals that share resources as part of systems of hospitals and health care institutions of the same religious affiliation; (3) as hospitals that are part of joint ventures and merged management systems with non-profit or for-profit nonreligious or public hospitals under a unified governing

(1990) (a guide to segregating private from public funds contributed to the building of medical facilities for purposes of allocation upon merger, acquisition or termination).

38. While religious hospitals are unique in their histories and community service records, and some churches, such as the Seventh-Day Adventist Church, eschew entirely almost any kind of public funding, the assets of most religious hospitals can be traced to four sources: 1) the contributions in money and donated services of the sponsoring religious order or church; 2) corporate and private donations; 3) public campaign financing, e.g., United Funds, etc.; and 4) federal and state government grants or low-interest, long-term construction loans. A substantial portion of the corporate and private donations are made based on hospitals' specific religious affiliation. National Coalition On Catholic Health Care Ministry, *Catholic Health Care Ministry In Transition: A Handbook For Responsible Leadership* (1995).

39. I.R.C. § 507(a)(4) exempts from federal income taxation organizations defined in Section 501(c)(3): "organized and operated exclusively for religious, charitable. . .or educational purposes."

board;⁴⁰ (4) as hospitals sold to or merged with a for-profit commercial health care corporations under contractual terms allowing them to retain original names and religious services. Some of these may be involved with multi-leveled businesses, whether subsidiaries or joint ventures, that are aggressively purchasing PPOs, HMOs, etc. or have for-profit spin-offs involving medical technologies, e.g., MRIs, etc. Some hospitals may have acquired minority ownership rights in health plans or delivery systems or contractual participation in them.

A large number of hospitals bearing denominational names, originally established by the churches, are no longer institutionally affiliated with the churches. They have become secular institutions or are now parts of commercial healthcare systems. Our focus will be upon those hospitals and health care systems retaining strong religious linkages.⁴¹

The American Hospital Association *Guide (2000)* lists two hundred and forty-four multi-hospital health care systems. Of these fifty-nine are church-related. Forty-eight of these systems are sponsored and operated by Catholic organizations, though not all of these include exclusively Catholic hospitals.⁴²

Providence Hospital in Washington, D.C., was founded in 1861 and continues to be operated by a Catholic order of sisters, the Daughters of Charity. The congressional charter of incorporation of the hospital was signed by President Abraham Lincoln, making Providence Hospital the oldest, continuously operating hospital in the nation's capital.

Providence Hospital, a 382-bed general service medical facility, with Carroll Manor Nursing and Rehabilitation Center, with 240 beds, forms the core of Providence Health System on its northeast Washington, D.C. campus. Providence is a teaching hospital affiliated both with Howard University School of Medicine and Georgetown University School of Medicine. Georgetown Medical Center, across the city, a nationally recognized research and graduate medical education university, is one of

40. There are a large number of faith-based hospitals that are affiliated with secular nonprofit or forprofit hospitals in systems that are secular in title. For example, two Catholic hospitals in California continue to bear their original religious names and missions as acquired members of Columbia HCA, Inc., a commercial health care system.

41. These brief institutional profiles have been compiled from information supplied by the hospitals themselves, chiefly through their web sites and brochures, or from cited cases and secondary sources provided and personal experience.

42. Healthcare Infosource, Inc., American Hospital Association, *AHA Guide to the Health Care Field, Sec. 6, Classification Code #21--Church-operated* (1999).

four Jesuit, Catholic medical schools in this country. It is also home of the first center for medical ethics, the Joseph and Rose Kennedy Institute of Ethics.⁴³

Providence Hospital came before the Supreme Court in 1899 in *Bradfield v. Roberts*,⁴⁴ a pivotal decision holding that public funds allocated by Congress for providing construction assistance to a hospital operated under the auspices of a church or religious order do not violate the Establishment Clause of the First Amendment. Since that decision the hospital has grown to include among its services distinguished programs in cardiology, geriatrics, maternity, oncology, orthopedics, and palliative care, a great variety of outreach programs, such as the OB/GYN Center for Life, offering prenatal and gynecologic services to women on a cost-free basis, community based alcohol and drug rehabilitation programs, and in-home visitation to the elderly.

Providence Hospital is obviously religious. Morning and evening prayers are recited over the audio system; each room has a crucifix. Mass is offered several times daily in the hospital chapel and sacraments are brought to patients by chaplains and their assistants. Providence Hospital is a member of the Catholic Health Association, headquartered in St. Louis.⁴⁵ The hospital is also one of eighty hospitals, nursing homes and clinics that form the Ascension National Health System. The Daughters of Charity National Health System was formed in 1994 to consolidate resources and revenues. Since then, in addition to Catholic hospitals, the system has acquired several public or community hospitals.⁴⁶ In 1999

43. The National Reference Center for Bioethics Literature is a specialized collection of 22,000 books and over 130,000 classified articles available as a research source for scholars and the general public. Available at <http://georgetown.edu/research/nrcbl> (last visited Apr. 25, 2001), or 800-MED-ETHX.

44. 175 U.S. 291 (1899); see Section V.B, *infra*.

45. The Catholic Health Association currently numbers 2000 hospital and extended care facilities as members, making it the largest private health-care provider association in the United States, accounting for about sixteen percent of hospital services nationwide. (2000 statistics) This number includes 57 multi-institutional networks, 247 health care centers, and 1556 specialized care facilities, such as hospices, sanatoria, and AIDS care institutions, in addition to more than 600 hospitals. CHA, 4455 Woodson Road, St. Louis, MO 63134-3797.

46. For example, in 1998 Niagara Falls Memorial Medical Center, a nonprofit community hospital serving many of Niagara Falls' poorest residents, in an effort to stave off financial collapse, joined the Daughters of Charity. Lucette Lagnado, *Religious Practice: Their Role Growing, Catholic Hospitals Juggle Doctrine and Medicine*, WALL ST. J., Feb. 4, 1999 at A-1.

Daughters of Charity and Sisters of St. Joseph Health System merged to form Ascension Health, based in St. Louis. Ascension Healthcare is the largest non-profit healthcare system in this country.⁴⁷

Ascension Health is one of forty-seven hospital systems developed out of individual hospitals built and sponsored by Catholic religious orders or dioceses in the past fifteen years.

Providence Hospital, as most other Catholic hospitals, adopted in its Charter and Mission Statement a dedication to the aims and objectives of the Catholic Health Association, as well as a determination to follow the *Ethical and Religious Directives* of the Association for religious and ethical decisions.⁴⁸

Loma Linda Medical Center located in Loma Linda, California, just thirty miles east of Los Angeles, is owned and operated by the Pacific Conference of the Seventh-Day Adventist Church. Loma Linda Medical Center is a part of Adventist Health System/West, an eight-member non-profit hospital system, related to the national Adventist Health System of thirty-three facilities currently.⁴⁹ Adventist Health System /West was challenged in California in 1994, in *In the Matter of Adventist Health System/West and Ukiah Adventist Hospital*,⁵⁰ in which the Federal Trade Commission, relying on *F.T.C. v. University Health, Inc.*⁵¹ and *United States v. Philadelphia National Bank*⁵² held it had jurisdiction to enforce

47. See *supra* note 12.

48. The most recent revision of the Directives is cited as: U.S. Catholic Bishops' Conference, *Ethical and Religious Directives for Catholic Health Care Services* (1994), reprinted in 24 ORIGINS 449 (1994).

49. See *Arriaga v. Loma Linda University*, 10 Cal. App. 4th 1556, 13 Cal. Rptr. 2d 619 (1992) (holding Loma Linda Medical Center exempt from California's Fair Employment Practices Act as a "religious employer." CAL. GOV. CODE § 12926(d)(1)) (West Supp. 1999). Glendale Adventist Hospital is also a member of the Adventist Health System/West. Elizabeth Ann Bouvia, suffering crippling advanced-stage multiple sclerosis, was a patient at Glendale Adventist when she asked for removal of her feeding tubes so she could die. The hospital staff refused on ethical grounds. Ms. Bouvia was then moved to a public hospital, where the staff also resisted her request. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986). Ms. Bouvia is alive and residing in private care at this writing. Note also *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (vindicating patients' rights to refuse medical treatment even against hospital providers' medical-moral judgment).

50. F.T.C. No. 9234 (April 1, 1994) (involving purchase of assets of a hospital by two nonprofit religious corporations).

51. 938 F. 2d 1206 (11th Cir. 1991).

52. 374 U.S. 321 (1963).

anti-trust regulations under Section 7 of the Clayton Act against business combinations of non-profit corporations.

Loma Linda Medical Center itself, a part of Loma Linda University, is incorporated autonomously as a religious corporation under California law. Loma Linda Hospital is not a public benefit non-profit corporation, but a corporation organized and operated "exclusively for religious purposes" under state law.⁵³ It is a constituent part of the Seventh-Day Adventist Church. The Medical Center, with nearly 5,200 employees, is a leading national research hospital and tertiary care center. Loma Linda is a national leader particularly in infant heart transplants and cancer treatment. The medical center was founded in 1905 by members of the Seventh-Day Adventist Church and has taken no public funds for subsequent construction of the vast hospital complex. Not only is Loma Linda chartered as a religious corporation, it specifically subscribes to the beliefs and moral directives of the Seventh-Day Adventist Church.⁵⁴ Loma Linda is a hospital serving the general public and embracing outreach services linked to seventeen hospitals and medical centers in California, Arizona, Nevada, Utah and Hawaii.⁵⁵

Beth Israel Deaconess Hospital in Boston was formed by the merger of Beth Israel and Deaconess Hospitals in Boston in November, 1989, and re-incorporated in 1996. Beth Israel Hospital was conceived by members of several Jewish congregations in Boston in 1901 forming the Mount Sinai Hospital Association in order to provide hospital services to the city's immigrant communities and to the public in an atmosphere in which their own sick would not have to bear the indignity of conversion attempts and could peacefully follow the rituals, prayers and dietary regulations of the Jewish faith.⁵⁶ The original effort failed, but the hospital's resources were transferred in 1916 to the newly-dedicated Beth Israel Hospital in Roxbury. In 1928 the hospital moved to a new 200 bed facility on Brookline Avenue and became a teaching affiliate of Harvard Medical

53. CAL. CORP. CODE §§ 9110 et seq. (West 1999).

54. Seventh-Day Adventist Church, General Conference, *Statement, Guidelines & Other Documents: A Compilation* (n.d.).

55. In addition to Loma Linda Medical Center, there are two other Seventh-Day Adventist Health Care systems, with eighteen hospitals headquartered in Rosewill, CA, and with another eighteen hospitals, based in Winter Park, FLA. <http://www.ahss.org> (last visited Apr. 25, 2001); <http://www.adventisthealth.org> (last visited Apr. 25, 2001).

56. SAMUEL GOROVITZ, *DRAWING THE LINE: LIFE, DEATH, AND ETHICAL CHOICES IN AN AMERICAN HOSPITAL* 3-7 (1991). See also TINA LEVITAN, *ISLANDS OF COMPASSION* 29-30 (1964); PAUL STARR, *supra* note 31, at 153-54.

School. By 1990 it had grown into Boston's largest private hospital, with 500 beds, sixteen buildings, its staff physicians organized into two dozen clinical departments, with a nursing staff of over 800 nurses, providing ambulatory care in fifty different units. As a major research center, Beth Israel supports several libraries and forty or more laboratories.

Until the merger and reincorporation of Beth Israel-Deaconness Hospital in 1996, trustees of Beth Israel Hospital, as well as donors, were prominent Jewish members of Boston's business and professional community. After the merger, Beth Israel remains a Jewish hospital and the preferred acute care provider for the Jewish community in Boston, while technically incorporated as a non-sectarian public benefit health care organization.

Beth Israel hospital was reorganized as a public benefit corporation under Massachusetts law in its by-laws and statement of purpose clearly espousing adherence to the beliefs and practices of Judaism. The hospital's internal policy statements covering ethical issues are available to staff and patients and interpreted by a board of medical ethicists, both Jewish and non-Jewish.⁵⁷

Deaconness Hospital was, independently, one of the Boston area's largest and most honored Christian hospitals. In 1896, as part of their missionary charter, Methodist deaconesses founded Deaconness Hospital to care for the city's residents. Deaconness remains affiliated with the United Methodist Church. Over the years the public dedication of the Hospital has been to the ethical principles and ministries of healing in the context of Christian faith commitments. The merger of Beth Israel and Deaconness in 1996 did not create a health care institution that is entirely secular in purpose, but rather the fusing and conjoining of these great religious traditions in the healing arts.

Beth Israel Hospital came before the Supreme Court in 1978 after the 1974 congressional amendment extending National Labor Relations Board coverage and protection to employees of non-profit health care institutions.⁵⁸ Beth-Israel Deaconness Hospital is part of a shared

57. See Gorovitz, *supra* note 56.

58. Coverage was achieved by deleting from the definition of "employer" in § 2 (2) of the National Labor Relations Act, 29 U.S.C. § 152 (2), the provision that an "employer" shall not include "any corporation or association operating a hospital, if no part of the net earnings inure to the benefit of any private shareholder or individual." Act of June 23, 1947, ch. 120, 61 Stat. 136. *Beth Israel Hosp. v. National Labor Relations Board*, 437 U.S. 483 (1978) (on the issue of the hospitals no-distribution and solicitation rules). *Beth Israel Hospital* was decided in close conjunction with *National Labor Relations Board v. Baptist Hospital, Inc.*,

resource health care system of hospitals in New England, staffed by eighteen hundred physicians.⁵⁹ Included in the system are six Deaconess hospitals, as well as the New England Baptist Hospital. Beth-Israel Deaconess is affiliated with community health centers in Boston, Dorchester, Roxbury, Quincy and other areas.

Baylor University Medical Center in Dallas, Texas, is a Baptist hospital.⁶⁰ It forms the core of the Baylor Health Care System, established in 1981, a seven member hospital group, which, in turn, is related to nine other major systems of Baptist hospitals, headquartered in Montgomery, Little Rock, Pensacola, San Antonio, Louisville, Birmingham, Coral Gables, Phoenix, Memphis and Atlanta. There are seventy Baptist hospitals in these systems.

Baylor University Medical Center began in Dallas in 1903 as Good Samaritan Hospital.⁶¹ A year later it was purchased by the Baptist General Convention of Texas, and re-named Texas Baptist Memorial Sanitarium. Fifty-five years later, as Baylor University Medical Center, it comprised five connecting patient hospitals and a cancer center as the second largest non-profit hospital in the United States.⁶² Baylor University Medical Center was split in 1943, when Baylor College of Medicine moved to Houston. In Dallas medical education continues, however, as the hospital is still a teaching and research hospital of Baylor University College of Medicine.

On March 3, 1997, Baylor Health Care System established legal autonomy from the Baylor University Board of Regents in Waco, Texas, while continuing to support the University's nursing and medical education programs. The Medical Center continues its union with the Southern Baptist General Convention of Texas. Baylor's articles of incorporation indicate that the trustees are appointed by the church body and the hospital is dedicated to the religious mission and beliefs of the Baptist faith.

Advocate Lutheran General Hospital in Park Ridge, Illinois, is a six-hundred bed hospital in Chicago's northwestern suburbs. It is a teaching hospital for the University of Illinois at Chicago Health Sciences Center, a

442 U.S. 773 (1979) (unfair labor practice to refuse to bargain with employee union).

59. *Id.*

60. Lana Henderson, BAYLOR UNIVERSITY MEDICAL CENTER (1978).

61. Susan Hall, *Baylor University Medical Center*, THE HANDBOOK OF TEXAS ONLINE, available at <http://www.tsha.utexas.edu/handbook/online/articles/view/BB/sbb3.html> (last visited Apr. 25, 2001).

62. *Id.*

Level I Trauma Center for both adult and pediatric care, and Level III perinatal and neonatal services. The medical staff consists of more than one thousand physicians, practicing in sixty-five specialties.

Advocate Lutheran General Hospital is the hub of the largest health care system in Chicago, Advocate Health Care, Inc. Advocate was incorporated in 1995, but actually traces its origins to hospitals founded by predecessor churches of the Evangelical Lutheran Church in America and the United Church of Christ. Advocate has eight hospitals with over three thousand beds and is Illinois' largest privately held full-service home health care company among its more than two hundred sites of care. In 1995, Evangelical Health Systems and Lutheran General HealthSystem, two faith-based organizations, joined to create Advocate Health Care. A common mission, values and philosophy were developed from the similar-mission oriented histories of both organizations.

In 1906 the Evangelical Synod of North America formed the German Evangelical Deaconess Hospital in Chicago. In 1934, the Evangelical Synod and the Reformed Church in the United States merged to form the Evangelical and Reformed Church. A subsequent merger with the Congregational Christian Churches formed the United Church of Christ (UCC) in 1957, and the health care organization became a UCC affiliate. The formation of the organization was a direct response of the church to the Christian imperative to include healing as part of its ministry.

Lutheran General HealthSystem was founded in 1897, originally as the Norwegian Lutheran Deaconess Home and Hospital. In 1904 the hospital came under the control of the Norwegian Lutheran Church, which later evolved into the Evangelical Lutheran Church, The American Lutheran Church, and now the Evangelical Lutheran Church in America.

In 1959 the Lutheran Institute of Human Ecology was formed to establish ministries in alcoholism and substance abuse, senior services, parish nursing, bio-ethics and medical education. Lutheran General HealthSystem grew after 1961 into a vertically integrated service organization committed to providing a continuum of health care for its communities.

Advocate Health's website declares: "The mission of Advocate Health Care is to serve the health needs of individuals, families and communities through a holistic philosophy rooted in our fundamental understanding of human beings as created in the image of God."⁶³

Affiliated with Advocate General Lutheran Hospital is the famous

63. Advocate Health Care, *What is MVP?*, available at <http://www.advocatehealth.com/about/mvp.html> (last visited Apr. 25, 2001).

Park Ridge Center for the Study of Health, Faith and Ethics.⁶⁴ The Center publishes a journal of bio-medical ethics quarterly, entitled *Second Opinion*.⁶⁵

Some religious hospitals have been sold to business enterprises operating vast commercial hospital systems. *St. Francis Hospital in Charleston, South Carolina*, is now a part of the Columbia/HCA, a Nashville-based for-profit health maintenance system. Columbia/HCA is the nation's largest for-profit health care chain, with reported net patient revenue of \$16,700,100,000 in 1999.⁶⁶

In 1995, financially strained and \$56 million in debt, the St. Francis hospital board sought merger with another of Charleston's three hospitals. When merger negotiations failed, St. Francis Hospital directors agreed to enter a joint partnership agreement with Columbia/HCA as the only way to preserve its financial viability.⁶⁷

Columbia/HCA paid \$200 million in a deal jointly to own and operate St. Francis, St. Vincent Charity Hospital and St. John West Shore Hospital in Cleveland, Timken Mercy Medical Center in Canton, Ohio, and Providence Hospital in Columbia, South Carolina, all hospitals wholly owned by the Sisters of Charity of St. Augustine Health System. The transaction marked the first time a Catholic health system signed such an agreement with an investor-owned health care chain.⁶⁸

64. The Park Ridge Center, *Our Mission*, available at <http://www.parkridgecenter.edu> (last visited Apr. 25, 2001).

65. *Id.*

66. Bellandi, *supra* note 11.

67. M. Rita Schroeder & John I. Mansfield, *Creating a Private Association: The St. Francis Experience*, HEALTH PROGRESS 41-57 (Sept. 1996).

68. The agreement also included Ohio Health Choice, the second largest preferred provider organization (PPO) in Ohio, and Professional Medical Equipment Services, a durable medical and fitness equipment corporation. BNA HEALTH REPORTER, Nov. 9, 1995. There have been instances in which public hospitals have been staffed under state contracts by religious organizations. For example, in 1959 the Daughters of Charity withdrew from a contract to operate City Hospital in Mobile, Alabama (now the University of South Alabama Medical Center). The original contract was patterned on an agreement with the State of Louisiana for operating Charity Hospital in New Orleans. Neither hospital became a member of the Catholic Health Association or was recognized as a religious hospital. Similarly, the North Philadelphia Health System, formed after the bankruptcy of St. Joseph Hospital and Girard Medical Center, both innercity facilities, as a system agreed to observe the *Ethical and Religious Directives for Catholic Health Facilities* and St. Joseph's continues to follow these principles, although it is no longer recognized as Catholic by the Archdiocese of Philadelphia, even though the Archdiocese supports its work to provide quality health care to

Columbia/HCA agreed to a fifty-fifty joint venture partnership, in which Columbia/HCA purchased half of the Catholic charity's assets. The Sisters reserved the right to nominate half of the partnership board, and retained a fifty percent interest in the assets of the new partnership. In the agreement Columbia/HCA made a commitment to continuance of the religious traditions and affiliation of the hospitals and their adherence to the *Religious and Ethical Directives of the Catholic Health Association*.⁶⁹ The symbolism of religion, religious prayers and chapel services continue.⁷⁰

St. Francis Hospital is no longer a member of the Catholic Health Association, which prohibits sale of a member hospital to any for-profit corporation.⁷¹ Additionally, it has lost its tax exempt status. The Catholic Health Association highlights the differences between offering health care services as a ministry and offering them as a means of obtaining shareholder dividends. Health care, the Association says, is a ministry, not part of an industry.

Each of these major hospitals is one of several in the market (or community) it serves. There are alternative hospitals and out-patient clinics in each city. Each hospital is unmistakably religious in character and purpose. Each is an organization affiliated with a larger denomination that subscribes to, teaches and observes a code of medical ethics rooted in religious belief and tradition.

There are, however, many religiously affiliated hospitals that are the sole medical service providers in the communities in which they serve. In these communities patient choice of acute care providers for needed or requested reproductive medical care is drastically constricted.

Sacred Heart Hospital in Eugene, Oregon, a subsidiary of a parent corporation, PeaceHealth, Inc., which is wholly owned as a non-profit corporation by the Sisters of St. Joseph of Peace, is in exactly this situation.⁷² In 1994 Sacred Heart began merger plans to integrate three

innercity patients. 4 *BNA HEALTH LAW REPORTER* 1451, Sept. 28, 1995.

69. Schroeder & Mansfield, *supra* note 67.

70. *Id.*

71. Transition to for-profit status entails a necessary shift in governance from the sponsoring religious organizations to shareholders. Loss of essential control is incompatible with continuing religious identity. See, Section VII,B,3, *infra*. Code of Canon Law, canon 301 (1983). *Tony and Susan Alamo Foundation v. Sec. of Labor*, 471 U.S. 290 (1984). See also Francis G. Morrissey, *What Makes an Institution 'Catholic'?* 47 *THE JURIST* 538 (1987).

72. See Jane Hochberg, *The Sacred Heart Story: Hospital Mergers and Their Effects On Reproductive Rights*, 75 *OR. L. REV.* 945 (1996).

other medical groups in Eugene: the Eugene Clinic, the Oregon Medical Group and the Medical/Specialists Group. Sacred Heart, the only general hospital in the community, would own the practices and take over the facilities and assets of these providers.⁷³ Part of the plan involved announced restrictions on abortions and artificial insemination services by affiliated physicians. A coalition of community advocates initiated strong protests and a campaign to stop the merger.⁷⁴ Among the obvious reasons given, was that the closing of these clinics to abortion services would single out other providers as targets of protest and violence, and “deprive[s] women of the option of turning to their own doctors for assistance in terminating unwanted pregnancies.”⁷⁵

In July 1995, PeaceHealth completed the merger. The following fall, ten more physicians joined PeaceHealth.⁷⁶ The result was that seventy percent of the hospital services in the entire county, in addition to outpatient clinics and physician networks, were controlled by PeaceHealth. Prior to the merger, the Eugene area was the only place for much of the State of Oregon in which a woman could receive an abortion. After the merger, the majority of the population of the City of Eugene, in which the Catholic population numbers about four percent, was significantly restricted in its choice of women’s health services by the limitations of Catholic ethical norms. PeaceHealth merged with

73. In 1974 Sacred Heart Hospital was a defendant in the most famous of the “conscience” cases brought under the free exercise clause of the First Amendment, *Chrisman v. Sisters of St. Joseph of Peace*, 506 F. 2d 308 (9th Cir. 1974). A 23-year old married woman, Barbara Ann Chrisman, sought a tubal ligation after her second birth at the hospital. Sacred Heart refused to allow the procedure to be performed there, so the woman received the operation at a nearby hospital. The woman brought a civil rights case in federal court subsequently against the hospital, alleging that the hospital deprived her of her civil rights under color of law. The hospital was tax exempt, regulated by the state and received funds under the federal Hill-Burton Act. The Ninth Circuit held that the state was not involved in invidious discrimination and refused to grant the plaintiff equitable relief because of the recently-enacted Church Act. *See* note 362 *infra*. The opinion concluded that, since the plaintiff received the procedure in another local facility, the issue was moot.

74. C.H.O.I.C.E., a leading opponent, included membership by Planned Parenthood, the American Civil Liberties Union, the National Abortion and Reproductive Rights Action League of Oregon, the Feminist Women’s Health Center, and Republicans for Choice. *See* Hochberg, , *supra*, note 72.

75. *Id.* (citing CYNTHIA GIBSON, CATHOLICS FOR A FREE CHOICE, RISKY BUSINESS: THE COMMUNITY IMPACT OF CATHOLIC HEALTH CARE EXPANSION, 3 (1995)).

76. *Id.*

Providence Healthcare after the Eugene transactions, adding hospitals in Portland, Medford, Seaside and Newberg, Oregon, and gaining affiliations in Washington State and Alaska. The consolidation of rural and small community hospitals⁷⁷ poses similar problems of restricted choice where the ultimate provider affiliates with a religious hospital.⁷⁸ Currently, there are forty-six communities in which Catholic hospitals are the sole providers.⁷⁹ Catholics make up less than one-fourth of the population in twenty-nine of these forty-six communities.⁸⁰

Some private hospitals can be recognized by prospective patients only with great difficulty and after careful investigation, as serving a religious mission, let alone as non-profit charities.

Mercy Healthcare, Sacramento, California, was formed in 1987 to provide management and support functions for the Sacramento,

77. The Health Care Financing Administration (HCFA) in 1996 revised its criteria under the Medicare and Medicaid programs for rural hospitals to be qualified as Essential Access Community Hospitals (EACH). Under the revised criteria, the HCFA may designate a hospital as an EACH if the hospital cannot be so designated by the state because it has fewer than 75 beds and is located 35 miles or less from another hospital. Hospitals in rural areas that are designated as EACHs by the HCFA are treated, for payment purposes, as sole community hospitals, which typically entitles the facilities to a higher level of payment for their inpatient services than they would otherwise receive. The Regulations are designed to facilitate development of network affiliations between rural EACHs and small rural facilities, known as Rural Primary Care Hospitals (RPCBs). Among criteria for EACH designation is that the hospital have "in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospital, to receive data from and transmit data to such primary care hospital, and to provide staff privileges to physicians providing care at such primary care hospital" EACH designation, thus, provides pooling of resources by creating acute care monopolies in the designated rural areas. The program is restricted to those states (7) that have been given federal grants for their activities to support it. The individual states provide certification of what constitutes adequate medical services at the designated hospitals. Rules and Regulations, Dep't. of Health and Human Services, Health Care Financing Administration: Medicare and Medicaid Program: Criteria for a Rural Hospital to be Designated As an Essential Access Community Hospital (EACH), 42 CFR Part 412, cited as: 61 F.R. 21969 (No. 93). As of this writing forty-six Catholic hospitals located in rural areas are designated by the Health Care Financing Administration as "sole community providers." 42 C.F.R. §§ 412.90, 412.92; Ikemoto, *supra* note 6.

78. See Ikemoto, *supra* note 6.

79. *Id.*

80. *Hospital Mergers: The Threat to Reproductive Health Services*, REPROD. RTS. UPDATE, Oct. 1995 at 2. (ACLU/Reprod. Freedom Project, New York).

California area Mercy hospital facilities. The core hospital is Mercy General Hospital, formerly Mater Misericordiae (Mother of Mercy) Hospital, founded in 1897 by the Sisters of Mercy. Most of the financing for the original Mercy Hospital buildings, as well as for subsequent additions and new buildings, was contributed by members of the Roman Catholic faith.

MHS is sponsored now by three religious orders of the Catholic Church: The Sisters of Mercy, Burlingame; the Sisters of Mercy, of Auburn; and the Sisters of St. Dominic of the Most Holy Rosary of Adrian, Michigan. The sponsoring orders of sisters “are organized under the auspices, and as an integral part, of the Roman Catholic Church for the purpose of furthering the Church’s teachings and tenets.”⁸¹ MHS’s articles of incorporation and bylaws reflect its religious mission: “MHS’s mission is to continue to incorporate the healing ministry of the Church and the values and principles of the *Ethical and Religious Directives for Catholic Health Facilities* into the practice of medicine.”⁸² MHS’s bylaws require that its activities be “carried on subject to the moral and ethical principles of the Roman Catholic Church,” and “[n]o activities and procedures shall be permitted within the facilities owned by the corporation which are contrary . . . to the Ethical and Religious Directives.”⁸³ The sole member of MHS is Catholic Healthcare West, a non-profit public benefit corporation.⁸⁴

81. *McKeon v. Mercy Healthcare, Sacramento*, 19 Cal. 4th 321, 323, 79 Cal. Rptr. 2d 319 (1998).

82. *Id.*; see also Seventh-Day Adventist Church, *supra* note 54.

83. *McKeon*, 19 Cal. 4th at 324.

84. Catholic Healthcare West is a merged management corporation with 48 hospitals in California, Arizona and Nevada. In 1992 CHW acquired its first non-Catholic facility, Methodist Hospital in Sacramento. In addition to hospitals, it has bought eight medical groups and a small stake in MedPartners, Inc., the physician-practice management giant based in Birmingham, Alabama. In 1997 it combined with Samaritan Health Systems of Phoenix, Arizona’s largest health-care provider with six hospitals. In October, 1999, CHW purchased South Valley Hospital in Gilroy, California, from Columbia/HCA Healthcare Corp., enabling it to close its nearby St. Louise Hospital in Morgan Hill, and move all its operations to the larger facility in Gilroy. Both South Valley and St. Louise lost over \$65 million in the last ten years. The consolidation will reduce annual overhead costs by an expected \$13.7 million and result in positive net income. CHW’s combined 1999 annual net patient revenues approached \$4 billion, making it one of the five largest U.S. hospital companies. In 1996 CHW paid out \$174 million for charitable and community programs in the various communities it serves. Catholic Healthcare West is governed by a board, known as the corporate member board, composed of 10 nuns appointed by their sponsoring orders. Direct management is

In 1987 California's Non-profit Corporation Act provided incorporation of non-profit organizations in one or other of three exclusive categories: (1) Non-profit public benefit corporation;⁸⁵ (2) non-profit mutual benefit corporation;⁸⁶ or (3) non-profit religious corporation.⁸⁷ Since at that time the third category was thought to apply to parish churches and closely-related religious organizations serving principally the members of the churches themselves, MHS chose to incorporate as a non-profit public benefit corporation. MHS is a health care corporation serving the public in general, not just its co-religionists.

MHS recently appeared as a defendant in an employment discrimination case filed by a terminated registered nurse on gender and racial grounds. MHS obtained summary dismissal at the trial level on the basis of the exemption from the California Fair Employment and Housing Act⁸⁸ for "a religious association or corporation not organized for private profit."⁸⁹ The Court of Appeal reversed, holding the exemption applicable only to entities organized under the Non-profit Religious Corporation Act,⁹⁰ not charities organized and operated as Public Benefit Corporations. The California Supreme Court reversed, in a unanimous decision, holding the exemption applicable regardless of the particular kind of corporate formation used by the hospital corporation.⁹¹ In other words, the California Supreme Court held that the form of incorporation is irrelevant to institutional religious exemption.⁹²

in the hands of CHW's separate 17-member management board of mostly lay directors. Day-to-day operations are in the hands of professional managers, however, the nuns must sign off on all major decisions, such as new acquisitions or corporate developments.

85. 26 U.S.C. § 501 (c)(3) (1994).

86. CAL. CORP. CODE §§ 7110 *et seq.* (West 1990).

87. CAL. CORP. CODE §§ 9110 *et seq.* (West 1990).

88. CAL. GOV. CODE §§ 12900 *et seq.* (West Supp. 1998).

89. CAL. GOV. CODE § 12926(d)(1) (West 1990).

90. CAL. CORP. CODE §§ 9110 *et seq.* (West 1990).

91. *McKeon v. Mercy Healthcare Sacramento*, 19 Cal. 4th 321, 79 Cal. Rptr. 2d 319 (1998).

92. The Court found that neither the language nor the history of California's Fair Employment Practice Act, Cal. Gov. Code § 12926(d)(1) require incorporation at all, let alone a particular kind of corporate structure. To take advantage of the exemption under state law, an employer need only be "religious" and "not organized for private benefit." *Id.* The Fair Employment Practice Act antedated the Nonprofit Corporation Law by twenty years and was not amended subsequently. Only after 1977 in California did nonprofit corporations have a choice of three corporation forms, that is, public benefit, mutual benefit, or

The importance of the *McKeon* decision for our purposes is not that the hospital won dismissal of a race and gender discrimination case on the basis of state-mandated religious exemption, a sad and arguably disallowed exemption had the case been brought under fair employment practices provisions of federal law,⁹³ but, rather, that the employee could build a plausible case for the Court of Appeal that the hospital was organized and operated as a secular entity.

Added to the fact that many, if not most, of the hospital employees did not share the religious faith of the hospital board was a board decision made by Catholic Healthcare West, the parent group headquartered in San Francisco, the previous summer to advertise "comprehensive women's health care services" as "CHW," rather than "Catholic" Healthcare West, in order to disguise its identity to prospective patient subscribers.⁹⁴ While the board vote to actually change the name of the hospital chain to fit a secular image narrowly failed, television commercials in California still run, advertising women's health services and sports medicine programs sponsored by "CHW" hospitals. Interested individuals must probe to discover the meaning of the "C", as, indeed, individual subscribers through group health insurance plans must

religious corporation. Religious nonprofit corporations have always been accorded separate treatment under California's nonprofit laws because of their unique protected status under the First Amendment to the United States Constitution. *See also* *Arriaga v. Loma Linda University*, 10 Cal. App. 4th 1556, 13 Cal. Rptr. 2d 619 (1992) (hospital incorporated as a religious corporation); *Kelly v. Methodist Hospital of S. Cal.*, 22 Cal. 4th 1108, 95 Cal. Rptr. 2d 514, 997 P. 2d 1169 (2000) (religious hospital was an exempt "religious employer" under California's Fair Employment and Housing Act).

93. Title VII, Section 710 of the Equal Employment Opportunities Act, 42 U.S.C. § 2000e(b) (1994). *See* the Civil Rights Act of 1991, adding 42 U.S.C. § 1981(a) covering lawsuits for intentional discrimination under Title VII, the ADA, and the Rehabilitation Act. *See also* *Pacific Union Conference of Seventh-Day Adventists v. Marshall*, 434 U.S. 1305 (1977); *Elbaz v. Congregation Beth Judea, Inc.*, 812 F. Supp. 802 (N.D. Ill, 1992); *EEOC v. Fremont Christian Schools*, 609 F. Supp. 344 (D. Cal. 1984); William W. Bassett, 1 RELIGIOUS ORGANIZATIONS AND THE LAW, Chap. 6, *Employment Standards and Policies*, §§ 6:15, 6:18 (and Supplement 1998); Consumer Attorneys of California, *Religious Charities As Employers in California: The Supreme Court's Stretch of Immunity from Work-Related Discrimination Suits*, 30 FORUM 10-14 (2000).

94. Aside from the name, Catholic Healthcare West's website, print and electronic media advertising contain no notice to prospective enrollees of any ethically restricted services or mention of the *Ethical and Religious Directives* of the Catholic Health Association. *See* <http://www.chw.edu> (last visited Apr. 25, 2001).

investigate lists of preferred provider hospitals to discover where particular services may be available.⁹⁵

Employees, as a matter of course, do not read mission statements in the articles of incorporation and bylaws of employing corporations. Neither do patients.

If religious identity is obscured, shall the constitutionally-protected rights of patients, as well of employees, be lost by default?

After the *McKeon* decision the state legislature revisited the “religious employer” exemption of the Fair Employment and Housing Act. Amendments, effective January 1, 2000, eliminate the exemption from employment discrimination law for religious hospitals serving the general public. The result of the new legislation is that public benefit non-profit religious health care organizations in California are fully subject, as other employers, to the anti-discrimination provisions of state labor law, except where religion is a bona fide occupational qualification for employment.⁹⁶

Many non-profit religious hospitals have formed systems with other local hospitals affiliated with different denominations.

Iowa Methodist Medical Center (IMMC) in Des Moines, Iowa, is affiliated with the United Methodist Church. It is a member of the Methodist Health Systems, served by the United Methodist Association of Health and Welfare Ministries in Dayton, Ohio. The Association

95. Ironically, it should be noted that, while the hospital system’s own advertising eschews the “Catholic” appellation, to give it broader patient and physician appeal, its unions, in a series of continuing acrimonious campaigns against the hospital system, in their advertising, to embarrass the hospital administration chide the system for its personnel failures as a “Catholic” hospital group! Kelly St. John & Benjamin Primental, *Hospital Chain’s Woes Continue to Mount*, SAN FRAN. CHRON., Aug. 2, 2000, at A17.

96. On October 9, 1999, Governor Davis signed into law a bill revising the religious-entity exemption by adding Sections 12922 and 12926.2 to the Government Code (Stats. 1999, ch. 913, 1,2). Section 12922 provides that an “employer that is a religious corporation may restrict eligibility for employment in any position involving the performance of religious duties to adherents of . . . the religion for which the corporation is organized.” Section 12926.2 provides statutory definitions for the terms “religious corporation”, “religious duties” and “employer.” That section further provides that employers covered by FEHA include “a religious corporation or association with respect to persons employed by the religious association or corporation to perform duties, other than religious duties, at a health care facility operated by the religious association or corporation for the provision of health care that is not restricted to adherents of the religion that established the association or corporation.” (12926.2, subd. (c)). These modifications to the religious-entity exemption went into effect on January 1, 2000.

numbers more than fifty Methodist hospitals. It is currently engaged in a self-study program, dubbed EAGLE, to provide guidelines towards hospital excellence. There are four Methodist multi-hospital systems identified as such. Many more Methodist hospitals share resources in systems with community, non-denominational and denominational hospitals of other churches.

Iowa Methodist Medical Center is Iowa's largest private hospital. It was opened in 1901 by deaconesses of the Methodist Church with thirty beds; it now has 710 beds on a forty-two-acre campus, and employs nearly four thousand people. In 1998 the Medical Center formed the Iowa Health Foundation and merged with Iowa Lutheran Hospital and Blank Children's Hospital.

Iowa Lutheran Hospital opened in 1914. Today it is a 465-bed acute care facility averaging more than nine thousand inpatient admissions and seventy thousand outpatient admissions every year. Christian chaplains, as well as local rabbis, minister to the religious needs of patients in the hospital, and the hospital broadcasts a daily in-house sermon for the benefit of patients, staff and visitors.

In 1987 IMMC figured in the Iowa Supreme Court's now classic decision adopting the "patient rule" in all informed consent cases.⁹⁷ The hospital itself, however, was released of liability for negligent failure to inform on grounds that the institution "does not practice medicine," thus, has no immediate "duty to inform a patient of matters that lie at the heart of the doctor-patient relationship."⁹⁸

The corporate service of each of these hospitals, as far as the religious order, church or denomination under whose auspices it was founded and continues to operate, is not a business. It is a fundamental and essential religious ministry, first provided historically to its own members, but contemporarily extended to the public in general without distinction.⁹⁹ In

97. *Pauscher v. Iowa Methodist Medical Center*, 408 N.W.2d 355 (Iowa 1987) (rejecting the so-called "professional rule", holding the physician's duty to disclose is measured by the patient's need to have access to all information material to making a truly informed and intelligent decision concerning the proposed medical procedure). Holding a Methodist hospital a "religious employer" under California's employment discrimination laws is *Kelly v. Methodist Hospital of Southern California*, 22 Cal. 4th 1108, 95 Cal. Rptr. 2d 514 (2000).

98. *Pauscher*, 408 N.W.2d at 361; see Section VII, *infra*; see also Kenneth Abraham & Paul Weiler, *Enterprise Medical Care Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 390 (1994).

99. "For the church, health and the healing apostolate take on special significance because of the church's long tradition of involvement in this area and because the church considers health care to be a basic human right which flows

fact, the financial and regulatory reality is that any kind of corporation, including acute-care hospitals, receiving federal funds, cannot serve its own faith communities without at the same time serving the general public on a nondiscriminatory basis.¹⁰⁰

All of these religious hospitals subscribe to the articulated ethics and beliefs of their church sponsors. Their healing ministry, indeed, is motivated and infused with an integrated conception of human life of which medical ethics is a vital component.¹⁰¹ Needless to say, the nearly one thousand church-affiliated hospitals in this country are an indispensable component of the nation's health care system overall.

II. HEALTH CARE MINISTRY IS A RELIGIOUS SERVICE INVOLVING BOTH CARE OF INDIVIDUALS AND GOVERNANCE OF INSTITUTIONS

In truth, religion, in St. Augustine's words, *aliquid totum esse*, is not a department of life, but a totality of vision and perspective.¹⁰² The substantive and radical value of religious freedom is not individual choices, but the liberty to believe in human life as a transcendent totality and act upon that belief, whether individually or in cooperative endeavors. One cannot lop off a particular practice or two by relativizing their relationships to the whole. While the particulars of religious ministry to the sick may change over time, with advancing technology or changing financial constraints, inspired and gratuitous service to the sick as such is an essential component of all Abrahamic denominations. Religious ministry to the sick, injured and dying is not peripheral, nor are the particularized moral conclusions directing medical interventions unrelated to the core content of faith.

When free exercise is in the balance, the issue is not whether or not a particularized constraint is reasonable, or exceptions may be drawn to it, or whether other religious providers do or do not go along with it, but,

from the sanctity of human life." *Health and Health Care: A Pastoral Letter of the American Bishops*, Nov. 19, 1981, p. 3. United States Catholic Conference (1982).

100. See National Coalition On Catholic Health Care Ministry, *supra* note 38.

101. See generally, ELLIOT N. DORFF, MATTERS OF LIFE AND DEATH: A JEWISH APPROACH TO MODERN MEDICAL ETHICS, 14-33 (1998).

102. Augustine, *De Doctrina Christiana*, 1, II; see also LOUIS DUPRÉ, THE OTHER DIMENSION: A SEARCH FOR THE MEANING OF RELIGIOUS ATTITUDES, 25-30, 50-61 (1972). St. Augustine is paraphrased by the United States Supreme Court in Chief Justice Burger's majority opinion in *Wisconsin v. Yoder*, speaking of the Old Order Amish, "religion pervades and determines the entire mode of life of its adherents." 406 US. 205, 210 (1972). Note also Judge Arlin Adam's description of religion in *Malnak v. Yogi*, 592 F. 2d 197, 208 (3d Cir. 1979), the Ninth Circuit's ruling in *Thomas v. Anchorage Fair Employment and Housing Commission*, 165 F.3d 392 (9th Cir. 1999).

rather, whether the individual health care provider may be free of the burden of the state to make practical decisions compelled by the core religious vision that he or she espouses.

Every religiously affiliated entity generally is both secular and religious to some extent, from small organizations like soup kitchens and parochial schools to large organizations like religiously affiliated universities and the Christian Science Monitor. The organizations are not legally disqualified for religious protections under federal and state constitutional jurisprudence simply because some of the services they perform may be duplicated in some manner by secular institutions.¹⁰³ The courts are incapable of parsing out various levels of religious sufficiency among the myriad types of religiously affiliated entities in order to determine when free exercise protections apply. Attempts to create religious sufficiency tests by the courts pose problems of impermissible theological conjecture and chilling government entanglement in religion. Any organization organized and operated with colorable religious motivation and substantial bona fide religious affiliations is presumptively the object of First Amendment solicitude under the religion clauses.

The government is incompetent, furthermore, to evaluate the link between religious faith and moral norms. Justice Brennan's concurring opinion in *Presiding Bishop of the Church of Latter-Day Saints v. Amos*,¹⁰⁴ that religious organizations, not just individuals, are protected under the free exercise clause of the First Amendment, is on point:

What makes the application of a religious-secular distinction difficult is that the character of the activity is not self-evident. As a result, determining whether an activity is religious or secular requires a searching case-by-case analysis. This results in considerable ongoing government entanglement in religious affairs. Furthermore, this prospect of government intrusion raises concern that *a religious organization may be chilled in its free exercise activity*. While a church may regard the conduct of certain functions as integral to its mission, a court may disagree. A religious organization therefore would have an incentive to characterize as religious only those activities about which there likely would be no dispute, even if it genuinely believed that that religious commitment was important in performing other tasks as well. As a result, the [religious] community's process of self-determination would be shaped in part by the prospects of litigation. A case-by-case analysis for all activities therefore

103. *Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 343-45 (1987) (Brennan, J., concurring).

104. 483 U.S. 327 (1987).

would both produce excessive government entanglement with religion and create the danger of chilling religious activity.

The risk of chilling religious organizations is most likely to arise with respect to *nonprofit* activities This substantial potential for chilling religious activity makes inappropriate a case-by-case determination of the character of a nonprofit organization, and justifies a categorical exemption for nonprofit activities.¹⁰⁵

Justice Scalia announced a similar principle of deference in crafting the majority opinion in *Employment Division, Department of Human Resources of Oregon v. Smith*:

It is no more appropriate for judges to determine the ‘centrality’ of religious beliefs before applying a ‘compelling interest’ test in the free exercise field, than it would be for them to determine the ‘importance’ of ideas before applying the ‘compelling interest’ test in the free speech field . . . [R]epeatedly and in different contexts, we have warned that courts must not presume to determine the place of a particular belief in a religion, or the plausibility of a religious claim.¹⁰⁶

The religious beliefs of hospital founders and administrators cannot be compromised without the state’s literally confiscating the hospitals. It is, therefore, a radical mistake to suggest that a private hospital can alter its ethics and remain essentially the same, suspend its moral judgment and remain a part of the church sponsoring it. The religious ministry to the sick is not individuated and compartmentalized. It emanates from a pervasive belief system as a practical corollary of faith-based conduct. Thus, religious ministry to the sick combines both personal care and the governance of institutions. Religious ministry seeks the overarching ambience of the faith community in support of the care of individuals. In this context it is pivotal to know what we are talking about. A Catholic hospital is sponsored by, and in a very real sense, belongs to the Church as a whole; it is not just a private, non-profit entity that happens to be administered by persons who happen to share the Catholic faith. Jewish hospitals, not just hospitals where Judaism is respected and its ritual observances followed, Protestant hospitals, not just private institutions employing Protestant chaplains--these corporate entities are the focus of this discussion. Thus, the faith-context of health care is not individuated

105. *Id.* at 343-45 (emphasis added).

106. 494 U.S. 872 (1990); see *United States v. Lee*, 455 U.S. 252, 262-3 (1982) (Stevens, J., concurring); *Hernandez v. Commissioner of Internal Revenue*, 490 U.S. 680 (1989).

in passing eponymous personal and idiosyncratic beliefs, but, rather, in the healing religious beliefs of the historic religious traditions.

Institutional exercise of the health care ministry within the religious communities is tied to the essential tenets of faith and morals of the churches as these are articulated and interpreted by proper authorities in the respective ecclesiastical polities. Characteristic of the hierarchical churches is that the episcopal leadership establishes basic principles that members voluntarily accept and to which they conform the direction of officially sponsored ministerial institutions.

Order and discipline in all denominations are protective of the religious integrity of sponsored agencies, organizations and institutions. The canon law of the Catholic Church may serve as an illustration of a more broadly followed pattern of institutional discipline and stewardship. The religious names of hospitals, indeed, proclaim, in most cases, their identity and affiliated mission. The canon law, church ordinances, books of discipline and rabbinical tradition, are particularized to ensure that the ownership, sponsorship, and control of the ministry reflect the faith of the sponsoring communities. In this sense, basic moral principles are translated into institutional governance. Health care ethical directives are enacted and agreed upon not only to assist the formation of individual conscience, but also to direct governing decisions in the administration of the hospitals.

The Code of Canon Law for the Roman Catholic Church, promulgated January 25, 1983, by the Apostolic Constitution, *Sacrae disciplinae leges*,¹⁰⁷ thus, forms an integral part of the governance structure of all Catholic hospitals. The various canonical institutes, religious orders of women and men, who administer Catholic hospitals do so, not as owners of these institutions, but, rather, as representatives of the Church itself under the authoritative directives of the canon law. Thus, they are not free to pick and chose among moral imperatives.

The hospitals, thus, in canon law are not simply corporate shells in which individuals may more efficiently serve the public charity as they wish, but properties entrusted to the Church to be used only for the ecclesiastical ministries of the care of bodies and souls.¹⁰⁸

107. English translation will be found in *The Code of Canon Law--Latin-English Edition*, (CLSA, 1983), pp. xi-xvi.

108. 1983 Code of Canon Law, C.577, C.676, C.1254 § 2. I will use the word "religious orders" as an accepted general term in common parlance. Technically, in the canon law there are major organizational differences between communities of the common life. Most of the Catholic hospitals in the United States were founded and continue to be operated by members of "religious institutes", as technically defined in the 1983 Code of Canon Law. 1983 Code C.573-606. The

In addition to the general prescriptions of the canon law, the practice of the Catholic health care ministry in the United States is governed, as stated, by the *Ethical and Religious Directives of the Catholic Health Association*.¹⁰⁹ The *Directives* are operative in all Catholic hospitals.

The *Directives* are a concise statement of the Roman Catholic teaching on health care ethics, to be applied in contemporary American society. The regulations are designed to assist and promote sound ethical reflection that leads to informed decision-making from a Catholic perspective.

Conscience, of course, is not a uniquely religious idea. Most people subscribe to the notion of an interior faculty that guides our moral judgments. The major religious traditions generally maintain, however, that judgments of conscience are more than natural insights. They are judgments illumined by faith (or darkened by error and vice). These judgments carry centuries of prayer and reflection. The churches teach their members that they are bound to obey certain judgments of their consciences.¹¹⁰ To suspend one's conscience in the face of decisions of profound human importance is simply to cut oneself off from one's ethical moorings. It is to mechanize life, becoming inhuman.

Medical ethics, therefore, in guiding religious health care organizations, relies on a number of fundamental moral principles, among which are: the dignity of the human person, the social nature of the person, the right to life, principles of double effect and of legitimate cooperation; the totality and integrity of the human person; growth through the acceptance of suffering; stewardship and creativity.¹¹¹

Tangible signs of religious faith and identity in an institution, as required by the custom of the sponsoring church bodies, include the availability of religious worship and counseling, and the prominence of the various symbols of faith; a priority given to pastoral care and mission education; church ownership and/or management; recognition by the proper hierarchical authorities, such as the bishop, the judicatory,

internal operating structures of these organizations will be found in their respective Constitutions, Bylaws and Directories

109. See U.S. Catholic Bishops' Conference, *supra* note 48.

110. I Tim. 1:19: ("hold fast to faith and a good conscience. Some men, by rejecting the guidance of their conscience, have made shipwreck of their faith.") See also 1 Tim. 2:9; Romans 14:22. See *Catechism of the Catholic Church*, at 1790, 1800 ("A human being must always obey the certain judgment of his conscience.").

111. CATHOLIC HEALTH ASS'N, *THE SEARCH FOR IDENTITY: CANONICAL SPONSORSHIP OF CATHOLIC HEALTHCARE* (1988).

rabbinical association, conference, or the conference of church leaders, that the institution is an integral part of the work of the church and, for hospitals, application of the ethical beliefs of the denomination. Without these elements an institution as such would not only lose membership in the church community, but would be disaffiliated as a church-sponsored institution. The hospital would not be a religious hospital, but rather a private hospital administered by individuals, many or most of who may share a common belief system.

In the discipline of all churches and synagogues it is a primary obligation of institutional administrators of all kinds bearing church affiliation to protect and ensure the religious identity of the institution and the religious use of its assets.¹¹² The canon law positively prohibits officers and directors of church-affiliated hospitals from disguising their identity or allowing that identity to be eroded through contractual or personnel management decisions.¹¹³

For the state, therefore, to deny the religious autonomy of the churches' organized ministries not only violates the free exercise of religion, but on an institutional level is confiscatory. It would stop in process vital coordinating efforts of persons to bring health care services to the public on a professional, permanent and enduring basis.¹¹⁴

It is very important for a statement of principle that we see medical-ethical decisions as part of a religious ministry intimately and inextricably tied to the governance of institutions themselves. Medical-ethical decisions are not just private acts of conscience. These decisions are motivated largely by religious traditions and convictions that are historically denominational in nature. Thus, the state cannot limit ethical decisions in isolation without striking at the very core of the religious institutions themselves.

There must be no doubt that without moral independence the religious sector in health care in this country will disappear. The essential legal structure of a private, religious institution is fundamentally corroded

112. 1983 Code C.601 (general obligation to observe canon law); Canon 1282 (dedication of church properties to religious uses); C.1284 (duty of diligence in stewardship); C.1254, C.634 § 1 (dedicated use of assets); C.1267 § 3 (observing intent of donors); and C. 1293 § 1, 1 (alienation of property) with C. 1336, 1377 and 1389 § 2 (sanctions). Adam J. Maida & Nicholas P. Cafardi, *CHURCH PROPERTY, CHURCH FINANCES, AND CHURCH-RELATED CORPORATIONS*, 179-188 (1984).

113. William W. Bassett, *A Note On the Law of Contracts and the Canonical* "59 PROC. CLSA 61 (1997).

114. CATHOLIC HEALTH ASS'N, *supra* note 111.

where the institution is forced to reject or violate the ethical norms, themselves the product of faith commitments, of its sponsoring congregation or church. It is, therefore, not only no solution, but also a destructive move, to relegate religion to a chaplaincy, to individual choices, or the mission of medical ministry to counseling sessions and prayers recited over public address systems in hospitals contracting for publicly-funded medical programs. Ethically acceptable medical decisions in the treatment of patients are a primary prerogative of a faith-based health care provider. A governmental attack upon an organization's faith commitment is an attack on the organization itself.

Labels and nostalgia should not be touchstones of decision in this area of the law. Neither should be monochromatic ideologies of standardized and homogenous public benefit or individualized constitutional rights considerations. A woman's constitutional right to an abortion, for example, does not translate into the obligation of the public,¹¹⁵ or all licensed medical professionals, to supply or refer it out in violation of their consciences.¹¹⁶ The Supreme Court's decision in *Vacco v. Quill*¹¹⁷ and *Washington v. Glucksberg*¹¹⁸ that competent adults have no constitutional right to assisted dying, necessitate as a corollary that private, religious hospitals cannot be forced by the state into providing direct death-inducing drugs or services.¹¹⁹ The free exercise of religious

115. *Harris v. McRae*, 448 U.S. 297 (1980).

116. I say this in response to contrary opinions expressed by Sylvia A. Law, *Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions*, 21 N.Y.U. L. REV. & SOC. CHANGE 279 (1994-95); Mary Ann Becker, *The Politics of Women's Wrongs and the Bill of Rights*, 59 U. CHI. L. REV. 453, 484-487 (1991). Emphasis upon public policy dicta taken from the Supreme Court's decision to permit the I.R.S. to withdraw tax exempt status from Bob Jones University for racially-discriminatory practices, *Bob Jones University v. United States*, 461 U.S.574 (1983), I believe, is exaggerated and misplaced when religious institutions are pushed, as a condition of tax exemption, to comply without scruple to the demands of extreme advocates of access for abortion-related services.

117. 521 U.S. 793 (1997) (holding that there is no constitutional right to physician-assisted death services).

118. 521 U.S. 702 (1997) (holding a state statute prohibiting assistance or cooperation in the suicide of another is not unconstitutional).

119. President Clinton signed the federal Assisted Suicide Funding Restriction Act of 1997 on April 30, 1997, according to which no funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services may be used to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. In

choice protected by the First Amendment applies to the states and is preemptive of state laws burdening religion.¹²⁰

A. Hospital Ethics and Religious Choices

For private, non-profit hospitals the service of justice for the sick and disabled, public advocacy of services and quality of care, and serving the underserved poor are paramount values closely tied to the health care mission. Religious hospitals add accessibility of pastoral care for patients in an ambiance wherein patients can be confident of the security and dignity of their religious choices. All the religious hospitals studied provide patients the services of ethical counselors of their choice, whether religious or not, to assist them in ethically-perplexing decisions.

One may look at organizational moral choice as a derivative personal decision. Membership in the church implies consent to its ethical directives. The religious hospital decides moral issues professionally consistently with the doctrine of the church-sponsors.¹²¹ For members of the church who freely and knowingly accept membership in the church, the denominational choice is a personal choice.¹²² In this society, anyone can freely leave a church, disaffiliate or differ conscientiously with matters of discipline or belief. Continuing use of the churches' ministries and

addition, federal funds may not be used to pay (in whole or in part) for health benefit coverage that includes any coverage of such an item or service or of any expenses relating to such an item or service. Some of the programs to which the restriction applies include: Medicare and Medicaid; Title XX Social Services Block Grants; the Public Health Service Act; the Federal Employees Health Benefits Program; Veterans Medical Care; Medical Services for Federal Prisoners; and grant programs under the Developmental Disabilities Assistance and Bill of Rights Act. The limit on payments does not apply to abortion, the withholding or withdrawing of medical treatment or medical care, the withholding or withdrawing of nutrition or hydration, or the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason. P.L. 105-12, 111 Stat. 23 (codified at 42 U.S.C. §§ 14401 *et seq.*).

120. *Cantwell v. Connecticut*, 310 U.S. 296 (1940).

121. *See generally*, amicus briefs submitted by various religiously affiliated organizations, including the General Board of Church and Society of the United Methodist Church, Agudath Israel of America, the Rutherford Institute, the United States Catholic Conference, in the case of Nancy Cruzan, a constitutional issue of informed consent based on state procedural and evidential standards. *Cruzan v. Director of Missouri Dep't of Health*, 497 U.S. 261, 264 (1990).

122. *See Guinn v. Church of Christ*, 775 P. 2d 766 (Okla. 1989); Richard L. Cupp, Jr., *Religious Torts: Applying Conscient Doctrine*, 19 U.C. DAVIS L. REV. 949 (1986).

organizational agencies implies, at least, a minimal level of personal acquiescence in its customs and order.

The hospital is an outreach agency of the church, deriving its religious identity from the sponsoring church. Whether one is a believer or not, the choice of a hospital should be an informed and uncoerced choice to use the resources of the facility. Whether the hospital is or is not dedicated to the doctrinal bases of religious choice in the meaning of life and the integrity of the human person a patient wishes to share should be no more unexpected or intrusive than the personal beliefs of the primary physician.

What is at issue here are the moral decisions made by religious hospitals that generally are prohibitive, rather than mandatory, where what is prohibited would be acceptable medical practice in a non-religious context. At present, the sensitive restrictions are in the provision of abortion, reproductive health services, some kinds of fertility procedures, and refusal to cooperate with physician-assisted suicide, where state law, such as that adopted by referendum in Oregon in 1989,¹²³ may permit. State intervention, then, is aimed at forcing private hospitals to do some things they object to, not to refrain from doing things that are medically unacceptable by any reasonable standard.

Religious hospitals, even, indeed, as individual persons themselves, do not take their ethical instructions from the government. As private entities making religious choices to refrain from services to which they have moral objections, they fall outside the constraints of constitutional imperatives. The religion clauses of the First Amendment protect religion, individually and collectively practiced, not economic, social or secular choices.

Private religious hospitals have particularized the healing ministry in different ways, always, however, under the overarching paradigm of preservation of life with self-sacrificing service to the person of those who are sick, injured and dying.¹²⁴

123. Physician assisted suicide may be permitted by state law, such as that adopted by referendum in Oregon in 1989. ORE. REV. STAT. §§ 127.800 *et seq.* (1996); *see also* *Lee v. Oregon*, 891 F. Supp. 1429 (Ore. 1995) (Oregon “Death With Dignity” Act does not provide sufficient safeguards for terminally-ill persons and, therefore, violates the Equal Protection Clause), vacated, *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

124. *See* Pope John Paul II, Ency. Lett., *Donum vitae: Instrucion on Respect for Human Life In Its Origin and On the Dignity of Procreation*, (Feb. 22, 1987) and Ency. Letter, *Evangelium vitae: The Gospel of Life* (Mar. 25, 1995). Directive 23, of the *Ethical and Religious Directives for Catholic Health Care Service*, speaks of the primary ethical concern in hospital care as the protection of human dignity in all cases. *See* note 48, *supra*. For a good comparative study of tort law and

B. Ethical Issues In Reproductive Medicine

All major religious traditions in America find abortion to be an issue of profound moral significance.¹²⁵ Termination of a human life in the womb is not simply an ethically indifferent act. Nor is it only transitory, personal and without societal concern.¹²⁶ Direct abortion is regretted, prohibited entirely in some religious hospitals, allowed under certain conditions in others, preceded by counseling, or, simply, on assurance of informed consent, or performed as a matter of physician-patient choice to avoid serious alternatives.¹²⁷ Definitional issues divide the churches, such as beginning points of human life, potential personhood and categories of balancing, substantial human values or trauma to the mother justifying intervention to destroy the fetus.

Similarly, the major religious traditions find embryo cell research intensely problematic and fraught with moral dangers. Contemporary reproductive bio-ethics is driven by modern technology. Major moral dilemmas appear now without historical precedent because modern bio-medical technologies create procedures and fertilization controls previously unthinkable. There is no store of historical religious reflection, for example, on vasectomies, tubal ligation, the pill, in vitro fertilization or embryonic research. What reflection exists is drawn largely from imaginative reflection upon grave bodily mutilations or the significance of the felt "quickenings" of fetal life.¹²⁸ The mutilations no longer occur in modern medicine and embryonic implantation we know occurs weeks

Jewish moral perspectives on the imperative to preserve and protect life, see Daniel Pollack, Chaim Steinmetz and Vicki Lens, *Anderson v. St. Francis-St. George Hospital: Wrongful Living From an American and Jewish Legal Perspective*, 45 CLEV. ST. L. REV. 621 (1997).

125. J. GORDON MELTON, *THE CHURCHES SPEAK ON ABORTION: OFFICIAL STATEMENTS FROM RELIGIOUS BODIES AND ECUMENICAL ORGANIZATIONS* (1989).

126. RONALD DWORKIN, *ABORTION: THE CLASH OF ABSOLUTES* (1990); John T. Noonan, Jr., "Abortion: An Almost Absolute Value In History," in *The Morality of Abortion 1* (J. Noonan, ed., 1970).

127. SAMUEL GOROVITZ, *supra* note 56, at 49. Because only 36% of all hospitals provide abortion services, women seeking an abortion find a serious shortage of hospital providers willing to perform them. 87% of all abortions are performed in clinics or in private doctors' offices. 84% of all United States counties have no identifiable abortion providers. National Abortion Federation, *Access to Abortion Fact Sheet*, at <http://www.prochoice.org/Facts/FS5.htm> (last visited Jan. 30, 2001).

128. See JOHN T. NOONAN, JR., *CONTRACEPTION: A HISTORY OF ITS TREATMENT BY CATHOLIC THEOLOGIANs AND CANONISTS* (1986).

before movement can be detected. Just twenty-five years ago Justice Harry Blackmun, in crafting the majority opinion in *Roe v. Wade*, found a second historical reason in prohibiting abortion to have been that it was extremely hazardous to pregnant women.¹²⁹ That argument carries little moral weight today beyond the necessary doctor-patient dialogue. So, ethical theories in reproductive medicine, beyond abortion itself, evolve from analogous reasoning.¹³⁰ There is less consensus than in previous years among religious bodies upon the cogency of the various analogic links to scriptural passages or traditional theological responses in modern reproductive technologies.

Whether the various contraceptive, as well as fertilization technologies, currently in use contain lines of grave moral concern seems to depend on both scientific perspective and the comprehension of ideational context.

Ethical decisions in the religious bodies must clearly be distinguished

129. 410 U.S. 113, 148 (1973).

130. There is some confusion about the definition of abortion. Spontaneous abortion, or miscarriage, refers to the spontaneous loss of a pregnancy before viability (at about twenty-five or twenty-six weeks of gestation). Losses after that point are termed "preterm deliveries," or, in the case of delivery of a fetus who has already died, "stillbirths." In the terminology commonly used for induced abortions viability is not at issue. Rather, any termination of a pregnancy by medical or surgical means is termed an abortion, regardless of the stage of the pregnancy. The most common early-trimester abortion procedure is suction curettage, usually performed in free-standing clinics or outpatient centers in hospitals. At twelve to twenty weeks gestation, the most common method is dilation and evacuation (D&E), which, because it takes more time and has higher risk of complications, is often done in a hospital setting. The other abortion procedure used in the second trimester is instillation abortion, in which a solution instilled into the amniotic cavity through the abdomen via amniocentesis results in the death of the fetus and termination of the pregnancy. Contractions signalling labor usually begin twelve to twenty-four hours later and culminate in expulsion of the dead fetus. For late term pregnancies, dilation and extraction procedures (D&X) are used, whereby the fetus is pulled from the uterus into the birth canal and the skull crushed to facilitate extraction. These latter procedures require ambulatory surgical services in a hospital setting. Gary S. Berger, William E. Brennar, and Louis G. Keith, *Second Trimester Abortion* (1981); Stephen L. Corson, Thomas V. Sedlacek, and Jerome J. Hoffman, "Suction Dilation and Evacuation," in *Greenhill's Surgical Gynecology*, (5th ed. 1986); David A. Grimes, "Surgical Management of Abortion," in *Te Linde's Operative Gynecology* (8th ed. 1992). Until the 1980s, the only available means for performing abortions were surgical. The development of a medical abortifacient, antiprogesterin drugs (e.g., RU-486), accompanied by the hormone prostaglandin, presents less invasive procedures. Baulieu, Étienne-Émile, ARU-486 As An Antiprogesterone Steroid: From Receptor to Contraception and Beyond, 262 JAMA 1808 (1989).

from social and political understandings of the role of government in regulating human reproduction. In respect for the plurality of consciences on these terribly sensitive issues, most favor legal rights to abortion and women's rights of reproductive self-determination. There is a difference between morality and law.¹³¹ The religious traditions, in the best sense, are instructive not judgmental.

Here we must set out, briefly and summarily, of course, a ethical perspective upon the major issues in reproductive medicine today, indeed, from the viewpoint of the large religious traditions maintaining institutional health care systems in this country.

1. *Elective Abortion*

In private hospitals retaining strong ties to their religious traditions abortion is rare and performed only for very serious therapeutic reasons or concern for the physical or mental wellbeing of the mother. Abortion on demand or simply as a remedy for contraceptive failure is neither advised nor routinely provided.

Jewish hospitals, as, indeed, the various branches of Judaism itself, are divided in interpreting the religious law in the face of a request to terminate an unwanted pregnancy.

According to the *Mishnah*, which is the record of oral interpretations of the Hebrew Scriptures, abortion is only permitted when a woman is in "hard travail" and her life is in danger.¹³² This, of course, would not include the vast majority of abortions actually performed in the United States. Not even in the most lenient interpretation of the *halakha* is there anything that allows abortion on demand, or as a means of *post factum* birth control.

There is certainly a bottom line in the Jewish religious tradition beyond which abortions are clearly not permitted. Late-term intact dilation and extraction, when the head or a majority of the body of a child has emerged, is the line at which that child cannot be killed, even if the mother's life is in danger, because, at that time there are two persons, two living souls.¹³³

In Jewish law, as in Roman law, the fetus has no independent "juridical personality" and would not be considered a person until birth.¹³⁴ Thus,

131. John Courtney Murray, *WE HOLD THESE TRUTHS: CATHOLIC REFLECTIONS ON THE AMERICAN PROPOSITION* (1960).

132. See Dorff, *supra* note 101, at 128-133.

133. *Mishnah, Oholot, 7:6*. J. DAVID BLIECH, *BIOETHICAL DILEMMAS: A JEWISH PERSPECTIVE* (1998); Immanuel Jakobovits, *Jewish Views On Abortion, in ABORTION AND THE LAW* (D. Smith, ed. 1967).

134. DAVID M. FELDMAN, *HEALTH AND MEDICINE IN JEWISH TRADITION:*

feticide was not considered murder. Therefore, a liberal tradition allows therapeutic abortion or abortion during the first forty days of pregnancy in cases of grave fetal abnormalities. Maternal rather than fetal welfare in these cases remains the criterion. Rabbinic rulings on abortion thus may be generalized: not the right to life, but the right to be born is not absolute, but may be abridged for serious reasons of the welfare of the mother. "Once the fetus has emerged . . .," however, "we may not set aside one life for another."¹³⁵

Catholic moral teaching on abortion is traditional and conservative, treating direct and intentional abortion as a serious sin and an unwarranted interference with the natural outcome of the reproductive process. Under the principle of double effect, indirect (permitted) abortions are those operations that have as their primary effect the health or wellbeing of the mother, with the death of the fetus a foreseen but not directly intended secondary effect. For example, removal of a cancerous uterus from a pregnant woman, or fallopian tube in cases of ectopic pregnancy, would be permitted. The principle is that the life of the mother is at least as precious as that of the fetus. She has no duty to assume a serious risk to her own life in order to sustain the child.¹³⁶

Catholic teaching does not depend on theories of personhood or moments of ensoulment of the fetus.¹³⁷ Rather, the concern is that respect for human life itself is the most fundamental of all goods, and the condition of their realization.¹³⁸ Thus, incipient human life is entitled to the benefit of the doubt in respect to its continuing right to live and have birth.

Catholic hospitals are explicitly prohibited from providing services "whose sole and immediate effect is the termination of pregnancy before viability."¹³⁹ Thus, direct termination of a pregnancy by killing the fetus is never permitted. Furthermore, "Catholic health care institutions are not

L'HAYYIM - TO LIFE (1986).

135. Mishnah, *supra*, note 133.

136. See Pope Pius XI, *Casti connubii* in THE PAPAL ENCYCLICALS 1903-1939 (1981; (1933). Vatican Cong. for the Doctrine of the Faith, *Declaration on Abortion*, 4 ORIGINS 186, 186 (1974).

137. See Thomas A. Shannon & Allan B. Wolter, *Reflections On the Moral Status of the Pre-Embryo*, 51 THEOLOGICAL STUDIES 603 (1990).

138. Lisa S. Cahill, *The Embryo and the Fetus: New Moral Contexts*, 54 THEOLOGICAL STUDIES 124 (1993); Carol A. Tauer, *The Tradition of Probabilism and the Moral Status of the Early Embryo*, 45 THEOLOGICAL STUDIES 33 (1984).

139. "Abortion, that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus is never permitted." *Ethical Directives*, *supra* note 50, Directive 45.

to provide abortion services, even based upon the principle of material cooperation.”¹⁴⁰ They may not condone intervention in extrauterine pregnancies if such intervention constitutes a direct abortion.¹⁴¹ Hysterectomies, as other invasive gynecological interventions, however, may be performed when necessary to cure a serious pathological condition, even when they will result in the death of the fetus.¹⁴²

The teachings of the *Eastern Orthodox Churches* on the issue of abortion coincide with those of the Roman Catholic Church.¹⁴³

Seventh-Day Adventist Hospitals, as a matter of policy, follow the General Conference Guideline on abortion.¹⁴⁴

The Church does not serve as conscience for individuals; however, it should provide moral guidance. Abortions for reasons of birth control, gender selection, or convenience are not condoned by the Church. Women, at times however, may face exceptional circumstances that present serious moral or medical dilemmas, such as significant threats to the pregnant woman's life, serious jeopardy to her health, severe congenital defects carefully diagnosed in the fetus, and pregnancy resulting from rape or incest. The final decision whether to terminate the pregnancy or not should be made by the pregnant woman after appropriate consultation. She should be aided in her decision by appropriate information, biblical principles, and the guidance of the Holy Spirit. Moreover, these decisions should be made within the context of healthy family relationships.¹⁴⁵

No elective abortions are performed in Seventh-Day Adventist hospitals.¹⁴⁶ Abortion is considered only if the mother's life is in serious physical jeopardy if the pregnancy is allowed to continue; it is considered

140. *Id.*

141. “In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.” Directive 48, *id.*; see also Directive 50. “Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.”

142. *Id.*, Directives 47, 53.

143. Stanley S. Harakan, *Eastern Orthodox Bioethics*, THEOLOGICAL DEVELOPMENTS IN BIOETHICS (Baruch A. Brody, et al eds. 1991).

144. GENERAL CONFERENCE OF THE SEVENTH-DAY ADVENTIST CHURCH, *STATEMENTS, GUIDELINES & OTHER DOCUMENTS*, GUIDELINES ON ABORTION 68 (1996).

145. *Id.* at 69.

146. I am grateful to Mr. W. Augustus Cheatam, Vice-President of Loma Linda University Medical Center, for this communication (on file with the author).

if rape or incest are involved. It is also considered if severe genetic or structural abnormalities of the fetus are diagnosed at an early stage of pregnancy. Extensive counseling is required. Thus, for example, Loma Linda University Medical Center does a very small number of abortions. The Medical Center serves as a major referral point for these genetic and structural abnormalities.

The Southern Baptist Convention, with approximately 14,000,000 members, a major linking influence in religious hospital systems, has issued a number of resolutions concerning abortion over the years.¹⁴⁷ These resolutions uniformly uphold the sanctity of developing human life and oppose abortion on demand. Abortion is morally permissible in rare cases of substantial danger to maternal life and health, serious fetal abnormalities and in cases of rape or incest. The 1982 Resolution on Abortion said:

Therefore, be it *Resolved*, That the messengers to the 1982 Southern Baptist Convention affirm that all human life, both born and unborn, is sacred, bearing the image of God, and is not subject to personal judgments as to "quality of life" base on such subjective criteria as stage of development, abnormality, intelligence level, degree of dependency, cost of medical treatment, or inconvenience to parents.¹⁴⁸

The Evangelical Lutheran Church in America, formed in 1988, by the merger of the American Lutheran Church and the Lutheran Church in America,¹⁴⁹ share with the Lutheran Church, Missouri Synod, a morally conservative and traditional doctrine on abortion and prenatal medical interventions endangering the integrity of fetal life.¹⁵⁰

Conservative Protestant views on the ethics of abortion generally coincide with those of the Seventh-Day Adventist guidelines, and are part of hospital policies of the more conservative Southern Baptist and American Baptist hospitals as well.¹⁵¹

The teachings of the leaders of the Reformation, including Martin Luther and John Calvin, remained uniquely authoritative in discerning principles of personal morality in the principal Protestant denominations until a generation ago. The moral consensus condemning abortion coincided with what pastors and church leaders took to be the early Christian theological teaching on the fully human nature of the unborn

147. See Melton, *supra* note 125, at 153-55.

148. See *id.* at 152.

149. See *id.* at 51-52.

150. *Id.* at 60.

151. *Id.*

child and the sacredness of its life.¹⁵² Emphasis upon personal autonomy, freedom of conscience, and the importance of the family as the focal point of procreation formed the larger context for theological reflection upon the bioethics of reproductive medicine. The strong pronatalist disposition of traditional Protestant spirituality was thus balanced by a degree of pastoral compassion, even if abortion was condemned at a formal level.¹⁵³

Protestant unanimity in this country broke in the 1960s under the influence of the situation ethics of Joseph Fletcher's attack upon Catholic "casuistry"¹⁵⁴ and the changing cultural ethos in which scientific developments in reproductive biology and feminist aspirations coincided. This provoked the abortion debates that continue to divide the American Protestant churches.¹⁵⁵ Lutherans, Episcopalians, Methodists, Presbyterians and the United Church of Christ, among others, have maintained their public position favoring the legality of abortion, while strongly pressed from within by traditionalists to develop an ethics of "justifiable reasons" for its choice.¹⁵⁶ Stanley Hauerwas suggested that Scripture is normative as "narrative", against Paul Ramsey's fundamentalist theme of embodiment, the coinherence of body and soul from conception, as explicitly tied to the express teachings of Scripture.¹⁵⁷ Among Protestants, only Unitarian/Universalists have adopted the position that women alone are the moral agents of free abortion

152. JOHN P. FRAME, *MEDICAL ETHICS: PRINCIPLES, PERSONS, AND PROBLEMS*. (1988) (Presbyterian and Reformed); James F. Gustafson, *A Protestant Ethical Approach*, *ON MORAL MEDICINE: THEOLOGICAL PERSPECTIVES IN MEDICAL ETHICS*, 403-412 (eds. Lammers & Verhey, 1987) (Lutheran).

153. *THEOLOGICAL VOICES IN MEDICAL ETHICS* (Allen Verhey & Stephen E. Lammers 1993).

154. JOSEPH FLETCHER, *MORALS AND MEDICINE: THE MORAL PROBLEMS OF THE PATIENT'S RIGHT TO KNOW THE TRUTH*. Contraception, Artificial Insemination, Sterilization, Euthanasia (1960).

155. E. BROOKE HOLFELD, *HEALTH AND MEDICINE IN THE METHODIST TRADITION: JOURNEY TOWARDS HOLINESS* (1986); *BIOETHICS YEARBOOK: THEOLOGICAL DEVELOPMENTS IN BIOETHICS: 1990-1992* (B. Andrew Lustig, et al eds. 1993); MARTIN E. MARTY, *HEALTH AND MEDICINE IN THE LUTHERAN TRADITION* (1983); *HEALTH/MEDICINE AND THE FAITH TRADITIONS: AN INQUIRY INTO RELIGION AND MEDICINE*. (1982); PAUL RAMSEY, *THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS* (1970) (Presbyterian); KENNETH L. VAUX, *HEALTH AND MEDICINE IN THE REFORMED TRADITION: PROMISE, PROVIDENCE, AND CARE* (1984); *MEDICAL ETHICS* (Robert M. Veatch ed. 1989).

156. KAREN LEBACQZ, *GENETICS, ETHICS AND PARENTHOOD* (1983).

157. STANLEY HAUERWAS, *A COMMUNITY OF CHARACTER: TOWARD A CONSTRUCTIVE CHRISTIAN SOCIAL ETHIC* (1981).

decision.¹⁵⁸ Unitarian/Universalists operate no hospitals.

Thus, in general, hospital systems affiliated with Protestant churches in this country have adopted policies limiting abortion to serious cases affecting the physical or psychological health of the mother. Elective abortions for gender selection, or birth control failure, are generally not condoned, while psychological trauma to the mother may be provided an expansive definition.

The largest pro-choice Protestant denomination, in the United States, the United Methodist Church, in its 2000 General Conference, voted by an overwhelming majority of 622-275 to oppose late term abortion. The exact wording of the legislative action is:

We oppose the use of late-term abortion known as dilation and extraction (partial birth abortion) and call for the end of this practice except when the physical life of the mother is in danger and no other medical procedure is available or in the case of severe fetal anomalies incompatible with life.¹⁵⁹

In the 2000 edition of *The Book of Discipline* of the United Methodist Church, this sentence will be added to the standing paragraph on abortion.¹⁶⁰ Most religious traditions, of course, are much more stringent than this. In no religious tradition involved in the provision of health care, however, is there a complete ethical indifference to the fate of human fetal life, or, indeed, to the implications of conspiracy in acts to destroy it.

2. Rape Trauma Intervention

Standard emergency room protocols for the treatment of victims of rape, and, particularly in cases of children and disabled adults, in cases of incest, involve the cooperation of medical personnel, hospital administrators, social workers and the police. There are four immediate objectives to treatment, all of which are urgent and time-centered. Medical assistance to the victim is foremost, as healing is directed both to physical and psychological injury. Health care personnel try to prevent infection of the victim from sexually transmitted diseases, foremost, of course, AIDS, as well as prevent a violently imposed pregnancy as a primary invasive effect of the assault. Sperm samples are collected to provide DNA evidence for subsequent prosecution of the perpetrator. Social service personnel collect history and triage the patient to

158. DAVID H. SMITH, *HEALTH AND MEDICINE IN THE ANGLICAN TRADITION: CONSCIENCE, COMMUNITY, AND COMPROMISE* (1986).

159. Boozang, *supra* note 6; Ikemoto, *supra* note 6.

160. Paragraph 36J, Social Principles, Resolutions, in the 1996 edition of the *Book of Discipline of the United Methodist Church*.

appropriate posttraumatic counseling services. Each case, of course, is different. All have two things in common: time is of the essence in every respect and the victim rarely has a choice of emergency facilities for care. The victim places herself totally in the hands of the hospital's trauma specialists.

The most common form of postcoital contraception for rape victims is the use of the morning-after pill, an estrogen or estrogen-progestogen combination, marketed as Estinyl and Ovral.¹⁶¹ The morning after pill prevents fertilization or implantation of the fertilized egg in the uterine wall. The morning-after pill is a vital part of the standard care for rape victims. Accepted emergency facility licensing directives require hospitals to provide rape victims "with anticonception and antivenereal disease treatment" unless medically contraindicated.¹⁶² Since state laws generally limit the number of Level I trauma center designations in each region,¹⁶³ for rape victims whose range of treatment choice is narrowed to practically zero, compliance with state law is vitally important. State laws allowing hospital compliance by referral to other hospitals are patently impractical, if not cruel to the victims themselves.¹⁶⁴

Only Catholic hospitals, out of concern for the probable life of the fertilized embryo, have serious concerns about use of the "morning-after" pill in rape trauma intervention.

Directive 36 of the *Ethical and Religious Directives* for Catholic hospitals allows use of the morning-after pill as a postcoital hormonal treatment to prevent conception if the victim is in a stage of her menstrual cycle before ovulation, but not after ovulation.¹⁶⁵ After ovulation,

161. Eugene F. Diamond, Rape Protocol, LINACRE QUARTERLY, Aug, 1993, at 8, 9. Postcoital insertion of intrauterine devices is also effective, but may be contraindicated by the victim's injuries.

162. CHI. MUN. CODE § 4-84-240 (1990); see also Boozang, *supra* note 6, at 1447.

163. See, e.g., ILL. ANN. STAT., ch. 210, para. 50/27 (Michie Supp. 1994); Boozang, *supra* note 6.

164. 77 ILL. ADMIN. CODE § 545.60(d)(3), app. A, pt. B(50(e)) (West 2000); see also Brownfield v. Daniel Freeman Marina Hosp'l, 208 Cal. App. 3d 405, 256 Cal. Rptr. 240 (1989) (rape victim sues hospital for not providing her information and access to the morning-after pill; holding victim may have medical malpractice claim for the hospital's failure to provide information vital to her choice of treatment; the right to receive important information should prevail over hospital's protection under the state's conscience clause - CAL. HEALTH & SAFETY CODE § 25955 (c)).

165. Directive 36, ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 48.

A female who has been raped should be able to defend herself against a

inhibition of implantation of an already fertilized egg by the use of the pill, in Catholic theology, may be abortifacient. The obvious difficulty with this ethical norm, of course, is that few rape victims know with certainty whether or not they have ovulated and the fact cannot be ascertained quickly by any extant diagnostic device. Thus, bishops and church authorities differ among themselves on the ethical use of the morning-after pill in all traumatic rape and incest interventions.

3. Fertility Control

Medical-moral ethicists attach a greater moral significance to permanent male (vasectomy) and female (tubal ligation) forms of fertility control, than to those of a temporary nature, such as the use of contraceptive pills, condoms, diaphragms, etc. They also distinguish the use of contraceptives by married persons and outside of marriage, based on the moral principle confining sexual relations to marriage. Overall, the principle of monogamous family life contextualizing the duty of procreation, in the value structure preeminently favoring human life, forms the traditional basis of ethical decision. There is a logical link between the ethical evaluation of contraception and contraceptive sterilization. Concern that anovulant drugs may also prevent implantation, for example, bring in considerations of the possibility of abortifacient effects allowing destruction of incipient embryonic life after fertilization. There are, obviously, significant moral differences between abortion and contraception.

Neither the Hebrew Scriptures nor the New Testament contain express

potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medication that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum.

ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 48.

The explanation offered by the Bishops' Conference for the acceptability of pre-ovulation use of the morning-after pill is:

Such efforts to prevent conception following rape need not be, morally speaking, acts of contraception such as have been excluded from Christian life by the constant and very firm teaching of the church. Rather, they can be undertaken as efforts to remove or neutralize the assailant's sperm or seminal fluid, whose continuing presence in the victim's body is a continuation of the assault which violated her bodily integrity.

Id.

norms against fertility control methods used in contemporary family planning.

4. Contraceptive Drugs or Devices

Orthodox *Judaism* gives a limited acceptance to some forms of contraception, based upon early Talmudic rabbinical consent to a woman's use of root potions to control fertility. Jewish law puts the duty of procreation on the male, and this obligation militates against a permanent impairment of fertility. The most acceptable contraception is that which interferes the least with the natural sexual act.¹⁶⁶ Conservative and Reform Judaism fully accept and endorse contraception as an acceptable method of family planning and to avoid abortion, provided it is not harmful to the parties involved.¹⁶⁷

The *Eastern Orthodox Churches* generally accept reasonable contraception, while condemning abortion. The multiple purposes of marriage, the lack of any definitive statement against contraception by the church, a synergistic cooperation between God and humans, and the need for responsible parenthood serve as the bases for the responsible use of contraception in marriage.¹⁶⁸

The *Catholic* moral tradition condemning artificial birth control was reiterated after four years of intense study by two international commissions of women and men by Pope Paul VI in 1968 in the encyclical *Humanae Vitae*. The rationale for the condemnation appears in paragraph 11, stating that the natural law "teaches that each and every marriage act must remain open to the transmission of life." In the next paragraph the pope refers to "the inseparable connection, willed by God and unable to be broken by man on his own initiative, between the two meanings of the conjugal act: the unitive and the procreative meaning."¹⁶⁹ Family planning, while important, must be restricted to natural means, such as following the rhythm method.

Directive 52 of the *Ethical and Religious Directives* for Catholic hospitals says "Catholic health facilities may not promote or condone contraceptive practices, but should provide, for married couples and the

166. Fred Rosner, "Contraception in Jewish Law," in *Jewish Bioethics*, pp. 86-96 (eds. Fred Rosner & J. David Bleich, 1979)

167. *Id.*

168. Stanley S. Harakas, "Eastern Orthodox Bioethics," in *Theological Developments in Bioethics, 1988-1990*, pp. 85-101 (eds. Brody, Lustig, Engelhardt, and McCullough, 1991); and Chrysostom Zaphiris, *The Morality of Contraception: An Eastern Orthodox Opinion*, 11 J. ECUMENICAL STUDIES 661 (1974).

169. Paul VI, Enc. *Humanae Vitae* (Human Life), trans. 66 *Catholic Mind* 35-48 (1968).

medical staff who counsel them, instruction both about the church's teaching on responsible parenthood and in methods of natural family planning."¹⁷⁰ Whether Catholic hospitals may provide information and counseling to patients, without technically promoting or condoning it, however, remains problematic.

Within *Protestant* Christianity the first break in the anti-contraception tradition occurred in 1930, when the Lambeth Conference of the Anglican Church, by a vote of 193 to sixty-seven, adopted a resolution recognizing a moral obligation to limit or avoid parenthood, and proposing complete abstinence as the primary and most obvious way, while also accepting other methods.¹⁷¹ Later the major Protestant churches and ethicists such as Reinhold Niebuhr and Karl Barth accepted contraception as a way to ensure responsible parenthood.¹⁷² Today there is little controversy and no moral distinction made between contraceptive methods in the mainline Protestant churches.

5. Sterilization

The morality of contraceptive methods determines the morality of sterilization in Jewish, Eastern Orthodox and the major Protestant Christian traditions. In Catholic theology, because of the permanent nature of sterilization, it is evaluated more strictly than temporary use of contraceptives.

For Catholic hospitals Directive 53 prohibits "direct" sterilization of men or women when performed solely for contraceptive purposes.¹⁷³ Medical or surgical treatment of pathological conditions that may also cause sterility as a side effect are, of course, permitted.

6. Counseling HIV-Infected Patients

There is no longer any doubt that information on safe-sex practices is vital to prevent the spread of AIDS. Containment of the transmission of the Human Immunodeficiency Virus (HIV), the cause of Acquired Immune Deficiency Syndrome (AIDS), is, in fact, the only way to hold in check the contagion. Public health officials are in agreement that, where

170. "Catholic health institutions may not promote or condone contraceptive practices, but should provide, for married couples and the medical staff who counsel them, instruction both about the church's teaching on responsible parenthood and in methods of natural family planning." *Id.* at 458.

171. RICHARD M. FAGLEY, *THE POPULATION EXPLOSION AND CHRISTIAN RESPONSIBILITY* (1960).

172. *Id.*

173. "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution when its sole immediate effect is to prevent conception." *Id.*

a cure is not in sight, the point of transmission is where avoidance counseling is crucial as a matter of public policy.¹⁷⁴ Many states, in fact, mandate counseling for HIV infected patients that includes information on a variety of ways to prevent HIV transmission.¹⁷⁵

The treatment of HIV-positive patients by religious hospitals dates to the onset of the infection and continues to be extensive and fully in compliance with public health policies, state laws and regulations. There remain, however, serious variances in preventive counseling, particularly, in advocacy of the use of condoms by sexually-active infected patients or their partners.¹⁷⁶

Non-Catholic religious thought presents no serious ethical dilemma in counseling sexually-active HIV patients about the use of condoms to prevent the spread of AIDS.

The United States Catholic Conference Board listing of programs and services that should be implemented to fight the spread of AIDS includes opposition to "safe sex" counseling on grounds that making it "safe" to be promiscuous is misleading.¹⁷⁷ The Board did, however, add a note of explanation allowing broader education to include safe sex details:

In such situations educational efforts, if grounded in the broader moral vision outlined above, could include accurate information about prophylactic devices or other practices proposed by some medical experts as potential means of preventing AIDS. We are not promoting the use of prophylactics, but merely providing information that is part of the factual picture. Such a factual presentation should indicate that abstinence outside of marriage and fidelity within marriage are the only morally correct and medically sure ways to prevent the spread of AIDS.¹⁷⁸

7. Fertility Enhancement Technologies

The most common assisted conception methods, in addition to artificial insemination, are in vitro fertilization, gamete intrafallopian transfer or

174. Antonia C. Novello, Herbert B. Peterson, J. Thomas Arrowsmith-Lowe, Joseph Kelaghan & Jeffrey A. Perlman, *From the Surgeon General, U.S. Public Health Service*, 269 JAMA 2840 (1993).

175. See, e.g., IND. CODE ANN. 16-41-14-10 (1997); N.Y. PUB. HEALTH LAW § 2781(5) (McKinney, 1993).

176. See Mireya Navarro, *Ethics of Giving AIDS Advice Trouble Catholic Hospitals*, N.Y. TIMES, Jan 3, 1993, at A1.

177. U.S. Conf. Admin. Board, *The Many Faces of AIDS: A Gospel Response*, 17 ORIGINS 481, 485.

178. *Id.* at 486. See James F. Keenan, Lisa S. Cahill, Jon D. Fuller, Kevin Kelly (eds.), *Catholic Ethicists On HIV/AIDS Prevention* (2000).

GIFT, or zygote intrafallopian transfer or ZIFT.¹⁷⁹ The introduction of in vitro fertilization in 1978 precipitated an intense debate among ethicists about the harm the new technologies could bring to children, families and the general societal understanding of procreation and parenthood.¹⁸⁰ As healthy children were born from these procedures ethical committees in at least eight countries issued statements accepting use of IVF in principle.¹⁸¹ Louise Brown, for example, the first person born of IVF, resulted from the union of the gametes of her biological parents. The use of these techniques was assumed to provide assistance for reproduction, usually in cases of women with blocked or damaged fallopian tubes, within the structure of traditional family life. Since then the variety of other uses of IVF for single women, and non-married couples, plus the specter of a future of parthenogenesis, cloning and ectogenesis, have intensified the debate on acceptable limits to the use of IVF.¹⁸² Preimplantation diagnosis, including embryo biopsy and sex preselection, adds further ethical variables, such as correcting genetic flaws after they have been diagnosed.¹⁸³

In 1987 the Roman Catholic Church declared the use of the new reproductive technologies morally unacceptable because they separate the procreative, life-giving aspects of human intercourse from the unitive, lovemaking aspects, which in Catholic theology are morally inseparable. Fertilization outside the body is "deprived of the meanings and the values which are expressed in the language of the body and in the union of the

179. A good review of the technologies and suggestions for regulatory initiatives can be found in: Keith A. Byers, *Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry*, 18 J. LEGAL MED. 265 (1997).

180. See RICHARD A. MCCORMICK, "Ethical Considerations of the New Reproductive Technologies," 46 FERTILITY AND STERILITY, Supplement 1:82 (1991); THOMAS A SHANNON & LISA S. CAHILL, RELIGION AND ARTIFICIAL REPRODUCTION: AN INQUIRY INTO THE VATICAN INSTRUCTION ON RESPECT FOR HUMAN LIFE IN ITS ORIGIN AND ON THE DIGNITY OF HUMAN REPRODUCTION (1988).

181. See LeRoy Walters, *Ethics and New Reproductive Technologies: An International Review of Committee Statements*, 17 HASTINGS CENTER REPORT 3 (1987).

182. See also Chaim Povarsky, *Regulating Advanced Reproductive Technologies: A Comparative Analysis of Jewish and American Law*, 29 U. TOL. L. REV. 409 (1997).

183. See Alan L. Traunson, *Preimplantation Genetic Diagnosis--Counting Chickens Before They Hatch*, 7 HUMAN REPRODUCTION 583 (1992).

human person.”¹⁸⁴ Furthermore, fertilization of multiple ova outside the body and cryogenically freezing them for possible later use threaten indiscriminate use and destruction.¹⁸⁵ Oocyte and sperm donation by third parties, embryonic implantation and surrogacy add to the ethical concerns for the new reproductive technologies as undermining the essential unity of marriage.

Lutherans,¹⁸⁶ Episcopalians,¹⁸⁷ Eastern Orthodox,¹⁸⁸ and some Jewish groups¹⁸⁹ have given limited approval to IVF. Some view the new technologies as an increased range of options for women;¹⁹⁰ others have branded the new technologies as demeaning to women, stigmatizing them, for example, as “fetal containers.”¹⁹¹

Ethicists argue that the notion of the nuclear family is threatened by the new technologies¹⁹² and that the potential for confusion and harm to children is immediate. Children may be considered as consumer products in the new economy. Traditional prohibitions upon adultery and incest are often violated by the use of third parties in the processes. Debate continues regarding the special status of the embryo and special respect

184. Congregation for the Doctrine of the Faith, “Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day,” UNITED STATES CATHOLIC CONFERENCE, 28 (1987).

185. See Jean Cohen, *The Efficiency and Efficacy of IVF and GIFT*, 6 HUMAN REPRODUCTION 613 (1991). The birth of the first infant to have been frozen as an embryo took place in Australia in 1984. Embryo freezing is now a routine option in IVF. *Id.*

186. Lutheran Church, Missouri Synod: Commission On Theology and Church Relations. Social Concerns Committee, *Human Sexuality: A Theological Perspective* (1981).

187. Episcopal Church, General Convention. *Journal of the General Convention of the Protetant Episocpal Church in the United Stat4s of America* (1982).

188. STANLEY S. HARAKAS, *HEALTH AND MEDICINE IN THE EASTERN ORTHODOX TRADITION: FAITH, LITURGY AND WHOLENESS* (1990).

189. DAVID M. FELDMAN, *HEALTH AND MEDICINE IN THE JEWISH TRADITION: L'HAYYIM - TO LIFE* (1986).

190. RUTH MACKLIN, *SURROGATES AND OTHER MOTHERS: THE DEBATES OVER ASSISTED REPRODUCTION* (1994).

191. ELIZABETH BARTHOLET, FAMILY BONDS. ADOPTION AND THE POLITICS OF PARENTING (1993); *In Vitro Fertilization: The Construction of Infertility and of Parenting*, ISSUES IN REPRODUCTIVE TECHNOLOGY: AN ANTHOLOGY, at 253-260, (ed. Helen Holmes, 1992); Linda Williams, *Biology or Society? Parenthood Motivaion in a Sample of Canadian Women Seeking In Vitro Fertilization* ISSUES IN REPRODUCTIVE TECHNOLOGY at 26-274.

192. Daniel Callaghan, *Bioethics and Fatherhood*, UTAH L. REV. 735 (1992).

due to it.¹⁹³

Several Catholic Directives concern issues related to fertility enhancement technologies. Drugs used to stimulate ova and sperm production are permitted, as well as some methods of assisted conception for married persons, following or in conjunction with natural intercourse.¹⁹⁴ Directive 40 disallows use of assisted fertilization methods of unmarried persons.¹⁹⁵ Similarly, the use of ova or sperm donated by third parties is prohibited.¹⁹⁶ Surrogacy is generally prohibited under Directive 42.¹⁹⁷

III. LEGISLATIVE INITIATIVES TO MANDATE DELIVERY OF COMPREHENSIVE REPRODUCTIVE MEDICAL SERVICES

A. Congress

The first attempt to use the authority of Congress to force all hospitals participating in federally-funded health care programs to provide the full array of reproductive medical services, including abortion, contraception and sterilization, was written into the failed National Health Security Act when introduced by the Clinton Administration in November, 1993.¹⁹⁸ After strident debate on the issue, twenty-nine members of Congress and Senators signed a manifesto, that abortion and contraceptive services must be a part of any prospective National Health Plan. Opposition galvanized immediately in the religious sector. In the hearings, the Catholic Health Association, etc., while supporting a inclusive national health plan, opposed the initiative to force private hospital provision of abortion, contraception and sterilization services. The United States Catholic Conference added to the opposition the threat that the Catholic Church would close its hospitals rather than permit their use for abortion services.¹⁹⁹

193. See Elizabeth L. Gibson, *Artificial Insemination by Donor: Information, Communication and Regulation*, 30 J. FAM. LAW 1-44 (1991).

194. Generally, any method that separates marital intercourse from conception is consider unethical. Thus, artificial insemination by a nonspousal donor, and any in vitro fertilization method, including zygote intrafallopian transfer and intracytoplasmic sperm injection. See DIRECTIVES 38, 41, *supra* note 51.

195. "Heterologous fertilization (AID). . . is prohibited because it is contrary to the covenant of marriage, the unity of the spouses and the dignity proper to parents and the child." *Id.*

196. "Homologous artificial fertilization (AIH) . . . is prohibited when it separates procreation from the marital act in its unitive significance . . ." *Id.*

197. *Id.*

198. H.R. 3600, 103d Cong., 2d Sess. (1993).

199. U.S. Catholic Bishops' Conference, *Resolution On Health Care Reform*,

There is no doubt that this bitter debate between advocates of abortion on demand and protagonists for the protection of the religious rights of institutional health care providers was a salient factor in the ultimate defeat of the Clinton national plan. What is particularly poignant in this episode was that, until this point in the debate, the strongest and most vocal proponents of national health care reform in the private sector, and, indeed, the most consistent supporters of single-payer health care reform were the religiously affiliated hospitals and the churches that sponsored them.²⁰⁰ The advocacy of leaders in the religious ministries of healing formed the staunchest support of the Clinton Administration in the early stages of the Congressional hearings. Once it appeared that the Clinton Plan would force all private medical service providers to perform abortions their support vanished. Defeat of the Clinton National Health Plan, with its forced abortion agenda, set the stage for the wholesale entry of commercial health maintenance organizations into the hospital "industry".

In 1997 Senator Barbara Boxer and Congresswoman Nancy Pelosi, both Democrats of California, introduced in Congress The Family Planning and Choice Protection Act.²⁰¹ This Act, again, would have forced all hospitals and health care facilities receiving federal funds, e.g., for Medicare, Medicaid, Social Security Disability, etc., to provide the full array of reproductive services, including direct abortion and in vitro fertilization, as a strict condition of qualification and compliance. The Act did not come to a vote in the 103rd Congress.²⁰²

23 ORIGINS 97 (1993); Peter Steinfelds, *Bishops Plot Stance If Health Plan Covers Abortion*, N.Y. TIMES, May 12, 1993, at 14.

200. The Catholic Health Association and the United States Catholic conference supported national health care reform as a way to provide blanket health care access to the poor. See, e.g., Lynn Wagner, *CHA Reform Agenda Finds An Ally In Clinton Plan*, MODERN HEALTHCARE, Oct. 11, 1993, at 26; Bishop John Richard, *The Church and Future Health Care Reform*, 24 ORIGINS 615, 618 (1995).

201. H.R. 2525; S. 1208 (103rd Congress). Medicaid currently provides funds for rape and incest abortions. 42 U.S.C. §§ 1396(a), 1396(a)(5),(17), (21) (1994); 42 C.F.R. § 440.210 (1995). See also *Hern v. Beye*, 57 F.3d 906, 909 (10th Cir. 1995); C. Lewis Borders, *Rape and Incest Abortion Funding Under Medicaid--Can the Federal Government Force Unwilling States to Pick Up the Tab?*, 35 U. LOUISVILLE J. FAM. L. 121 (1996).

202. The Equity in Prescription Insurance and Contraceptive Coverage Act, H.R. 2174, 105th Congr. (1997), introduced by Senator Olympia Snowe, which would have mandated that all private insurers paying for prescription drugs also cover contraceptive drugs and methods has not been voted on.

The Patients' Bill of Rights, brought to Congress and shelved in the 105th Congress, was debated and finally passed narrowly by the Senate in the 106th Congress. In an effort to get the stronger House version through the Senate, however, Senator Edward Kennedy re-introduced it as an amendment to the Republican bill. On reconsideration, the bill failed to get sufficient support in a fifty-three to forty-seven vote on June 11, 2000.²⁰³

The clash of Democratic and Republican versions of the Bill was consistently shadowed by efforts of the abortion lobby in Congress to attach federal demands for abortion rights to reverse the federal conscience clauses protecting religious institutional providers and force hospitals participating in both public and private health maintenance plans to provide abortions. These efforts lacked sufficient support in Congress to pass. Thus, the Patients' Bill of Rights, failed in 2000, provided no federal initiative, aside from its general information disclosure mandates, to force the reversal of the federal or, indeed, state conscience clauses.²⁰⁴

1. Medicare, Medicaid and Related Programs

The federal Medicaid statute clearly provides that recipients shall have access to family planning services.²⁰⁵ Indeed, the Medicaid regulations adopted by the Department of Health and Human Services and presumptively applicable to the states, require states to provide funding for abortions when the pregnancy results from rape or incest or threatens

203. See *supra* note 4.

204. *Id.*

205. See 42 U.S.C. § 1396d(a)(4)(C) (1994). Medicare, with its companion legislation, Medicaid, began in 1966. Medicare provided basic hospital and physician care insurance for all elderly entitled to Social Security. Medicaid is a program of medical assistance for the low-income patients, covering all ages. Between 1966 and 1972 Medicare's administrators met the demands of medical providers for a largely hands-off stance by public regulators. Out of this period emerged rapid inflation of Medicare's expenditures and ineffective efforts to control costs. Between 1972 and the early 1980's there was a dispersal of government regulations among federal and state agencies. The Health Care Finance Agency (HCFA) took over administration in 1977. In 1983 a new form of hospital reimbursement, the diagnosis-related group (DRG) method of prospective payment, was adopted to cut costs. Two new federal oversight institutions were established in the mid-1980's as peer review agencies, the Prospective Payment Commission (to monitor DRGs) and the Physicians Payment Review Commission. Lawrence A. Brown, *Technocratic Corporatism and Administrative Reform in Medicare*, 10 J. POL. POL'Y & LAW 579 (1985); DAVID G. SMITH, *PAYING FOR MEDICARE: THE POLITICS OF REFORM* (1992).

the life of the mother.²⁰⁶ In 1997, however, Congress expanded the scope of the federal conscience clause statutes to cover religious providers of Medicaid, Medicare and related federal programs.²⁰⁷ Thus, religious hospitals, as well as Medicaid and Medicare managed care plans, are permitted to refuse to provide reproductive health care services to which they object on religious or moral grounds. Federal Medicaid and Medicare statutes, however, require managed care and insurance plans to inform all potential subscribers of any services not covered due to provider religious beliefs.²⁰⁸

The legislative history of the 1997 Congressional amendments reveals an intent by Congress that states provide alternative service facilities for referral, as well as information, for subscribers to obtain reproductive services where those are restricted by a primary provider due to religious objections:

If the managed care provider with which a beneficiary is enrolled is unwilling or unable to provide a particular service (such as a full range of nondirective counseling, referral, and services for reproductive health care), the State must treat such a service as having been 'carved out' of its contract with the organization and take positive steps to ensure that the service is truly available without burden to beneficiaries through another system or provider and that the beneficiaries know of this availability.²⁰⁹

It is very important to note, therefore, that under the federal health care funding programs the burden of referral and provision of alternative providers and facilities for restricted reproductive medicine is *on the states*. The burden in federal law upon referral and provision of alternative reproductive health care service facilities is not on the individual religious hospital as a federal/state contract provider. It is on the public, through the agency of the states.

B. State Legislatures

On a state level, however, there appears to be growing support for some limitations upon the ethical autonomy of private hospitals and institutional health care systems in the area of reproductive medical services. Mandated coverage of family planning services in health

206. Dept. of Labor, Health and Human Services, and Education Appropriations Act, 1998, Pub. L. No. 105-78, tit. V, §§ 509-510, 111 Stat. 1467, 1516 (1997).

207. Balanced Budget Act of 1997, Pub. L. No. 105-33, tit. IV, § 1852(j)(3), 111 Stat. 251, 295-97.

208. *Id.*

209. H.R. Rep. No. 105-149, at 598-99 (1997).

insurance plans, for example, is a part of state law in Virginia,²¹⁰ Maryland,²¹¹ Hawaii,²¹² Montana,²¹³ Rhode Island,²¹⁴ and West Virginia.²¹⁵ Both California and Illinois, while providing coverage for a broad spectrum of fertility treatments as well, provide conscience clauses allowing employers to exclude such services for conscientious reasons.²¹⁶

Subscriber notification requirements, at least in information brochures on Medicare and Medicaid plans, appear now in the laws of California, Illinois, Massachusetts, Nebraska, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Washington, and Wyoming.²¹⁷ Many states provide now also for open access mechanisms, whereby alternative provider services may be made available to insurance enrollees by referral or contract.²¹⁸

In 1999, California legislators defeated the most extensive re-writing of state law to force delivery of contraception, sterilization and abortion by all hospitals, including private religious institutions. Subsequently, purged of its stigmatizing features, the proposal was re-introduced as a disclosure provision for health insurance plans and enacted into law without opposition of the churches in September 2000.

210. VA. CODE ANN. § 38.2-3407.5:1 (Michie 1999).

211. MD. CODE ANN., HEALTH-GEN. II § 19-701(e)(2)(vii) (2000).

212. HAW. REV. STAT. ANN §§ 431.10A-116.6, 432:1-604.5 (Michie 1998).

213. MONT. CODE ANN. § 33-31-102(2)(h)(iv) (1997).

214. R.I. GEN. LAWS § 27-18-30(a)(1998).

215. W. VA. CODE § 33-25A-2(1),(11) (2000).

216. CA. HEALTH & SAFETY CODE § 1374.55 (West Supp. 1999); CAL. INS. CODE § 10119.6(a) (West 1993); 215 ILL. COMP. STAT. ANN. 5/35 m(a), (b)(1)(A) (West 1993 & Supp. 1998). In the past few years a number of non-profit religious managed care organizations have been created to serve Medicaid managed care patients, targeted populations, such as the poor, uninsured, or marketed primarily to co-religionists in conjunction with health care provider systems. For a discussion on the interface of state mandated coverage requirements for insurance plans and the conscience clauses, *see White, supra* note 8, at 1738-42.

217. *See Rachel B. Gold, Special Analysis: Provider 'Conscience' Questions Re-emerge in Wake of Managed Care's Expansion*, STATE REPRODUCTIVE HEALTH MONITOR 18 (1997).

218. For example, WASH. REV. CODE ANN. § 48.43.065(2)(c) (West, 1999) ("The insurance commissioner shall establish by rule a mechanism. . . to recognize the right to exercise conscience while ensuring enrollees timely access to services and to assure prompt payment to service providers.") *See also* N.Y. SOC. SERV. LAW § 364-j(4)(a)(iii)(c) (McKinney, Supp. 1999) (providing reimbursement on a fee-for-service basis when patients use Medicaid providers outside their managed care plans).

On June 4, 1999, the Kuehl-Thomson Health Benefits Act of 1999,²¹⁹ was defeated in the California Assembly by a vote of thirty-nine noes to thirty-one ayes.²²⁰ The eighty-seven page bill would have mandated extensive changes in state law and deprived religious hospitals of various exemptions and programmatic qualification requirements for participation in state health service plans if these hospitals refused to provide or contract out a definitional array of reproductive services.²²¹ It would have further stigmatized non-conforming hospitals by creating public lists of "limited service health care providers."²²² The Kuehl-Thomson Bill was reconsidered on June 10, 1999, and then placed in the inactive file in the Assembly on the sponsors' promise to re-introduce the legislation in the next session.²²³

Between February 8 and June 10, 1999, the Kuehl-Thomson Bill was read and debated three times in the Assembly, underwent extensive winnowing and amendment, but before final defeat went before the state Assembly substantially intact. Because this legislation mirrors, in whole or in part, initiatives currently pending in several other states, it is important to provide a careful and accurate analysis of its provisions to assess the strength of state public policy concerns. Articulation of these concerns and the public policy changes advocated are extensive and precise in the bill. Thus, the Kuehl-Thomson bill supplies a basis for reflection upon the prospective role of states in the absence of strict, compensating federal laws, in forcing the issue of ethical autonomy for religious hospitals.²²⁴

The Kuehl-Thomson Health Benefits bill revolved around a

219. AB 525 (Cal. 1999).

220. Co-authors of AB 525 in the Assembly with Assembly Members Kuehl and Thomson were Members Aroner, Calderon, Firebaugh, Honda, Jackson, Keeley, Longville, Mazzoni, Romero, Shelley, and Wildman (all Democrats), and in the Senate, Senators Figueroa, Hayden, and Solis (all Democrats).

221. AB 525.

222. *Id.*

223. *Id.*

224. The basic premise of state mandated disclosure requirements of hospital-provided services, of course, is that the present health care plans involving religious hospitals do not fully inform consumers of restrictions on expected services in policies purchased. While there is a great deal of anecdotal evidence in advocacy literature to this effect, to date, however, there is no record of successful litigation on the basis of fraudulent or deceptive representation (Restatement, Torts, § 531 (ALI 1999)) or unfair trade practices against religious hospitals for failure to disclose restrictions in the area of reproductive medicine in their primary contracts.

definitional re-writing of Section 1345 of the California Health and Safety Code, to amend Section (c) “Comprehensive reproductive health services” to read:

(c) “Comprehensive reproductive health services” means all services relating to patient counseling, diagnosis, and treatment for reproductive health including, but not limited to, any of the following:

- (1) Preconception services.
- (2) Pregnancy-related services, including prenatal care, surgical, and medical *abortion*, and surgical and medical *sterilization*, including, if medically appropriate, at the time of labor and delivery.
- (3) *Fertility management*.
- (4) Sexually transmitted infections.
- (5) Emergency *contraception*.
- (6) Breast and reproductive health cancers.
- (7) Coverage for federal Food and Drug Administration (FDA) approved prescription and nonprescription *contraceptive methods*.²²⁵

A new section then was added, to read:

1367.105. (a) On or after July 1, 2000, where a health care service plan provides a list of providers to potential enrollees, enrollees, or contracting providers, the health care service plan shall list all licensed facilities with which the health care service plan is contracting . . .

(b) The provider listing described in subdivision (a) shall indicate with an asterisk (*) those licensed hospital and ambulatory surgical centers that do not provide sterilizations, emergency contraception for rape victims, or abortions.

(c) The provider listing described in subdivisions (a) and (b) shall include a statement on each page where a facility is identified with an asterisk (*), as required in subdivision (b), in no less than 12-point type and shall read as follows:

This hospital or ambulatory surgical center does not provide one or more of the following services: emergency contraception for rape victims, sterilizations, or abortions. If you need these services, you should talk with your doctor about how you can get them. You can also call your health plan at (insert membership services telephone number).²²⁶

225. AB 525, 1999-2000 Gen. Sess. § 9 (1999) (emphasis added).

226. AB 525, 1999-2000 Gen. Sess. § 11.

Around this basic description of comprehensive reproductive health care services to include provision for abortion, sterilization and contraception, the bill wove a tight net of coercion and disclosure requirements. It amended the Corporations Code to add consideration to the provision for comprehensive reproductive health care services mentioned to the factors the Attorney General must consider in giving consent to the transfer of control, responsibility or governance of the assets of a non-profit public benefit health care corporation to another entity.²²⁷ It prohibited the California Health Facilities Financing Authority from issuing revenue bonds to assist any health care facility that does not provide directly or arrange for the provision of the designated reproductive health services.²²⁸ It amended the Public Employee's Medical Hospital Care Act to prohibit the board from approving a health benefits plan that excludes, limits, or restricts the provision of reproductive health services unless the plan also contracts with and makes available and accessible to its enrollees a similar licensed facility that does not exclude, limit, or restrict the service.²²⁹ Moreover, the bill would have mandated the board to require any plan that provides a list of providers to employees, annuitants, or contracting providers to include, as provided under the bill, designated information in the listing, including identifying those licensed hospitals and ambulatory surgical centers that do not provide the designated reproductive health services.²³⁰ Similar disclosure requirements would have been laid on every disability insurer in the state.²³¹

The Kuehl-Thomson bill also would have changed the fundamental licensure and regulatory structure of health care service plans, as provided in the Knox-Keene Health Care Service Plan Act of 1975,²³² to require a health care service plan, as a condition for licensure by the Commissioner of Corporations, to provide a list of providers to potential enrollees, or

227. AB 525, 1999-2000 Gen. Sess §§ 1-3, amending CAL. CORP. CODE §§ 5914, 5917 and 5919 (West 1999).

228. AB 525, 1999-2000 Gen. Sess. § 4, amending CAL. GOV. CODE §§ 15438.5, 15459 (West 1999).

229. *Id.*

230. AB 525 1999-2000 Gen. Sess. § 6-8, amending Cal. Gov. Code §§ 22774, 22778, and 22790 (West 1999).

231. AB 525, 1999-2000 Gen. Sess. §§ 16-18 (amending CAL. INS. CODE §§ 10123.12, 10140 (West 1999), and adding §§ 10123.22, 10291.5, 10604.1, and 10702.2).

232. AB 525, 1999-2000 Gen. Sess. §§ 19-22, amending CAL. INS. CODE § 10198.71.

contracting providers to include information in the listing, identifying those licensed hospital and ambulatory surgical centers that do not provide the designated services.²³³ Requirement for licensure would also require proof of contract services for the plan or arrangements for these provided in other similar licensed facilities.

The California Health Facility Construction Loan Insurance Law, administered by the Office of Statewide Health Planning and Development, would be similarly changed to exclude insurance coverage for loans to nonconforming health care facilities.²³⁴ It would require the Commissioner of Insurance to provide a list of providers that identifies hospitals and ambulatory surgical centers that do not provide the reproductive services designated.²³⁵

The Medi-Cal program, administered by the State Department of Health Services would have required licensed facilities restricting reproductive services to contract with and make available to enrollees similar licensed facilities that do not exclude the services.²³⁶

The Kuehl-Thomson Health Benefits bill, in effect, was a coercive regulatory effort designed to stigmatize religiously affiliated hospitals with a penalty of second-class categorization and deprivation of rights to participate in state-sponsored public finance programs and insurance plans.

After defeat in June, 1999, the Kuehl-Thomson Act was remanded to committee where substantial amendments were made to change the bill simply into a disclosure mandate for health care service plans, disability insurance plans, and California's version of Medicaid, Medi-Cal subscription lists.

Hospitals and other providers of health services, such as physicians, health facilities and other organizations licensed directly to deliver or furnish health care services were exempted from coverage. Furthermore, all direct disqualifying provisions that would have created a second-class category of religious hospitals, cutting them off from participation in public contracts and financing programs, were dropped. With these amendments, the religious hospital providers dropped their opposition.

The Kuehl-Thomson Act, with disclosure requirements for health

233. AB 525, 1999-2000 Gen. Sess. § 23, adding CAL. INS. CODE § 10705.1.

234. AB 525, 1999-2000 Gen. Sess. §§ 4-5, amending CAL. GOV. CODE §§ 15438.5 and 15459.

235. AB 525, 1999-2000 Gen. Sess. § 7, amending CAL. GOV. CODE §§ 22778, 22790.

236. AB 525, 1999-2000 Gen. Sess. §§ 24-27, amending CAL. WELF. & INS. CODE §§ 14016.5, 14016.71, 14016.8 (West 1999), adding Section 14016.9.

service plans, disability insurance policies and Medi-Cal programs, was passed, approved by the Governor on September 2, 2000, and filed with the Secretary of State on September 8, 2000.²³⁷

California law now requires the following paragraph, with appropriate variations, to be inserted in 12-point boldface type, and posted in a prominent location on the websites of (1) health care service plans that cover hospital, medical and surgical benefits;²³⁸ (2) disability insurance plans covering hospital, medical or surgical benefits which provide lists of network providers to prospective insureds and insureds;²³⁹ and (3) Medi-Cal service plans to ensure that all Medi-Cal beneficiaries receive and all Medi-Cal managed care plans include:

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.

Subject licensed health care service plans may omit this disclosure requirement where they contract for services with providers which already supply all these reproductive health services.

In addition to legislative schemes requiring disclosure, classification and disqualification of hospital participation in programmatic public financing and health insurance plans, state initiatives *mandating coverage* of reproductive services should be mentioned, though they touch religious hospitals only tangentially, not as providers, but rather as employers.

In California again, for example, the Contraceptive Equity Act of 1999 includes most religious organizations in a requirement that employers pay for contraceptives in prescription insurance plans.²⁴⁰ Catholic Charities of Sacramento filed suit on July 21, 2000, arguing that the law, which took effect January 1, 2000, violates the California Constitution, as well as the

237. CAL. HEALTH AND SAFETY CODE §1363.02 (West 1999).

238. Adding § 1339.80 to the Cal. Health and Safety Code.

239. Adding § 10604.1 to the Cal. Insurance Code.

240. CAL. HEALTH & SAFETY CODE § 1367.25; CAL. INS. CODE § 10123.196 (West 2000).

First and Fourteenth Amendments to the U.S. Constitution.²⁴¹ Plaintiffs request a permanent injunction barring enforcement of the Act and a declaration that the law is unconstitutional.

The law is written so that insurance companies are held responsible for including contraceptives in employer policies. The law's "conscience clause," narrows the definition of "religious employer" to worshipping communities, deliberately excluding religiously affiliated organizations providing health care, social service and educational programs to the public, i.e., hospitals, public benefit charitable organizations, such as religious charities, and colleges and universities.²⁴² Among all mandated service statutes in states adopting them, only California's fails to embrace public benefit religious organizations under the protection of its conscience clause.

Plaintiffs argue the statute constitutes a cramped state definition of "religion," imposing upon the churches that sponsor public benefit charities its own definition of what constitutes "religious" and what constitutes "secular" activities. This would force religiously affiliated hospitals, for example, to pay for insured services to which they have moral and religious objections.²⁴³

Several states have passed similar legislation in the past two years.

The District of Columbia's bill on contraceptive coverage, with no conscience clause, was pocket-vetoed by Mayor Williams.²⁴⁴ On the other hand, Maryland passed contraceptive insurance coverage legislation, with broad conscience clause exemptions in 1996, without strong objection from the churches.²⁴⁵

241. *Catholic Charities of Sacramento v. California*, N. 00AS03942, filed August 28, 2000.

242. CAL. HEALTH & SAFETY CODE § 1367.25(b)(1); CAL. INS. CODE § 10123.195 (d)(1).

243. The legislative record of this bill indicates targeting of Catholic hospitals, legislative distinctions among religious organizations and attempts at theological distinctions, all clearly violations of the First Amendment. *Church of Lukumi Babalu Aye v. City of Hialeah*, 508 U. S. 520 (1993); *Larson v. Valente*, 456 U.S. 228 (1982); *Corporation of the Presiding Bishop of the Church of Latter-Day Saints v. Amos*, 483 U.S. 327 (1987).

244. David A. Fahrenthold, *Council Recess Mixes Business, Pleasure*, THE WASH. POST, Sept. 14, 2000, at J.03.

245. See *supra* note 211. To date, thirteen states have passed legislation mandating insurance coverage of contraception where a policy covers prescription drugs or devices. See CAL. INS. CODE 10123.196 (West 2000); DEL. CODE ANN., title 18, 3559 (2000); 1999 Conn. Acts 99-79 (June 3, 1999); GA. CODE ANN. 33-24-59.6 (2000); HAWAII REV. STAT. 431:10A-116.6, 431:10A-116.7, 432:1-604.5

IV. HOSPITAL REFERRALS, CONTRACTING OUT SERVICES, AND THE PROBLEM OF MORAL COOPERATION

Many religious hospitals and acute care systems sponsored by churches or religious organizations have affiliated with or share management resources with public or private hospitals that are either non-religious or sponsored by other religious organizations permitting medical procedures prohibited in the primary facility. In this way the hospitals may offer counseling and referral services to patients, directing them for the disapproved services to other facilities. This is particularly true in the area of medical practice involving reproductive health care decisions. The model, of course, resembles the common practice of sharing expensive technical and scientific resources in other areas of medical practice, or cooperative financial and managerial resource-pooling schemes. Right now the ethical problems of referral and cooperation in the provision of reproductive medical services are intensely controversial.

Of solutions offered by advocates of open access to private, religious health care providers for the array of reproductive medical treatments and procedures not currently available, most fix upon the need for *the religious hospitals to accommodate themselves* to specific patient requests.²⁴⁶ “Creative accommodations” by private hospitals, using referrals, contracted out services, creation of separate facilities, financing and sharing resources with out-patient clinics, etc. are catalogued and appraised by their proponents.²⁴⁷

These solutions overlook the requirements of federal law. Federal law provides the burden of accommodation, at least under federally-financed health care plans, is *on the state*.²⁴⁸ Private accommodations are more severely limited, from an ethical perspective, than their advocates seem to realize. To be very blunt, at least abortion on demand runs against the moral traditions of all the major religious denominations in this country as an intrinsically moral evil. To suggest “creative accommodations” of health care professionals in the direct termination of fetal life, without

(Michie 2000); IOWA CODE 514C.19 (2000); ME. REV. STAT. ANN., tit. 24, 2332-J, ME. REV. STAT. ANN., title 24-A, 2756, 2847-G, 4247 (West 2000); MD. CODE ANN. INS., 15-826 (2000); NEV. REV. STAT. ANN. 689A.0415 *et seq.* (Michie 2000); N.H. REV. STAT. ANN., tit. 37, 415:18-i (2000); 1999 N.C. SESS. LAWS 90 (June 30, 1999); R.I. GEN. LAWS 27-18-57, 27-19-48, 27-20-43, 27-41-59 (2000); 8 VT. STAT. ANN. 4099c (2000). Insurance plans offered to federal employees must meet similar requirements. See Pub. L. No. 106-58-113 Stat. 430 (1999).

246. See *supra* notes 6-8.

247. See, *e.g.*, Boozang *supra* note 8.

248. See Balanced Budget Act, *supra* note 207.

moral limitations upon development, circumstances, reasons, alternative options or conditions, is simply unrealistic. Biological technologies of anti-conception or fertility enhancement pose less drastic ethical challenges, while still skirting the peripheries of “pro”-creation, touching religious conscience where the quintessentially individuated mystery of divine love in giving human life is concerned.

“Creative accommodations” eroding the most basic religious commitments of private health care professionals, thus, are not a final answer. In most cases they are not really feasible. Where tried, they leave a trail of misgiving, temporizing and moral ambivalence.

The largest hospital in Arkansas, for example, St. Vincent Infirmary Medical Center in Little Rock, is operated by St. Vincent’s Health System, owned by Denver-based Catholic Health Initiatives. Under an arrangement with the Arkansas Women’s Health Center, St. Vincent’s operated a sterilization unit under the terms of its purchase in June, 1998, of Doctors’ Hospital, a non-religious, private hospital across the street from St. Vincent’s. Prior to the purchase, the doctors of Doctors’ Hospital performed abortions and sterilizations. After acquisition, St. Vincent’s stopped abortion services, but agreed to allow sterilizations to continue in a special facility near the obstetrics ward. The room at the new St. Vincent’s Doctors’ Hospital was leased by Arkansas Women’s Health Center, which paid rent to the hospital, along with a set fee for each sterilization to compensate the hospital for supplies used.

When the sterilization unit opened on July 1, 1998, a storm of protest arose within the Catholic community, with hospital administrators justifying the arrangement under the terms of the ethical principles of material cooperation, while the head of the Catholic Medical Association condemned the arrangement, saying he had never heard of an arrangement like the one in Arkansas.

The referral program at St. Vincent’s Doctors Hospital ended in 1999 after Pope John Paul II told the local bishop and other American bishops visiting Rome that permitting sterilizations is a “grievous sin and source of scandal.”²⁴⁹

Referral and contracted out services are not a principled solution to the dilemma persons face who request services refused by the selected health care provider. Can the states require licensed hospitals to provide neutral counseling or refer out patients for services the hospitals themselves do not provide because of their own ethical restraints? The moral problem is far more complex than those who propose referral and contract services

249. Deborah Halter, 35 THE NAT. CATH. REPORTER, October 15, 1999 at 10.

as an easy solution to the comprehensive public access dilemma seem to think. Ultimately, referral largely overlooks the difficult straits of already existing patients by forcing them into situations of grave inconvenience, and expense, to say nothing of pain. For these patients, full disclosure of the limited obstetrical services offered by the hospital before admission is the only reasonable alternative.

The referral solution for covered contract services, whereby a religious hospital refers patients who seek reproductive health services, such as nontherapeutic abortion, not provided by the primary facility, to other, neutral hospitals or clinics for treatment, is both temporary and arbitrary. Because individual counselors and referral agents may not be required to make the reference under the protection of the various conscience clause provisions, in fact, mandated referral systems will not work. Counseling provided by the same persons who wish to deny the treatment desired initially, may be both distasteful and morally objectionable. A referral in many cases *may* be made, but *must* not be made; may be made with sympathy, understanding and provision of necessary information, or may be made reluctantly and with overtones of personal disempowerment.

Referral away from the primary provider means, in many cases, more than simply embarrassment and discomfort for patients requesting these services. It may be more dangerous, medically risky, more painful and more expensive. One need only consider the human cost to a patient requesting postpartum tubal ligation after a caesarian section in a primary facility. The tubal ligation may have to be performed later, entailing new surgery, at a distant, strange facility and at additional expense to the HMO or insurance provider. The convenience of both delivery and sterilization procedure together, a usual sequence of surgical procedures, will necessarily be forfeited by the patient. Or what of the rape victim brought into a primary emergency facility, told after completion of forensic tests, that she must go elsewhere for state-mandated therapeutic care? Examples could be multiplied.

Affiliations of Catholic and non-Catholic hospitals or facilities are governed by Part 6 of the *Ethical and Religious Directives*, "Forming New Partnerships With Health Care Organizations and Providers."²⁵⁰ Four guidelines are provided for negotiating health care mergers: (1) Directive 67 states that "[d]ecisions that may lead to serious consequences for the identity or reputation of Catholic health care services or entail the high risk of scandal should be made in consultation with a bishop"; (2) Directive 68 states that any partnership affecting the identity of Catholic

250. See ETHICAL DIRECTIVES, *supra* note 48.

health care institutions “must respect church teaching and discipline”; (3) Directive 69, states that “[w]hen a Catholic health care institution is participating in a partnership which may be involved in activities judged morally wrong by the Church, the Catholic institution should limit its involvement in accord with the moral principles governing cooperation;” and (4) Directive 70 states that “[t]he possibility of scandal . . . is an important factor that should be considered when applying the principles governing cooperation.”

The moral principle involved in the cooperation and referral situations is called the principle of moral cooperation.²⁵¹ This principle differentiates the action of the provider of ethically-prohibited services from the action of the cooperator in making the referral in two ways; the first is between formal and material cooperation. If the referring cooperator *actually intends* the object of the prohibited act, the cooperation is ethically wrong. Formal cooperation can be explicit, as, for example, when the referring agent intends an abortion to be procured. Implicit formal cooperation is attributed when, even though the cooperator denies intending the wrongful act, i.e., the abortion, no other explanation can distinguish between the cooperator’s intent or purpose and that of the abortion provider.

On the other hand, if the cooperator does not intend the object of the wrongdoer’s activity, the cooperation is said to be material and can be morally licit. Thus, the attenuation of ethical complicity does not occur simply because the act of generic referral is more remote from the evil than physically participating in the evil itself, but rather from ignorance of the outcome or the referring agent’s non-direct intention. Some sort of on-balance judgment, a weighing of values, must occur to justify the material involvement. Only very serious consideration of patient well-being justifies the remoteness of moral involvement.²⁵² A person who

251. BERNARD M. ASHLEY & KEVIN O’ROURKE, *HEALTH CARE ETHICS: A THEOLOGICAL ANALYSIS*, 283-284 (3d ed. 1989); BERNARD HARING, II *THE LAW OF CHRIST* 496 (1963); C. HENRY PESCHKE, I *CHRISTIAN ETHICS* 251-252 (1981); GERMAIN GRISEZ, 3 *THE WAY OF THE LORD JESUS: DIFFICULT MORAL QUESTIONS*, App. 2, 876-884 (1997).

252. See James F. Keenan, *Cooperation, Principle of*, *NEW DICTIONARY OF CATHOLIC SOCIAL THOUGHT* 232, 234 (Judith A. Dwyer, ed., 1994). This may be similar to Governor Mario Cuomo’s reasons for his pro-choice stance on abortion as a political principle. Cuomo argued that, to promote social harmony and leave open the possibility that Catholic moral teachings would become much more widely held in the long run, Catholic public officials should not use their offices to advance those religious teachings that are now highly contentious in society. Mario M. Cuomo, *Religious Belief and Public Morality: A Catholic Governor’s*

suspends his or her moral judgment in referral sets his or her conscience aside for a greater good.

The Supreme Court in three vital decisions regarding medical assistance at the termination of life, *Cruzan*,²⁵³ *Vacco*²⁵⁴ and *Glucksberg*,²⁵⁵ weighed into the traditional and accepted jurisprudence of cooperation and causality, the so-called double effect rule, to flesh out in practical terms differences between direct and indirect, or formal and material in the terms of religious moral teaching on cooperation, that are more than abstract.

The ethical problem of material cooperation, however, cannot rest at this point. Within the churches themselves, there is great controversy over the issue. One must have a very short memory, indeed, to have forgotten the intensity of church lobbying that went into the so-called "gag orders" of the Public Health Services Act of 1988,²⁵⁶ tried on free speech grounds in *Rust v. Sullivan*.²⁵⁷

In 1970 Congress added Title X to the Act, authorizing the Secretary of the Department of Health and Human Services to "make grants to and enter into contracts with public and non-profit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services."²⁵⁸ Section 1008 of the Act, however, provided that "none of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning."²⁵⁹

By 1986 widespread abuses of Title X funds prompted an extensive audit by the Government Accounting Office, followed by congressional action suspending the program. Among the findings were that 117 hospitals receiving Title X funds and eighty-five percent of Planned Parenthood Clinics were using the funds in programs featuring counseling and referral for abortions. Furthermore, funds were being used to pay dues in organizations lobbying for programs advocating abortion as an acceptable method of family planning. Hearings on Senate Bill 1366, providing a four-year reauthorization of the funding bill, with new, more

Perspective, 1 NOTRE DAME J. C. ETHICS AND PUB. POL'Y 13 (1984).

253. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 278 (1990).

254. *Vacco v. Quill*, 521 U.S. 793 (1997).

255. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

256. 42 U.S.C. §§ 300 et seq.; Senate Hearings 100-378, Senate Committee on Labor and Human Resources, S. 1366. July 30, 1987.

257. 500 U.S. 173 (1991).

258. 42 U.S. C. § 300 (a).

259. 42 U.S. C. § 300 (a)-6.

stringent regulations, were conducted in the summer of 1987.²⁶⁰

The Department of Health and Human Services issued amended regulations for the reauthorized program on February 2, 1988,²⁶¹ in general, prohibiting activities that encourage, promote or advocate abortion.²⁶² Counseling and referral for abortion services were clearly inconsistent with the ethical principles of a majority of prospective private agency funding recipients.

The new regulations provided “clear and operational guidance” to grantees about how to preserve the distinction between Title X programs and abortion as a method of family planning.²⁶³ The regulations attached three principal conditions on the grant of federal funds for Title X projects. First, the regulations specify that a “Title X project may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning.”²⁶⁴ Title X projects must refer every pregnant client “for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of the mother and the unborn child.”²⁶⁵ The list may not be used indirectly to encourage or promote abortion,

such as by weighing the list of referrals in favor of health care providers which perform abortions, by including on the list of referral providers health care providers whose principal business is the provision of abortions, by excluding available providers who do not provide abortions, or by ‘steering’ clients to providers who offer abortion as a method of family planning.²⁶⁶

The Title X project was expressly prohibited from referring a pregnant woman to an abortion provider, even upon specific request.²⁶⁷

Second, the regulations broadly prohibited a Title X project from engaging in activities that “encourage, promote or advocate abortion as a method of family planning.”²⁶⁸

Third, the regulations required that Title X projects be organized so

260. Senate Committee, *supra* note 256.

261. 42 C.F.R. Pt. 59.

262. President Clinton signed an order misspending these regulations.

263. 42 C.F.R. Part 59, 53 Fed. Reg. 2922 (Feb. 2, 1988).

264. Section 59.8 (a)(2) and 59.8 (v)(2) of the Public Health Service Final Rules, 53 Fed. Reg. 2922 (Feb. 2, 1988). *Id.*

265. Section 59.8.

266. *Id.*

267. *Id.*

268. Section 59.8(a).

that they are “physically and financially separate” from prohibited abortion activities. To be deemed physically and financially separate, “a Title X project must have an objective integrity and independence from prohibited activities. Mere bookkeeping separation of Title X funds from other monies,” the regulations add, “is not sufficient.”

Rust v. Sullivan involved a facial challenge under the free speech clause of the First Amendment to the prohibition of counseling and referral services involving abortion. Finding the regulations a fair interpretation by the Secretary of Congressional intent under the Act, the Court then addressed the issue of viewpoint discrimination involved in the regulations’ prohibition of “all discussion about abortion as a lawful option—including counseling, referral, and the provision of neutral and accurate information about ending a pregnancy—while compelling the clinic or counselor to provide information that promotes continuing pregnancy to term.”²⁶⁹ The Court held the prohibition constitutional, as a valid implementation of congressional choice favoring childbirth over abortion.

My purpose in citing *Rust v. Sullivan* is not to re-examine the Supreme Court’s upholding of viewpoint-based suppression of speech as a condition for acceptance of public funds in this case. It is, rather, to note that the prohibition against “counseling and referral” of abortion-related services was put into the regulations implementing the Public Health Service Act in 1988 precisely at the insistence of the religious lobbyists who at that time argued before Congress that the very people to oppose abortion on ethical grounds also oppose attempts to counsel and refer pregnant women for that very purpose.²⁷⁰ In other words, ten years ago Congress included the “gag order” in a publicly-funded health services program because Congress was told that, in the moral judgment of its opponents, counseling and referral shared equally the ethical evil of abortion itself.

Prior to *Rust v. Sullivan*, the Supreme Court examined the Adolescent Family Life Act,²⁷¹ providing federal funds to public and nonpublic private organizations and agencies for services and research in the area of premarital adolescent sexual relations and pregnancy. In *Bowen v. Kendrick*²⁷² in 1987 the Supreme Court upheld the Act’s provision of federal funding to church-related private agencies against a challenge

269. 500 U.S. 173 (1991).

270. 42 C.F.R. Part 59, Public Health Service Final Rules, 53 Fed. Reg. 2922 (Feb. 2, 1988).

271. 42 U.S.C. §§ 300z et seq. (1982 ed. and Supp. V).

272. 487 U.S. 589 (1987).

under the Establishment Clause.

Not expressly discussed by the Supreme Court in *Bowen v. Kendrick*, however, is a similar gag order. The Adolescent Family Life Act restricted the awarding of grants to “programs or projects which do not provide abortion or abortion counseling or referral,” except that the program may provide referral for abortion counseling if the adolescent and her parents request such referral.²⁷³ Once again, the restriction on counseling and referral of abortion services found its way into the Act because of the churches’ religious ethical concerns expressed to Congress.

The Adolescent Family Law Act was enacted by Congress in 1982; the Public Health Services Act regulations was implemented in 1988. Both prohibit, at the insistence of the churches that operate hospitals and related health service agencies, the very counseling and referral that many hospitals affiliated with these same churches now want to engage in to allow mergers and acquisitions to go ahead without strong local community opposition. The Supreme Court upheld the constitutionality of both Acts, including their respective gag orders, against challenges under the doctrine of unconstitutional conditions. One wonders now how serious ethical challenges to counseling and referral services may be. It seems strange that within just one short decade religiously affiliated hospitals could do an about-face on a doctrine alleged to be grounded in the natural law itself. If the “about-face” is just an expediency, however, then one wonders about the extent of its longevity.

In 1995 the U.S. Senate and the House passed different versions of the Medical Training Nondiscrimination Act of 1995.²⁷⁴ Both bills provided exemption for medical students and institutions to opt out of the requirement that OB-Gyn programs train residents to perform elective abortions. The training requirement forms part of the policy implemented by the Accreditation Council for Graduate Medical Education.²⁷⁵

Both bills added to the conscience clauses an amendment eliminating the requirement for accreditation that students desiring abortion training be referred to other provider institutions. Referral requirements were also represented to Congress as conscientiously objectionable.²⁷⁶

273. *Id.* at 597; 42 U.S.C. § 300z-10(a).

274. S. 971, 104th Congr., 1st Sess. (June 20, 1995); H.R. 1932, 104th Cong., 1st Sess. (June 27, 1995). Codified at 42 U.S.C. § 238N (1996).

275. The policy was unsuccessfully challenged in *St. Agnes Hospital of Baltimore, Inc. v. Riddick*, 748 F. Supp. 319 (D. Md. 1990).

276. It should also be mentioned that the Civil Rights Restoration Act of 1988 overturning *Grove City College v. Bell*, 465 U.S. 555 (1984), and applying Title IX

The problem of material cooperation by way of referrals in cases in which patients seek the medical services of church-related providers where reproductive medicine is concerned, has been accentuated by the recent experience of the religious social service providers in Germany.²⁷⁷ The story is one of great personal hurt, outrage, compromise and indignation caused by referral measures taken under political pressure for what majoritarian political parties deemed perfectly good reasons.

Nanette Funk, several years ago, prepared an insightful analysis of the German referral system for legally permissible first trimester abortions.²⁷⁸ For those who wish to provide abortion access in this country through state-mandated referral services, Funk's recording of the profound personal trauma caused to pregnant women by state-mandated referrals under the German Pregnancy and Family Assistance Act of 1995 is eye opening. Even without the counseling antecedent required in Germany before referral, a system of enforced referrals can easily become a social nightmare.

State enforcement, like state agency verification of claims against workers' compensation funds, of course, would require not only records, but periodic access by public agencies to private hospital records. State review of patient records, in turn, necessitates that the contents of the records be mandated, storage and confidentiality are assured, and proper indexing be provided. Thus, pregnant women seeking abortion referrals would be put to the task, in the presence of hospital staff whose religious commitment is to avoid the destruction of the fetus altogether (a position arguably at odds with that of the petitioner) creating a record of their request. The content of the record may include a brief medical history, plus the reasons the patient may have for the referral, as well as notice of what stage she is in in her pregnancy at the time. In Germany referral records also noted whether the petitioner had had previous abortions. The bottom line in any scheme of state enforcement of referral services is that the mechanism of sanction makes women dependent upon the person charged with providing referral, in a public context, in which there is no ultimate assurance of how the record produced may be used. More than that, it required a woman to give and explain her reasons for desiring the

to entire institutions of higher education rather than simply discrete programs, is "abortion neutral", i.e., the Act expressly states that the failure of a college or university to provide abortion services to students is not a form of "gender discrimination" - 20 U.S.C. § 1688 and statutory notes (1988).

277. "On File," 27 ORIGINS 546 (1997).

278. Nanette Funk, *Abortion Counseling and the 1995 German Abortion Law*, 12 CONN. J. INT'L. L. 33 (1996).

abortion to an entirely unsympathetic person.

State mandated referral services by the very organizations that themselves have deep ethical objections to abortion was so profoundly humiliating to women petitioning that it set off strident opposition in Germany that continues until today.²⁷⁹ So vociferous has been the opposition that Caritas, the international Catholic social service organization, and the Catholic Women's Social Services Agency (SKF), which together had supplied 259 of the 1625 certified referral centers in Germany, simply pulled out of the system altogether. Neither religious organizations charged with referral nor women seeking abortions want the system to continue.

In the United States if a referral system were state-sanctioned, even without overt counseling components, the element of explanation of reasons and dependence could not be avoided. One can hardly imagine in this country, furthermore, a defendant hospital in litigation to protect its accreditation against a surveillant health department placing before a court cartons of records of abortion referrals, with attendant discovery orders to go after the abortion providers to ascertain the outcomes of these cases--while the names, addresses and histories of petitioning women become a matter of public record.

Rather than state mandated referrals, it is better simply to get the state entirely out of the coercion process in the area of sensitive reproductive choices. Only in this way can the consciences of both hospitals and patients be respected. Mandated records and surveillance by the state would simply cut off any other avenue of creative service to the public which the different religious hospitals can provide according to their circumstances.

V. MONOPOLIZATION AND HOMOGENIZATION OF HEALTH CARE SERVICES ARE NOT COMPELLING STATE INTERESTS

Non-profit hospitals developed out of the charitable hospital movement of the nineteenth century.²⁸⁰ As changes in medical technology, scientific progress and industrial growth expanded, voluntary hospital missions were enlarged to provide facilities to the general public for the care of the sick, rather than simply tending the indigent sick of particular communities. The government stepped in to share the costs of expanding operating budgets around the turn of the century. Since then the growing presence of federal, state and municipal governments in hospital care has provided an empirical basis for the social role of

279. *Id.*

280. PAUL STARR, *supra* note 31, at 145.

government in general welfare programs.²⁸¹ That role today is indispensable.²⁸² It stops short, however, of complete absorption of the churches' role in the voluntary sector providing disinterested charitable services.

Public monopolization of the delivery of health care services in this country would demand suppression of the private sector, whether non-profit, religious, secular or community-oriented, or for-profit. This, of course, would require massive governmental funding of a national plan, however worked out with the states on a block grant or direct pay basis. Such a system, in the foreseeable future, does not appear imminent.

Ratcheting down from public ownership to more intense regulation and surveillance, however, approaches homogenization of health care instead of government monopolization. The issue then is one of degree. How much tightening of licensure and accreditation standards for private hospitals around a mandated provision of medical services is feasible? Too much, of course, would simply start the clock ticking towards a total withdrawal of churches and private philanthropic organizations from institutionalized health care. Existing religious hospitals and hospital chains would be sold off to the for-profit sector, leaving health care in this country to be divided among the "haves" with private group or individual insurance plans and the "have-nots" to be relegated to public facilities. Even the most extreme zealots of majoritarian public policies must see that such a move would be both politically infeasible and socially disastrous.

In this country there are four systems for the provision of institutionalized health care services, all tightly regulated by both federal and state governments and serving the public on non-discriminatory bases. Permutations in the religious non-profit sector match the vast changes in for-profit insurance and hospital merger activities in public awareness. In addition to these two contrasting systems, are publicly supported hospitals, local and community service oriented and non-profit, secular hospitals founded and operated by private or corporate philanthropies. All serve the public nondiscriminatorily and depend, more or less, upon the provision of overarching public medical plans, such

281. For an analysis of social factors influencing the development of health care systems since World War II, see ELI GINZBERG, *THE MEDICAL TRIANGLE: PHYSICIANS, POLITICIANS, AND THE PUBLIC* (1990).

282. Forty percent of current health care expenditures involve government funds. In many states the elderly are the dominant consumers of medical care. Medicaid funds compose the bulk of nursing home revenues. *The Impact of Medicaid Managed Care On the Uninsured*, 110 HARV. L. REV. 751 (1997).

as Medicare, Medicaid and state counterparts.²⁸³ To an uneven degree all receive financial support from the provision of managed care services. The tax advantages, as well as the exemption privileges of ERISA-regulated, employer-based plans provide the largest source of incentives driving managed care using all of these hospital resources.²⁸⁴

Private institutions contract with the government for the delivery of governmental services— because the government cannot or has decided not to monopolize the field.²⁸⁵

Pluralism in delivery of health care,²⁸⁶ therefore, crosses two axes, public and private, non-profit and for-profit. It is both competitive and complementary.

The non-profit sector provides cost-saving, flexibility, personalization, experimentation, creativity, community orientation and community loyalty. The for-profit sector is driven to hold down escalating costs, thereby providing the competitive quality services that enable comprehensive health care to come within the reach of the broadest possible public. It is in the best interests of society to secure the health of each sector, and the integrity of each competing system.

There is a vital role for private non-profit hospitals to play in the health care enterprise. A decade ago Dean Robert Clark of Harvard wrote of the disfunctionality of the private non-profit hospital corporation.²⁸⁷ He thought it should disappear from the health care scene as an anachronism in a market dominated by public and for-profit players. The reasons he gave, largely turning upon the difficulty of competing and fragmented private institutions securing access to the financial resources necessary to continue in this market, lose their cogency as shared resources achieved through creative hospital mergers provide market strengths formerly not predictable.

Studies of the hospital market since that time, however, have vindicated a valuable niche for the private hospital, as well as for

283. Title XIX of the Social Security Act of 1965 established the Medicare and Medicaid programs. 42 U.S.C. §§ 1396-1396v (1994).

284. Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 118, 125 (1995).

285. CARL ESBECK, *THE REGULATION OF RELIGIOUS ORGANIZATIONS AS RECIPIENTS OF GOVERNMENTAL ASSISTANCE* (1996); Gail D. Edson, *Medicare and Managed Care*, 44 U. KAN. L. REV. 807 (1996).

286. See John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311 (1997).

287. Robert Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980).

pluralism in hospital services. The wholesale state imposition of public policies upon religious dissenters in the health care fields would create the social and scientific downside of lost initiative and destruction of already-proven creativity in providing financially sound medical services.

Changes in the contemporary market have not undercut the increased ability of private non-profit hospitals to price their services below market,²⁸⁸ serve the poor and indigent, and add flexibility to their care services.

America has achieved a level of medical service that is unequalled precisely because of the pluriformity of health care systems serving the public. Federal government challenges to mergers of non-profit hospitals, beginning in 1988, were pinned on the prospective loss of competitive flexibility in holding down prices.²⁸⁹ Empirical studies since that time, however, have shown that not only do non-profit hospitals and health maintenance organizations behave differently than for-profits, but that, overall, they generally set lower prices for services provided.²⁹⁰ Moreover, the unique values of religious non-profit hospitals, in concern for local community, provision of care for the poor and uninsured, loyalty of staff, physicians and patients, and the profile of disinterested public service support their very strong fundraising profile. The best examples of loyalty and support are the private non-profit hospitals sponsored by members of local communities and overseen by boards of directors drawn from those same communities. The equity holder of the non-profit organization, Frank Sloan says, is not a remote shareholder, but the community itself, however defined.²⁹¹

The bottom line in non-profit hospital conversions to for-profit status, of course, is the loss of community control of the institutions and restraints in the flexibility permitted hospital administrators to provide

288. See William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J. LAW & ECON. 437 (1995); David J. Behinfor, *Exclusive Contracting Between Hospitals and the Use of Economic Credentialling*, 1 DEPAUL J. HEALTH CARE L. 71 (1996).

289. See *United States v. Carilion Health Sys. and Roanoke Valley Hospital*, 892 F.2d 1042 (4th Cir. 1989); *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990). Earlier lawsuits to stop hospital mergers involved for-profit hospitals. See, e.g., *American Medical Internat'l*, 104 F.T.C. 1 (1984).

290. The most recent study to verify these conclusions, as applied to HMOs, is David U. Himmelstein et al, *Quality of Care in Investor-Owned vs Not-for-Profit HMOs*, 282 J.A.M.A. at 159 (July 14, 1999).

291. Frank Sloan, *Property Rights In the Hospital Industry*, HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITAL AND HEALTH INSURANCE 106 (H.E. Frech III ed. 1988).

below-cost services to the poor. What, in effect, a for-profit conversion does is to give up community control to investors. The desire for rising profits directly clashes with disinterested service of the poor, as well as the interests of those who pay monthly premiums enabling them to use the hospital as a service provider. It directly undermines the freedom religious hospitals need to refuse to provide some services, otherwise profitably delivered, for ethical reasons, making them less competitive in the markets they serve.

The loss of the religious sector in the administration of non-profit hospitals serving the public, which an excessive regulatory frenzy would force, thus, would be a serious loss of efficient and creative health care in this country.

A. Institutionalized Health Care Ministries Are Protected Free Exercise of Religion

Since 1940 in *Cantwell v. Connecticut*,²⁹² the Supreme Court has compiled an impressive list of *activities* that it considers to be essentially exercises of religious faith, protected under the free exercise clause of the First Amendment. For example, the Court has protected as core exercises of religious belief the right to worship,²⁹³ the right to preach and disseminate religious literature,²⁹⁴ the right to donate, own and dispose of property for religious purposes,²⁹⁵ the right to provide for the education of children,²⁹⁶ the right to certify, ordain and assign ministers of religion,²⁹⁷ the right to organize religious communities,²⁹⁸ the right to conscientious objection to public policy decisions,²⁹⁹ and the fundamental right to belief and expression of belief.³⁰⁰ A religious hospital, in reality, is, for the sponsoring churches, the institutionalized *locus* of all these rights and functionalities. This list has been augmented in federal courts. Lower courts, indeed, have added further elucidations of public service as protected religious ministries. For example, recently the Federal District

292. 310 U.S. 296 (1940).

293. *Church of Lukumi Babalu Aye v. City of Hialeah*, 508 U.S. 520 (1993).

294. *Follett v. McCormick*, 321 U.S. 573 (1944); *Cantwell v. Connecticut*, 310 U.S. 296 (1940); repeated in dicta in *Texas Monthly v. Bullock*, 489 U.S. 1 (1989).

295. *Presbyterian Church in the United States v. Mary Elizabeth Hull Memorial Church*, 393 U.S. 440 (1969); *Jones v. Wolf*, 443 U.S. 595 (1979).

296. *Wisconsin v. Yoder*, 406 U.S. 205 (1972).

297. *Serbian Eastern Orthodox Diocese for the United States and Canada v. Milivojevic*, 426 U.S. 696 (1976).

298. *Kedroff v. St. Nicholas Cathedral*, 344 U.S. 94 (1952).

299. *Gillette v. United States and Negre v. Larsen*, 401 U.S. 437 (1971).

300. *United States v. Ballard*, 322 U.S. 78 (1944).

Court for the District of Columbia in *Westminister Presbyterian Church v. Board of Zoning Appeals*³⁰¹ held that feeding the hungry is a core religious exercise that can be curtailed by the state only to serve compelling state interests.

In addition to the *activities* listed, the Supreme Court has also listed a number of *organizations* that, while performing services that are also performed by secular organizations, are themselves considered pervasively religious. The list runs from parochial primary and secondary schools,³⁰² through publishing houses,³⁰³ even to gymnasiums.³⁰⁴ The lower courts have added newspapers³⁰⁵ and retirement homes.³⁰⁶ Both California³⁰⁷ and the state of Washington, until this time, have considered religiously affiliated hospitals³⁰⁸ and nursing homes as religious organizations.³⁰⁹

As we shall explain in the next section of this essay, Congress itself, in enacting the Church Amendment (the federal conscience clause) clearly intended to protect religious decisions in private religiously affiliated hospitals in health care where there may be some doubt about their constitutional protection.³¹⁰ That concern is now more attenuated, as free exercise protections have expanded since the early 1970s.³¹¹

Concurring in *Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*,³¹² Justice Brennan said in

301. 862 F. Supp. 538 (D.D.C. 1994).

302. See, e.g., *Lemon v. Kurtzman*, 411 U.S. 602 (1971); *Wolman v. Walter*, 433 U.S. 229 (1977); and *Aguilar v. Felton*, 473 U.S. 402 (1985).

303. *Texas Monthly v. Bullock*, 489 U.S. 1 (1989).

304. *Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327 (1987).

305. *Feldstein v. Christian Science Monitor*, 555 F. Supp. 974 (D. Mass. 1983).

306. *E.E.O.C. v. Presbyterian Ministries, Inc.*, 788 F. Supp. 1154 (W.D. Wash. 1992).

307. *Kelly v. Methodist Hospital of Southern California*, 22 Cal. 4th 1108, 95 Cal. Rptr. 2d 514 (2000).

308. See *City of Tacoma v. Franciscan Foundation*, 972 P.2d 566 (Wash. Ct. App. 1999).

309. *Farnam v. CHRISTA Ministries*, 807 P.2d 830 (Wash. 1991).

310. See *infra* Section V.C.

311. All "living wills" or advance health care directive statutes, as well as those providing durable powers of attorney for health care decisions, contain "conscience clauses," relieving health care professionals of the obligation to act against their conscientious beliefs. See *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 289 n.2-4. (O'Connor, J., concurring).

312. 483 U.S. 327 (1987).

specific reference to the religious motivation of non-profit activities of public service offered by church-related charities:

The risk of chilling religious organizations is most likely to a rise with respect to *nonprofit* activities. The fact that an operation is not organized as a profit-making commercial enterprise makes colorable the claim that it is not purely secular in orientation. In contrast to a for-profit corporation, a nonprofit organization must utilize its earnings to finance the continued provision of the goods or services it furnishes, and may not distribute any surplus to the owners. This makes plausible a church's contention that an entity is not operated simply in order to generate revenues for the church, but that the activities themselves are infused with a religious purpose. Furthermore, unlike for-profit corporations, nonprofits historically have been organized specifically to provide certain community services, not simply to engage in commerce. Churches often regard the provision of such services as a means of fulfilling religious duty and of providing an example of the way of life a church seeks to foster.³¹³

The standard First Amendment jurisprudence setting the definitional limits upon the content of the free exercise of religion may also be derived from the Supreme Court's direction in cases involving protected core manifestations of religious faith, such as preaching and solicitation, conscientious objection to war, the refusal of employees to work in violation of their religious conscience and the direct state abridgment of the right to worship.³¹⁴

The free exercise of religion is a personal right of individuals, as well as a collective right of individuals through the organizations they create as vehicles for cooperation in the expression of their religious faith.³¹⁵ Churches and church organizations, as well as individuals, are protected by the First Amendment's free exercise clause.³¹⁶

A careful re-read of the Supreme Court's decision in *Pierce v. Society*

313. 483 U.S. 327, 344 (1987) (emphasis in opinion).

314. *Church of Lukumi Babalu Aye v. City of Hialeah*, 113 S. Ct. 217 (1993).

315. See Frederick M. Gedicks, *Towards a Constitutional Jurisprudence of Religious Group Rights*, 1989 WIS. L. REV. 99 ; Liza W. Hanks, *Justice Souter: Defining 'Substantive Neutrality' In An Agenda of Religious Politics* 48 STAN. L.REV. 903 (1996).

316. See generally *Watson v. Jones*, 80 U.S. 679 (1872); *Kedroff v. St. Nicholas Cathedral*, 344 U.S. 94 (1952); *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Larson v. Valente*, 456 U.S. 228 (1982); *Church of Lukumi Babalu Aye v. City of Hialeah*, 508 U.S. 520 (1993).

of *Sisters*³¹⁷ in 1925, indicates that the basis of the Court's judgment that Oregon's law restricting parental rights to choose private religious schools for the education of their children is not an expansive disquisition on parental rights to control their children's schooling, such as might later be derived from a reading of *Wisconsin v. Yoder*,³¹⁸ nor was it the First Amendment's guarantee of the free exercise of religion by the Sisters of the Holy Names. It was, rather, that state monopolization of elementary and secondary school education violates the taking clause of the Fourteenth Amendment by abridging the rights of those owning and administering existing private schools. The Fourteenth Amendment in 1925 was undoubtedly applicable to the states. The Court said:

[A]ppellees asked protection against arbitrary, unreasonable, and unlawful interference with their patrons, and the consequent destruction of their business and property. Their interest is clear and immediate, within the rule approved . . . where injunctions have issued to protect business enterprises against interference with the freedom of patrons or customers.³¹⁹

Only in dicta do parental rights appear.³²⁰ The free exercise clause is hardly mentioned, because at that time application of the religion clauses of the First Amendment to the states was problematic.³²¹

If patients have a right to choose the health care providers they want and can afford, do they not also have the right to choose religious, private, non-profit health care institutions? Is this right any different than the parental right to choose the appropriate schooling of their children? Furthermore, if religion motivates the choice, is the choice not also protected under the free exercise provisions of the First Amendment against state burden or confiscation? Of course, it is. Conversely, no doubt, the choice would be meaningless if institutional care givers were

317. 268 U.S. 510 (1925).

318. 406 U.S. 205 (1972).

319. 268 U.S. at 536 (citations omitted).

320. The fundamental theory of liberty upon which all governments in this

Union repose excludes any general power of the state to standardize its children by forcing them to accept instruction from public teachers only. The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.

Pierce v. Society of the Sisters of the Holy Names of Jesus and Mary, 268 U.S. 510, 535 (1925).

321. The free exercise clause was applied to the states in *Cantwell v. Connecticut*, 310 U.S. 296 (1940).

prohibited by the state from exercising their religious conscience in matters of health care provision.

The suggestion urging monopolization and homogenization of institutionalized health care by the state is not only short-sighted, it would also violate the taking clause of the Fourteenth Amendment,³²² as well as the free exercise clause of the First Amendment, made applicable to the states by the Fourteenth. Under our federal constitution the state is limited to licensure, accreditation, enforcement of medical and health protection standards, and securing full and complete disclosure of hospital services.

Whether religious hospitals have a free exercise right to ethical autonomy as organizations in refusing to provide desired and legal medical procedures to the general public, however, may not be clearly evident from the history of judicial protection of either free exercise or challenging religious establishment individually. On the other hand, under the “hybrid” rights analysis the Supreme Court announced in *Employment Division, Department of Human Resources v. Smith*,³²³ and then affirmed in *City of Boerne, Texas v. Flores*,³²⁴ combining religious conduct with another or other constitutionally-protected rights, such as freedom of association, the constitutionally-protected liberty interest in privacy and informed consent, may bring medical-moral decisions under the strict scrutiny test of the free exercise clause of the First Amendment. This would require a compelling state interest and least restrictive means justification for significant burdens placed by the state upon religious hospitals’ ethically prohibitive choices.³²⁵

The religious choices of patients to select health care providers must be respected. This axiom is as true as is the choice by adults of prescribed medical services. Any new service alignment or structural change in the institutions providing health care must ensure that members of the public have access to services which respect their own religious beliefs. This, I take it, is the radical public policy purpose behind the “conscience clauses,” to protect both institutional and personal choices of conscience.

Persons have a First Amendment right under the free exercise clause to chose religious organizations for their health care needs, as well as for

322. “[N]or shall any State deprive any person of life, liberty, or property, without due process of law.”

323. 494 U.S. 872 (1990).

324. 521 U.S. 507 (1997).

325. See Heather L. Carlson, *Freedom At Risk: The Implications of City of Boerne v. Flores On the Merger of Catholic and Non-Catholic Hospitals*, 17 ST. LOUIS U. PUB. L. REV. 157-181 (1997).

their collateral religious decisions. While federal and state regulatory compliance rules in programmatic funding plans must be followed by all providers, the radical right to a religious ambience for medical care is unquestioned.³²⁶

If conscientious health professionals are coerced into violating their religious conscience either by state regulation or by the pressures of the market, it is likely that they will abandon or sell their hospitals. While religious ministry to the sick and dying will remain as a voluntary service in hospitals by patient demand, institutionalized health care ministry in the private sector will cease to exist. This would be an incalculable loss to the country.

Private, disaffiliated acute care facilities competing nose to nose with the for-profit sector would not last long without the stimulus to sacrifice provided by transcendent faith commitment. The end result would be a for-profit health delivery system for those who could afford the insurance premiums and a public health system for the poor. Private charity would have disappeared from that area of social interaction which historically was quintessentially and definitionally "charity" itself.

Standardization of health care by running roughshod over the individualized religious sensitivities of health care professionals will assure the pullout of the voluntary sector. This, I believe, will destroy a vitally important part of this society. Maintenance and protection of the rights of conscience of religiously-motivated health care providers is a compelling state interest. There is no equally compelling state interest in destroying this right.

The recent jurisprudence of the Supreme Court in the matter of patients' rights, in fact, strengthens the argument for the religious ministry of care for the sick by putting it into the category of a core exercise of faith protected by the First Amendment. This appears, not so much in the case law involving institutions, such as seen in the parochial school cases, but, rather, in the case law forming around patients' rights, particularly the right to determine medical care or its withdrawal in end-of-life situations.³²⁷

B. Corporate Configurations Masking the Private Religious Mission

What does a religious hospital look like? A generation ago the question would have been facetious. When federal and state conscience

326. See *Children's Healthcare Is a Legal Duty, Inc. v. Vladeck*, 938 F. Supp. 1466 (D. Minn. 1996) (Christian Science exemption from several Medicare requirements may violate the Establishment Clause).

327. See *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990).

clauses were first enacted to protect the moral choices of health care professionals, the definition of a “religious” hospital was unnecessary. The answer was obvious. Today the question preoccupies state and federal legislators and judges. The religious identity of private hospitals a generation ago was apparent in their names, public display of religious symbolism, uniformed personnel, chapels and prominent religious services. The persons who had given their lives to the religious ministry to the sick in all the churches were esteemed members of faith communities; their calling attracted thousands of the most idealistic and generous women and men. Today vocations are few, average ages are rising, and the visibility of religious personnel in the hospitals is dimming.

The buildings that housed the religious ministry of that time have now been torn down and replaced with faceless mirrors of replicative hospital architecture, cookie-cutter business boxes; meditation rooms replaced chapels; billing and records offices employ crowds of clerks; medical technology and treatment efficiencies have abbreviated hospital stays; chaplaincies are ecumenical and, sometimes, part-time. Costs, competition, the budget constraints of public programs such as Medicare and Medicaid, advanced scientific and technical progress, marketing and public relations needs, and increased public involvement, however, are not the only factors responsible for changes in the facade of the private religious hospitals. More important, I believe, has been the consistent attempt by private religious hospitals to separate themselves out from their pervasively religious sponsors, so that they may continue to qualify for federal and state loan, financing and contract program funding without running afoul of a serious Establishment Clause challenge. With Medicare and Medicaid in 1965, added to already-existing federal and state construction and financing programs in place to subsidize hospital construction, there was a real concern in the late 1960s that religious hospitals would be disqualified constitutionally from participation. Pervasively-religious elementary, secondary and higher education were about to lose any chance of public assistance in the Supreme Court.³²⁸

In order to preserve federal funding, hospitals were advised to expand their boards of directors to seek broader public participation, open their hiring policies for staff and administration and blunt the religious imagery to dampen the appearance of religious influence. The Supreme Court’s precedent, set in the last century in *Bradfield v. Roberts*,³²⁹ provided authority for private religious hospitals to keep a religiously-motivated

328. See e.g., *Horace Mann League v. Board of Public Works*, 220 A.2d 51 (Md. 1966).

329. 175 U.S. 291 (1899).

ministry while at the same time garnering public funds for health care services as a secular benefit to society.

The financial life of the hospitals depended not only on scientific progress and administrative efficiencies; it depended also on their continuing qualification to share in the rich stream of money coming from federal and state agencies and programs. This story needs to be retold briefly to understand how the religious hospitals that have survived have grown in professional excellence and esteem as public benefit corporations, while at the same time seeing their success mixed with a very worrisome loss of public understanding of their essentially religious ministries of love and concern for the sick and the poor.

In 1899 the Supreme Court decided affirmatively the constitutionality of public funding of private, religiously affiliated hospitals in *Bradfield v. Roberts*.³³⁰ In so doing, the Court set precedent for the legal nature of the hospital corporation. The legal character of the corporation is derived, the Court held, from the law of its incorporation, its charter, by-laws and the law of the incorporating state or jurisdiction, not from the nature of the sponsoring religious denomination.

Federal funds had been used to build a wing of Providence Hospital in the District of Columbia. The hospital was conducted by the Daughters of Charity, a religious congregation of women of the Roman Catholic Church. Answering a challenge to the constitutionality of the grant under the Establishment Clause, the Supreme Court in an opinion written by Justice Rufus Peckham stated:

Whether the individuals who compose the corporation under its charter happen to be all Roman Catholics, or all Methodists, or Presbyterians, or Unitarians, or members of any other religious organization, or of no organization at all, is of not the slightest consequence with reference to the law of its incorporation, nor can the individual beliefs on religious matters of the various incorporators be inquired into. Nor is it material that the hospital may be conducted under the auspices of the Roman Catholic Church . . . That fact does not alter the legal character of the corporation, which is incorporated under an act of Congress, and its powers, duties and character are to be solely measured by the charter under which it alone has any legal existence.³³¹

The corporation itself is governed by the internal law of its incorporation under the laws of the state in which it has its legal existence.

330. *Id.*

331. *Id.* at 298.

The Court added:

This corporation “is not declared the trustee of any church or religious society. Its property is to be acquired in its own name and for its own purposes; that property and its business are to be managed in its own way, subject to no visitation, supervision or control by any ecclesiastical authority whatever, but only to that of the Government which created it.”³³²

Thus, regardless of the faith commitments of administration and staff to a religious ministry to the sick, hospitals as such were considered secular entities performing similar services.

The hospital is an entity separate from the church or religious order which operates it. The corporate assets and properties belong to the hospital itself, and not to the sponsoring church. Thus, a hospital operated “under the auspices of a church” is not a church itself, nor is it pervasively religious. The religious faith of the hospital staff was a private matter, of which the courts need take no cognizance.

The Supreme Court ruled in *Bradfield* that the Establishment Clause was not violated by a grant of public funds to a hospital managed under the auspices of a church. *Bradfield* remains unchallenged in the First Amendment jurisprudence of the Supreme Court and has been cited 239 times for the proposition that church-related hospitals are public benefit corporations, unlike the churches themselves, which are primarily religious in character.³³³ Incorporation of a hospital under state law subjects the governance of the hospital to state law, and, thus, to some extent separates it from the pervasive control of church law and ordinances.³³⁴ The corporation essentially is a public benefit corporation, sponsored by a church, administered by its own law and cognizable on a “neutral principles” basis by the civil courts.³³⁵ Thus, there is a clear legal difference between a public benefit corporation administered under the auspices of a church and a religious organization as such. The use of the denominational name by the corporation is not legally conclusive of its nature.

Bradfield v. Roberts established an unbroken precedent, putting health

332. *Id.* at 299.

333. *See, e.g.,* *Simkins v. Moses H. Cone Memorial Hosp.*, 323 F.2d 959 (4th Cir. 1963); *Lynch v. Spilman*, 431 P.2d 636 (Cal. 1967); *Seale v. Jasper Memorial Hosp. Foundation*, 1997 Tex. App. LEXIS 5248 (1997) (WL 606857 (Tex. App)).

334. JOHN J. McGRATH, *CATHOLIC INSTITUTIONS IN THE UNITED STATES: CANONICAL AND CIVIL LAW STATUS* (1968).

335. *Jones v. Wolf*, 443 U.S. 595 (1979). *See also Hazen v. Catholic Credit Union*, 681 P. 2d 856 (1984); *cf. Farnam v. Crista Ministries*, 807 P. 2d 830 (1991).

care ministry into a different dimension of legal classification than the religious services of churches, parochial schools, shelter facilities, etc. *Bradfield's* depiction of medical care as secular service, and incorporated hospitals as secular entities, was essential for the justification of massive amounts of federal and state funds that went into private hospital construction under the Hill-Burton Act and subsequently, as well as the administration of tax-funded programs through the private religious sector in health care.

Because of *Bradfield* and its consistent subsequent citation, religious hospitals both qualified as recipients of governmental funding, and became subject to employment discrimination statutes without general exemption. The business of religious hospitals, in public terms, came to be more closely parallel to that of commercial counterparts, not the churches. It is for this reason that special statutory protections for religious hospitals and their ethical choices became necessary and were enacted by the Congress and the states in the middle 1970's as the "conscience clauses".

The use of secular nonprofit incorporation statutes to separate out public benefit institutions operated by the churches, therefore, created entities of a mixed classification. They remain subject to the canon law and ordinances of the church from the vantage point of the church itself, as it may enforce by consensual arrangements the discipline of its own faith and belief. In the eyes of the law, however, such corporations are not wholly religious entities in character and operation. Without control of religious identity in general hiring, the hospitals have developed physician, nursing and administrative staffs, in many cases, lacking in personal loyalty to the doctrinal beliefs of the sponsoring churches.

Where nonprofit charitable corporations are funded almost entirely by fee-based services, and are recipients of federal, state and local government programs, and where these same organizations are required by public regulations to serve the public on a nondiscriminatory basis, the corporations are clearly different from the parishes, synagogues, religious orders and religious training institutions of a strictly religious nature of the denomination itself. They are technically nonprofit charitable corporations operated *under the auspices of the churches* as affiliated sponsoring bodies, not owned by the churches as such.

From the point of view of the state, public benefit corporations fulfill a primarily secular purpose in serving the needs of society and, thus, from the government's viewpoint are secular in nature. Thus, when Congress enacted the Hill-Burton Act in 1946 to provide federal funding for

hospital construction³³⁶ constitutional objections to the use of these funds by religious hospitals had already been resolved.

From the vantage point of the church itself, however, hospitals remain permeated with religious values and vital parts of the churches' overall religious mission to the world. The services they perform are religiously motivated; the loyalty they retain to the moral values of the church sponsor is deeply treasured, but not unquestioned. Most hospitals and acute-care health services facilities, such as hospices and long-term convalescent organizations related to the churches are really mixed corporations.

With these general principles in mind religious hospitals began a major corporate reconfiguration in the 1970s, which continued with amendments and restructuring alterations through the 1980s. Because of perceived threats to their continuing ability to contract for public services, receive public funds and undertake federally-subsidized research and training programs,³³⁷ the endangerment of religious assets due to exposure to liability suits with the decline or demise of charitable immunity protections,³³⁸ and the need to enlarge their boards of directors to include community leaders with expertise in health-care administration and fund-raising, the hospitals began to metamorphose through various forms of corporate reorganization.³³⁹ This has significantly altered their religious appearance.

Concern that religious hospitals could be lumped together with

336. The Hospital Survey and Construction Act of 1946, 78 Stat. 447, 42 U.S.C. §§ 291 *et seq.* (1964).

337. Four major federal funding programs were of interest to the hospitals: 1) The Hospital Survey and Construction Act of 1946 (Hill-Burton Act), 42 U.S.C. §§ 291 (1964) (providing construction grants and low-cost, long term federally-guaranteed loans for hospital construction and improvement), augmented and refined by the National Health Planning and Resource Development Act of 1974, 42 U.S.C. §§ 300(o)-(t); 2) the Medicare and, later, Medicaid, Act, 42 U.S.C. §§ 1396 *et seq.*, providing federal funds in terms of contracted services; 3) the Social Security Disability Act, §§ 401 *et seq.*; and 4) the Research Appropriations Acts, 42 U.S.C. §§ 280b *et seq.* providing research and training funds to hospitals under various of the programs operated by the Department of Health and Human Services.

338. See EDWARD GAFFNEY ET AL, ASCENDING LIABILITY IN RELIGIOUS AND OTHER NONPROFIT ORGANIZATIONS (1984).

339. This "incorporation" movement is chronicled with particular emphasis upon institutions of higher education by J. R. Preville, *Catholic Colleges, the Courts and the Constitution: A Tale of Two Cases*, 58 CHURCH HISTORY 204 (1989).

parochial schools³⁴⁰ and religious colleges and universities³⁴¹ by a skittish and not-too-predictable Supreme Court was not allayed by the Court's decision in *Tilton v. Richardson*³⁴² and Chief Justice Burger's majority decision, which almost verbatim paralleled *Bradfield v. Roberts*³⁴³ in application of the separate incorporation principle to colleges and universities. As vast amounts of money were needed to sustain quality, perceived as coming primarily from governmental sources, the hospitals themselves saw an urgency in separate, expanded incorporation to create independent public benefit corporations that would reflect the community constituencies upon which they depended.³⁴⁴ Not only the Hill-Burton Act,³⁴⁵ by now running the course of its legal existence, but the adoption of Medicare as a part of the Social Security System in 1965³⁴⁶ could be disallowed religious hospital participation if the hospitals appeared to be too narrowly religious and exclusionary. Hospital construction and financing had gone public. Even religious hospitals were no longer "pervasively sectarian" in structure or constituencies, so could share in the provision of publicly-funded medical service contracts and programs.

In hospitals and shelter facilities,³⁴⁷ the twin civil exigencies of accommodation for public funding and protection from civil liability

340. See, e.g., *Everson v. Board of Education*, 330 U.S. 1 (1947); *Lemon v. Kurtzman*, 403 U.S. 602 (1971); *Committee for Public Education and Religious Liberty v. Regan*, 444 U.S. 646 (1980).

341. *Horace Mann League v. Board of Public Works*, 220 A.2d 51 (Md. 1966).

342. 403 U.S. 672 (1971) (holding the Higher Education Facilities Act of 1965, as modified, constitutional as applied to religiously affiliated higher education).

343. 175 U.S. 291 (1899).

344. In this setting the Catholic Hospital Association was instrumental in obtaining a grant from the Danforth Foundation to fund a study of the juridic nature of civilly incorporated charitable institutions conducted under church auspices. That study was published in 1968 by John J. McGrath, who had joint appointments to the School of Law and the School of Canon Law of the Catholic University of America as *CATHOLIC INSTITUTIONS IN THE UNITED STATES: CANONICAL AND CIVIL LAW STATUS* (1968). McGrath concluded that charitable corporations administered under church auspices were essentially civil, not religious entities. McGrath suggested that the religious affiliation of the corporation could be retained only by quorum provisions in corporate charters to permit board and officer selection from among members of the sponsoring religious bodies, who could permeate the "spirit" of the corporation by their personal faith.

345. See *supra* note 205.

346. 42 U.S.C. §§ 301 *et seq.*

347. See *Arneith v. Gross*, 699 F. Supp. 450 (1988); *Wilder v. Bernstein*, 848 F.2d 1338 (2d Cir. 1988).

merged. To address these demands religious hospitals opened up their staffing and admissions policies, as well as reconfigured their directing boards of trustees, and set new qualifying criteria for high administrative offices, open to lay men and women, not always of the church membership, as ways of making themselves more attractive to the public and constitutionally more acceptable to receive public funding.³⁴⁸

Hospitals, unlike churches and their closely-related primary and secondary schools,³⁴⁹ fell under the jurisdictional expansion of the National Labor Relations Board in the 1970's. Courts held the unionization of hospital staff and professional medical personnel did not involve sensitive religious burdens as would state entanglement with the education of children.³⁵⁰

Similarly, the proliferation of federal and state decisions applying Title VII anti-discrimination in employment standards³⁵¹ to religious hospitals effectively crippled the private hospitals in their ability to make employment and retention decisions with a view towards retaining their religious identity. To this extent the hospitals were clearly without privilege, as distinguished from the churches themselves.³⁵²

The result of this re-incorporation movement was not only to prepare the hospitals to take part in the mergers and developing systems of the present. It was also to make them less religiously homogeneous than they had been in the past. Hiring policies, board memberships and even hospital chaplaincies and chapel services have become more attuned to their secular counterparts in public and non-profit hospitals.

The re-incorporation movement, separating hospital facilities as independent corporations from their sponsoring religious bodies, and

348. The criteria laid down by the Supreme Court for disposition of funds under the Higher Education Facilities Act of 1965 in *Tilton v. Richardson*, 403 U.S. 672 (1971), namely, that public monies can only be used for secular purposes, i.e., not construction or subsidy for chapels, chaplaincies or religious services and that the facilities be open and available to the public on a nondiscriminatory basis, set parallels in the uses of public funds by private hospitals. The key seems to be the "pervasively sectarian" complexion of institutions disallowed public funding under the Establishment Clause.

349. *National Labor Relations Board v. Catholic Bishop*, 440 U.S. 490 (1979).

350. *See Beth Israel Hosp. v. NLRB*, 437 U.S. 483 (1978); *supra* note 58.

351. Title VII is Section 700 *et seq.* of the Civil Rights Act of 1964, containing the prohibitions against unfair labor practices including discrimination in employment based on race, national origin, or ethnicity, religion, sex or, later, disability. 42 U.S.C. §§2000 *et seq.*

352. *See Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327 (1987).

dampening religious symbolism and religious control in hiring to meet public construction loan and programmatic conditions, in just one generation, has hidden the religious ministry to the sick behind bland neutral facades. For prospective hospital patients and insurance purchasers today it is not always easy to distinguish a religious hospital from another private, community or, in many cases, commercial health care franchises. The building and the billing lack the lofty compunction of faith and the symbolism of disinterested love.

C. Conscience Clauses: A Limited Legislative Pre-Condition to a Free, Competitive and Pluralistic Health Care Market

Whether the free exercise clause of the First Amendment required the state to accommodate the religious beliefs of cooperating individuals by exemptions to facially-neutral state laws imposing substantial burdens on that belief, or whether such accommodations were matters of prudence and legislative choice, a theory currently espoused by the majority of the Supreme Court in *Smith*,³⁵³ and carried over but not expressly affirmed in *Flores*,³⁵⁴ conscience clause exemptions for religiously-motivated moral choices by private church-related hospitals were necessary for the healthy maintenance of a free, competitive and pluralist health care system overall.

The “conscience clauses” of federal and state provenance began to appear in the early 1970’s when three converging factors in publicly-available religiously affiliated health care became operative. These factors were: 1) The loss of obvious religious symbolism and structures in hospital construction funded largely out of federal monies available through the Hill-Burton Act; 2) the expansion of hospital governance boards under the impetus of the ecumenical movement and local support imperatives; and 3) shifts in scope of service from local, faith-based communities to the general public by hospital personnel no longer obviously cloaked in religious habits and symbolism. Religious hospitals, and related health care institutions, particularly the almost 2000 affiliated with the Catholic Health Association, changed administrative modalities, reached out to the public and became less obviously religious.

In 1973 the Federal District Court for Montana in *Taylor v. St. Vincent’s Hospital*³⁵⁵ enjoined a Catholic hospital from refusing to allow

353. *Employment Division, Dep’t. of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990).

354. *City of Boerne, Texas v. Flores*, 521 U.S. 507 (1997).

355. 369 F. Supp. 948 (D. Mont. 1973). Earlier patient challenges to hospital refusals to provide reproductive health services had been directed at public hospitals. See generally, *McCabe v. Nassau County Medical Ctr.*, 453 F.2d 698

post-partum tubal ligation procedures in its facilities.³⁵⁶ Under the sponsorship of Senator Frank Church (D. Idaho), Congress responded quickly to the request of several church-related hospital systems by enacting legislation, generally known as the federal "Conscience Clauses," or the Church Amendment.³⁵⁷ The Conscience Clauses initially protected hospital recipients of federal funds and their staffs from being required to participate in abortion or sterilization procedures that conflict with the providers' religious or moral beliefs.³⁵⁸

One year later, Congress expanded the Conscience Clauses to permit a health care provider to refuse to perform any health services or research that conflicts with personal religious or moral beliefs. The federal statute, in its broadest form, now reads:

No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.³⁵⁹

The 1974 amendment extended the scope of the protective clauses to health care providers receiving funds under any program administered by the Secretary of Health and Human Services.³⁶⁰

The legislative history of the federal conscience clause exemption reveals two basic suppositions in the law: 1) that the exempt medical decisions are genuine products of religious beliefs or moral convictions; and 2) that the conscience clauses protect medical personnel from constraints forced upon them by courts, public officials or other public

(2nd Cir. 1971) (patient suing public hospital for refusal to sterilize her on her request); *Doe v. Pickett*, 480 F. Supp. 1218 (S.D. W. Va. 1979) (suit against public health services for denying birth control services to minors without parental consent); *Doe v. Mundy*, 378 F. Supp. 731 (E.D. Wis. 1974) (suit against county hospital for refusal to permit elective abortions).

356. *Taylor*, 369 F. Supp. 948.

357. 42 U.S.C. § 300a-7 (1988).

358. 42 U.S.C. § 300a-7(b),(c) (1988). After Congress passed the Church Amendment the district court in Montana dissolved its injunction. The Ninth Circuit Court of Appeals affirmed. *Taylor v. St. Vincent's Hosp.*, 523 F.2d 75, 78 (9th Cir. 1975). A later case instituted by several women to force a religious hospital to provide sterilization services was dismissed on summary judgment in favor of the hospital. *Ham v. Holy Rosary Hospital*, 529 P.2d 361 (Mont. 1974).

359. 42 U.S.C. § 300a-7(d).

360. *See also* 42 U.S.C. § 300a-7(e).

authority.³⁶¹ Patients' requests for exempt services are not in any way privileged.

A careful review of the later-enacted corresponding state exemption statutes including hospitals as such along with individuals, and elimination of the federal funding limitations, reveals a uniform condition that the hospitals be religious or church-related. There are no exemptions for for-profit health care organizations or secular facades that serve as cultural or residual appendages of churches shielding commercial enterprises. Nor is the issue of monopolized community healthcare even addressed in generalized legislation that is nearly a quarter of a century old.

The constitutionality of the federal conscience legislation under the Establishment Clause of the First Amendment was upheld by the Ninth Circuit Court of Appeals in *Chrisman v. Sisters of St. Joseph of Peace* that same year.³⁶² The right of a religious hospital to refuse staff privileges to a doctor to perform abortions in the hospital was upheld by the Ninth Circuit in *Watkins v. Mercy Medical Center*.³⁶³ The right of a nurse to obtain compensatory and punitive damages, as well as attorney fees, under a state conscience clause for having been demoted and harassed by a hospital administration for her refusal to participate in abortions was vindicated by the Florida Court of Appeals in *Kenny v. Ambulatory Centre of Miami*.³⁶⁴

Following the lead of Congress, forty-four states adopted their own conscience clauses to protect health care providers from being required to provide services that conflict with their religious and moral beliefs.³⁶⁵ Twenty-eight states provide protection only in refusing to perform abortions. Nine states cover abortion and contraception. Five states provide cover against patient demands for abortion and sterilization. One state protects refusal of abortion, contraception, sterilization, euthanasia and similar practices. One state's conscience clause mentions abortion, sterilization, and artificial insemination. Illinois provides comprehensive protection to religiously affiliated hospitals against patient or public

361. See §§ 300a-7(b),(c).

362. 506 F.2d 308 (1974) (Hill-Burton Act hospital recipients are not required to perform sterilization). *Chrisman* was later interpreted in *Wisconsin Health Facilities Authority v. Linder*, 280 N.W. 2d 773 (1979), as having held that hospital recipients of Hill-Burton funds are not required to perform sterilization or abortions.

363. 364 F. Supp. 799 (D. Idaho 1973) (the doctor's argument that hospital refusal was a deprivation of his constitutional rights failed).

364. 400 So. 2d 1262 (Fla. App. 1981).

365. See Wardle, *supra*, note 6.

demands for all morally objectionable medical procedures.³⁶⁶

Among state statutes most cover both individuals and institutions. A minority protect only individual health care professionals. For those that protect or mention institutions, some only cover hospitals, while a minority of statutes cover only private, not public, health-care providers.³⁶⁷

In 1977 the United States Supreme Court in *Poelker v. Doe*³⁶⁸ held that a city-owned public hospital was not required to fund nontherapeutic abortions for indigent women.

The Supreme Court upheld the Hyde Amendment,³⁶⁹ which refused to provide federal funds to pay for abortions under "Medicaid," in *Harris v. McRae* in 1980.³⁷⁰

The fate of federal and state conscience clauses in the lower courts has been uncertain. In some cases they have received strict or even hostile interpretations. For example, the California Court of Appeals held in *Erzinger v. Regents of the University of California* that the federal conscience clause protects only persons directly and immediately involved in abortion services.³⁷¹ Thus, the University of California could require students to participate in a comprehensive health-care program that included provision for abortions. The Court noted:

The crucial words [in the federal conscience clause] are "performance of abortions or sterilizations." The proscription applies when the applicant must participate in acts related to the actual performance of abortions or sterilizations. Indirect or remote connection with abortions or sterilizations are not within the terms of the statute.³⁷²

Likewise, in *Spellacy v. Tri-County Hospital*,³⁷³ a Pennsylvania court held that a part-time admissions clerk who claimed that she was fired by the hospital as a result of her refusal to participate in the admission

366. *Id.* at 179-180.

367. *Id.* at 182-184.

368. 432 U.S. 519 (1977).

369. Pub. L. No. 96-123, 93 Stat. 923, 926 (1979).

370. 448 U.S. 297 (1980). In a companion case to *McRae*, *Williams v. Zbaraz*, 448 U.S. 358 (1980), the Court upheld an Illinois statute prohibiting state medical assistance payments for all abortions except those necessary to preserve the life of the woman.

371. 137 Cal. App. 3d 389, 187 Cal. Rptr. 164 (1982).

372. *Id.* at 394.

373. 18 Empl. Prac. Dec. (CCH) § 8871 (Pa. C.P. De.Cty), *aff'd*, 395 A. 2d 998 (Pa. 1978).

procedures of abortion patients was not protected by the state's conscience clause because her position was one of mere "ancillary" or "clerical" assistance.

In California a rape victim sued a private religious hospital because it refused to provide her with information about the "morning-after" pill.³⁷⁴ The court declined to apply the state's conscience clause³⁷⁵ because it opined that the pill was not an abortifacient, notwithstanding the weight of medical testimony to the contrary.

The New Jersey Supreme Court in 1976 in *Doe v. Bridgeton Hospital Association*³⁷⁶ held that private, nonreligious hospitals may not refuse to allow first trimester elective abortions. The Court reasoned that the three private nonprofit hospital defendants, as nonprofit institutions, were organized to serve the general public and could not discriminate in the provision of their services. The Court held that New Jersey's conscience clause did not apply to nonsectarian private hospitals.³⁷⁷

Public hospitals and their professional staffs were stripped of their protection by the First Circuit Court of Appeals in *Doe v. Hale Hospital*,³⁷⁸ stating that the policy of a public hospital that totally prohibited elective abortions violated the privacy rights of women who wanted first trimester abortions. In *Gray v. Romeo*,³⁷⁹ the federal district court in Rhode Island held that employees of a health care institution did not have a federally protected right to refuse to participate in the court-ordered withdrawal of a feeding tube and life support system from a patient, because the federal conscience clause applied only to participants in federal health service programs. The Fourth Circuit Court of Appeals in *Doe v. Charleston Area Medical Center*³⁸⁰ refused to protect a community hospital under the federal conscience clause because it held the hospital had not proved its objections to elective abortions were based

374. *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405, 256 Cal. Rptr. 240 (1989).

375. CAL. HEALTH & SAFETY CODE § 25955.(West 1999).

376. 366 A.2d 641 (N.J. 1976).

377. The court cited dicta from Justice Blackmun's strict interpretation of the Georgia conscience clause in *Doe v. Bolton*, 410 U.S. 179, 197-98 (1973): "These provisions obviously are in the statute in order to afford appropriate protection to the individual and the *denominational* hospital." (emphasis added). Georgia's statute contained no such limitation.

378. 500 F. 2d 144 (1st Cir. 1974).

379. 697 F. Supp. 580 (D.R.I. 1988).

380. 529 F.2d 638 (4th Cir. 1975).

on moral grounds.³⁸¹

*Hodgson v. Lawson*³⁸² in the Eighth Circuit was a case dealing with a state conscience clause which was part of a larger challenge by physicians and patients who argued that Minnesota's abortion law was unconstitutional. Although the case focussed mostly on abortion guidelines and procedures, the Eighth Circuit held that the state conscience clause applied only to private hospitals, and not to public hospitals. The conscience clause stated: "No *person* or hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist, or submit to an abortion for any reason."³⁸³

Besides stating that public hospitals must perform abortions, the court, in a footnote, recognized the well-established principle that the receipt of public funds alone does not change a private hospital into a public hospital.³⁸⁴ Therefore, in this case the private hospital was not required to perform abortions.

The most recent case in this line, however, is *Valley Hospital Ass'n v. Mat-Su Coalition for Choice*,³⁸⁵ in which the Supreme Court of Alaska upheld a permanent injunction against a non-religious, non-profit hospital which had adopted a policy prohibiting abortions at the hospital. The Court held the hospital was a quasi-public entity because it operated under a state certificate of need program, received construction and operating funds from the state, was the only hospital in the local community and its board was elected by a public membership. As a quasi-public entity the hospital could be liable under state action principles for depriving citizens of their constitutional rights. The court noted that the Alaska constitution protects reproductive autonomy more broadly than does the federal constitution and the hospital's policy prohibiting abortions violated the fundamental state right to privacy. Since Valley Hospital Association was *not affiliated with any religious denomination*, it could not raise a free exercise defense or claim the

381. See also the two dissenting opinions in the Montana Supreme Court's case, *Swanson v. St. John's Lutheran Hospital*, 597 P.2d 702 (Mont. 1979), in which a wrongful termination suit was won by a nurse refusing to participate in hospital sterilization and abortions. For a contrary holding, see *Free v. Holy Cross Hospital*, 505 N.E.2d 1188 (Ill. App. 1987) (nurse discharged for refusal to evict a bedridden patient on what the court terms "emotional," not religious grounds).

382. 542 F.2d 1350 (8th Cir. 1976).

383. *Id.* at 1356 (emphasis added).

384. *Id.*

385. 948 P.2d 963, 965-73 (Alaska 1997).

protection of the state conscience clause.

In 1991 the New Jersey Supreme Court in *Hummel v. Reiss*³⁸⁶ in dicta suggested that a religious hospital may have an obligation to discuss abortion with a patient in the context of genetic counseling and, then, on advice of her physician, provide transfer services to other facilities for the patient-requested abortion. The *Hummel* court intimated 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 are contrary to the hospital's religious and moral standards. The Court grounded its assertion on the common law doctrine of informed consent, i.e., the professional health care provider's common law duty to obtain a competent patient's informed consent before commencing treatment.³⁸⁷

Protection of the rights of health care professionals and institutions of their religious and moral choices cannot depend in the future upon the courts' interpretation of local conscience clauses or the applicability or scope of the *Smith-Flores* standards. It must involve state and federal legislation to secure against patient demands all morally objectionable procedures and services that offend the religious conscience of providers.³⁸⁸

On that note, let it be clear that the conscience clauses and the case law interpreting them are directed to the protection of "religious" hospitals, and to the integrity of moral choices by objecting individuals. In neither federal nor state statutes is there a general safeguard of public, secular or commercial hospitals.

VI. THE COUNTERVAILING PRINCIPLE: THE PATIENT'S RIGHT TO FREE AND INFORMED CHOICE

Religious exemptions that are institutional in nature cannot remain absolute if the reality behind names and affiliations becomes increasingly less religious, less charitable and more monopolistic than when exemptions first were granted. Put another way, church-related hospitals and acute care facilities risk loss of moral autonomy the more secular, the larger, the more monopolistic and the more commercial they become.³⁸⁹ The reason for this is that the institutional right to limit the choice of medical services provided is directly correlated to patients' rights

386. 589 A.2d 1041 (N.J. Super. Ct. App. Div. 1991).

387. See PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 57 (1987).

388. See Wardle, *supra* note 6, at 219-230.

389. THE CATHOLIC HEALTH ASS'N, *supra* note 111.

meaningfully to choose care providers.³⁹⁰

Aside from the obvious inequity in HMO contracts enrolling persons induced to pay for health care insurance plans covering medical services and procedures in provider hospitals that subsequently refuse to provide these services, or, indeed, contract them out to other providers, the largest incentive to reexamination of the limitations upon choice contained in the conscience clauses is the counterbalance of patients' rights to free and informed choice.³⁹¹

Patient autonomy derives from the accepted philosophical premise of our democratic form of government that each human being is individual, free and has the fundamental right (whether derived from God, natural law, or other basis) to control his or her own person, so long as that person's acts do not interfere with others.³⁹² The law recognizes self-determination in the health care context through the doctrine of informed consent,³⁹³ as well as under the protected individual liberties enumerated under the Fourteenth Amendment.³⁹⁴ These principles empower the individual patient to control the decisions made about his or her medical care.³⁹⁵ The right to control individual medical decisions extends even to the point of refusing life-sustaining treatment to the point of death.³⁹⁶

The principle of informed consent is the very linchpin of medical ethics today. "Consent implies freedom from any external and internal compulsion," as the *Health Care Ethics Code* of the Catholic Health Association of Canada says.³⁹⁷ "Informed consent exists when an individual possesses the competence, freedom and information required in order to make a reasonable decision for her or his own best interest."³⁹⁸

390. Thomas R. Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 NOTRE DAME L. REV. 639-670 (1996).

391. See Susan M. Wolf, *Toward A Systemic Theory of Informed Consent in Managed Care*, 35 HOUS. L. REV. 1385, 1631 (1999).

392. See JOHN STUART MILL, ON LIBERTY 13 (ed. Stefan Collini, 1989) (1859).

393. See ALAN MEISEL, THE RIGHT TO DIE, 15 (2d ed. 1995).

394. *Cruzan v. Director, Missouri Dep't. of Health*, 497 U.S. 261, 286-87 (1990).

395. PAUL S. APPLEBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987); Ruth R. Faden & Tom L. Beauchamp, A HISTORY AND THEORY OF INFORMED CONSENT (1986).

396. *Cruzan*, 497 U.S. at 261; *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990).

397. CATHOLIC HEALTH ASSOC. OF CANADA, HEALTH CARE ETHICS CODE 71 (1991).

398. See also ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 48, Directives 26, 27.

Informed consent is the counterpart of the principle of self-determination, lying at the very heart of the American legal system. Perhaps the most rigorous tests of self-determination we have experienced in recent years, and the most clear and, indeed, poignant articulation of its centrality in medical ethics is found in situations where the patient's will is not explicit. The most dramatic examples of the great pains courts will take and legislatures will mandate³⁹⁹ may be the right-to-die cases, when authorities struggle to ascertain what a person who has become incompetent would want others to do to care for her. The Supreme Court addressed the constitutionality of Missouri law providing procedure and clear and convincing evidence standards to find out the preference of a person who had lost the capacity to articulate that preference in *Cruzan v. Missouri Department of Health*.⁴⁰⁰ The Court said:

[T]he choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. . . . A State is entitled to guard against potential abuses in such situations⁴⁰¹

Similarly, in the two right-to-die cases decided in 1997, *Vacco v. Quill*⁴⁰² and *Glucksberg v. Washington*,⁴⁰³ the Supreme Court expressed a serious concern for the free and informed choices of terminally-ill patients before the pressure of outside forces. Once again the Court said:

[t]he State has an interest in protecting vulnerable groups--including the poor, the elderly, and disabled persons--from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician-assisted suicide as 'ludicrous on its face'. We have recognized, however, the real risk of subtle

399. A list of state by state informed consent statutes until 1991 is found in Leonard J. Nelson, III, *Informed Consent*, 2 MEDICAL MALPRACTICE, 22.11 (David W. Louisell & Harold Williams, eds., 1987). See also, *Cruzan*, 497 U.S. 261, at 290-91 (O'Connor, J., concurring) (1990). Informed consent is usually seen as a court-made area of the law, not one dominated by the legislatures.

400. 497 U.S. 261 (1990).

401. *Id.* at 284.

402. 521 U.S. 793, 808 (1997).

403. 521 U.S. 702, 731 (1997).

coercion and undue influence in end-of-life situations The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. New York Task Force 120 (“[A]n insidious bias against the handicapped--again coupled with a cost-saving mentality--makes them especially in need of Washington’s statutory protection”). If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.⁴⁰⁴

It must not be forgotten that the Supreme Court tied the principle of informed consent to the moral autonomy of the person herself⁴⁰⁵ in each of the decisions it rendered in the five abortion cases coming after *Roe v. Wade*.⁴⁰⁶ *Roe*, and its companion case, *Doe v. Bolton*⁴⁰⁷ depicted the states as protectors of human life, but forbade them from preventing abortions in the first trimester of pregnancy. Abortion was made a fundamental right, requiring a standard of strict scrutiny to judge the validity of state legislation burdening the woman’s right. *Roe* also allowed the states very little authority to restrain later abortions even after viability of the fetus.⁴⁰⁸ The states were allowed broad powers, however, which the Court set out in detail, to protect the health of women.⁴⁰⁹

In fact, the Court referred to the preambles to the American Medical Association resolutions which “emphasize ‘the best interests of the patient’, ‘sound clinical judgment’, and ‘informed patient consent,’ in contrast to ‘mere acquiescence to the patient’s demand.’”⁴¹⁰ The Court’s decision in *Roe v. Wade*, controversial as it was, subordinated the woman’s right to privacy to the professional judgment of physicians, reminiscent of the discarded professional rule of physician discretion in providing patient information. It did, however, provide the background

404. *Id.* (citations omitted).

405. Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 379-380 (1990); Lisa Napoli, *The Doctrine of Informed Consent and Women: The Achievement of Equal Value and Equal Exercise of Autonomy*, 4 J. GENDER & LAW 335 (1996).

406. 410 U.S. 113 (1973).

407. 410 U.S. 179 (1973).

408. *See, e.g., Stenberg v. Carhart*, 120 S. Ct. 2597 (2000) (Supreme Court strikes down Nebraska’s partial birth abortion prohibition).

409. *Id.* at 149-51.

410. *Id.* at 143.

for the states to enact legislation providing women with information necessary to make the abortion decision.

Beginning with *Planned Parenthood of Central Missouri v. Danforth*,⁴¹¹ and followed by *City of Akron v. Akron Center For Reproductive Health*,⁴¹² *Thornburg v. American College of Obstetrics and Gynecologists*,⁴¹³ and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁴¹⁴ the Court struggled with the issue of women's right to informed choice in the abortion situation.

Prior to *Casey* the Court assumed that the patient's position in abortion cases was articulated by the abortion provider and that opposition to the woman's right to an abortion was represented by the states.⁴¹⁵ After upholding an informed choice statute in *Danforth*, striking one down in *Akron* and another in *Thornburg*, as excessive burdens on the woman's right to choose, over sustained dissenting opinions, the Court in 1989, with *Webster v. Reproductive Health Services*,⁴¹⁶ by a plurality changed the Court's position that abortion was a fundamental right. It held that the right was a liberty interest protected by the Due Process Clause of the Constitution. The *Webster* decision upheld another Missouri statute restricting abortion, except where the woman's life or health was in danger, after a physician had determined that the fetus was viable. This decision split the Court again, even as to the continuing meaning and significance of *Roe v. Wade*.

In 1992 in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, Justice O'Connor wrote for the plurality of the court, ruling that a Pennsylvania informed consent statute was constitutional.⁴¹⁷ The Court stated:

In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed. If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be

411. 428 U.S. 52 (1976).

412. 462 U.S. 416 (1983).

413. 476 U.S. 747 (1986).

414. 505 U.S. 83 (1992).

415. Thomas Eller, *supra* note 390, at 654.

416. 492 U.S. 490 (1989).

417. *Id.* at 881-887.

permissible.⁴¹⁸

Thus, in the context of abortion, which the Court in *Casey* finally acknowledged as a serious medical, moral and psychological decision for both patient and attending physician, with potentially devastating after-effects upon a woman, the Justices affirmed the patients' fundamental right to informed consent. The Court put aside the implication that abortion is a minor medical procedure, largely placed under the direction of the attending physician, and repealed the trimester approach as basically flawed.⁴¹⁹ On the right of informed consent, the Court concluded: "Thus, a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure." *Casey* required that women must be fully informed when making subjective decisions on abortion and their subjective decisions are unreviewable. It both protected the right to an abortion and secured in the jurisprudence of the Supreme Court the fundamental right to patient autonomy. It is an autonomy protected against coercion, duress, fraud, ignorance and false information. *Casey* affirmed a concept of patient's rights consistent with the patient rule in informed choice decisions in majority tort rulings in the courts below, rejecting the paternalism that diminished patient's right to information under the so-called professional rule of physician's disclosure obligations. "At the heart of liberty," the Court said, "is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."⁴²⁰

In the lower courts the evolution of tort law towards protection of patients' choices is clearly rooted in patient self-determination.⁴²¹ In the landmark case of *Canterbury v. Spence*⁴²² the D.C. Circuit articulated the

418. *Id.* at 882.

419. *Id.* at 872-73.

420. *Casey*, 505 U.S. at 851; *Pauscher v. Iowa Methodist Medical Ctr.*, 408 N.W.2d 355 (Iowa 1987).

421. Among the many significant studies published on patient choice, we may mention those of Susan Renfer et al., *The Woman's Right to Know: A Model Approach to the Informed Consent of Abortion*, 22 LOY. U.CHI. L.J. 409 (1991)(containing the Model Woman's Informed Choices Act); Alan Weisbard, *Informed Consent: the Law's Uneasy Compromise With Ethical Theory*, 65 NEB. L.REV. 749 (1986).

422. 464 F.2d 772 (D.C. Cir. 1972).

value of self-determination as the fundamental reason for adopting a reasonable person rule: “[t]he root premise is the concept, fundamental to American jurisprudence, that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body.’”⁴²³

Informed choice is absolutely necessary to patient power. “A patient should not only be given the information necessary to be a party to decisions about her care,” Lisa Napoli has written,

but also the information necessary to have a position of equality with her doctor. Instead of being acted upon, women would make their own decisions about what is best for them and would achieve, in addition to increased happiness and physical well-being, a great measure of autonomy than they previously have been accorded.⁴²⁴

In the leading case articulating the “patient rule” of choice, namely, that the patient, not the doctor, is entitled to measure the amount of information necessary for an informed decision whether to submit to a particular medical procedure, the Iowa Supreme Court made a necessary distinction between “medical” choices and “personal” choices:

[T]he patient’s right to make an intelligent an informed decision cannot be exercised when information material to that decision is withheld. Although most aspects of the physician-patient relationship necessarily must be dominated by the superior skill and knowledge of the physician, the decision to consent to a particular medical procedure is not a medical decision. Instead, it ordinarily is a personal and often difficult decision to be made by the patient with the physician’s advice and consultation. In order to make his or her informed, decision, the patient has the right to expect the information reasonably necessary to that process will be made available by the physician.⁴²⁵

Case law out of which the prevailing jurisprudence on informed choice has developed to this point is fixed on the patient-doctor relationship. It is the doctor who is required to assist the patient with pertinent

423. *Id.* at 780 (quoting Judge Cardozo in *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914); see also, Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

424. Lisa Napoli, *supra* note 405, at 358-59.

425. *Pauscher v. Iowa Methodist Medical Ctr.*, 408 N.W.2d 355, 359-60 (Iowa 1987). The Supreme Court of Iowa exonerated the hospital in this case, holding the duty to provide information necessary to assess the risks of medical procedures is on the attending physicians, not the hospital as such.

information on the risks and benefits of suggested medical procedures. The next step is to extend the obligation to curtail misinformation allowed to continue in health insurance plans that, effectively, burdens the patient's right to choose which procedures will or will not be possible in preferred provider hospitals.

Hospitals' ethical independence must be measured by the informed right and feasibility of choice of those contracting for their services.⁴²⁶ The corollary, of course, is that the greatest contemporary threat to religious autonomy in health care comes from within the hospitals and their care delivery systems themselves. To remain free to curtail otherwise legally-permissible medical procedures the hospitals must accentuate their religious identity in unmistakable terms so that patients know what their choices are, avoid monopolization of general health services in particular communities, and restrain the semblance of competitive commercialization. Patients must know in advance what services are or are not available from contract health care providers and practically and feasibly be able to act on those choices.

A. The Free Exercise Clause Does Not Preclude Reasonable Regulations to Protect Patient Rights Where Hospitals Themselves Impair the Possibility of Informed Choice

There is no doubt that the churches in America have a constitutional right as religious organizations to sponsor and operate institutions reflecting their religious beliefs. They have a constitutional right to maintain control over the kinds of medical services they provide. The legally protected right of religious choice in belief is absolute,⁴²⁷ in conduct is conditioned by compelling state interests.⁴²⁸ The right belongs to persons, as well as to groups of persons cooperating in religious organizations to conduct ministries to their membership⁴²⁹ as well as to the public.⁴³⁰ The right, however, is not without limit. The Supreme Court put the limit upon free exercise in conduct prohibited by generally-

426. In general, a person's consensual adherence to the discipline and practices of a church constitutes a waiver of what otherwise may amount to an actionable tort, e.g., defamation in the shaming cases. See *Guinn v. Church of Christ*, 775 P.2d 766 (Okla. 1989).

427. See note 5, *supra*.

428. *Reynolds v. U.S.*, 98 U.S. 145 (1879).

429. *Serbian Eastern Orthodox Diocese for the United States and Canada v. Milivojevich*, 426 U.S. 696 (1976).

430. *Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327 (1987).

applicable laws or injurious to others.⁴³¹

The First Amendment free exercise clause supports a limited claim of privilege and exemption from generally applicable laws where an organization is obviously religious and patients are free to choose its services among other alternatives. Otherwise not.

Where patients cannot reasonably know that hospital services they have requested will not be provided because of a disguised hospital choice, the institutional privilege must cede to patients' rights. The compelling state interest in forcing hospitals and health care systems to provide full and complete disclosure of their affiliations and restrictions upon service clearly derives from the state's interest in curtailing fraud, coercion and duress.

B. The Limitations Upon Institutional Autonomy

From what we have been able to gather of the policies and the jurisprudence of the courts under the free exercise clause of the First Amendment, the autonomy of private health care organizations in the scope of their protected ethical decisions is not unlimited. There are at least five indisputable pre-conditions to institutional liberty interests in the public provision of reproductive health care services. These are the boundaries required by the right of patients freely to consent to the medical services they choose.

1. Where Health Care Services Are Monopolized and No Viable Alternative Is Provided to Patients

Where there are alternative providers easily and economically available to patients, state coercion of moral choices in religious hospitals is not the least restrictive means to achieving generally accessible and comprehensive patient care.⁴³²

The monopolization of health care services caused by hospital mergers and acquisitions is the most serious single reason to limit the breadth of organizational discretion in ethical medical choices. The problem has been intensified and aggravated where pre-acquisition negotiations have proceeded in secrecy and information dribbled out to the press piecemeal before final announcement of the *fait accompli*. This, of course, excludes the very people most intimately affected, namely, the public who serve as the patient base, rendering their personal anxieties moot before

431. Employment Div., Dep't. of Human Resources of Oregon v. Smith, 494 U.S. 872 (1990).

432. Michael S. Jacobs, *When Antitrust Fails: Public Health, Public Hospitals, and Public Values*, 71 WASH. L. REV. 899 (1996); William G. Kopait & Tanya B. Vanderbilt, *Unique Issues In the Analysis of Non-Profit Hospital Mergers*, 35 WASHBURN L. J. 254 (1996).

immovable long-distance decision-makers.

In *Amelia E. v. Public Health Council*⁴³³ the Center for Reproductive Law and Policy brought suit against the New York State Department of Health and the Public Health Council, alleging their failure to consider the “public need” of the Troy, New York, community in allowing the merger of a Catholic and a non-Catholic hospital. The merger would eliminate entirely the family planning services offered by the non-Catholic hospital. This diminution of services would have a direct impact on low-income, rural and young women in the community.⁴³⁴

Where rural or small community hospitals are acquired by large religiously affiliated hospital chains the euphemism “sharing resources” must be fleshed out in the hardship, particularly to local women, in continued loss of reproductive health care services. Since, as I have previously stated, many religious hospitals cannot provide ethical justification for referral or provision of contracted out services in these areas, the only reasonable solution is for state hospital accreditation agencies simply to prohibit acquisitions and mergers that substantially destroy a community’s base of reproductive health care, until such time as the public may be able to provide these services in alternative, accessible public facilities.

The obvious corollary, of course, is that the burden of continuing provision of reproductive health services that would be curtailed by the ethical restraints of religious hospitals, is on the state, not on the private hospital. Prevention of monopolization of hospital services, therefore, is not adequately addressed by simply prohibiting rural or community hospital acquisitions. And it cannot be achieved by state enforced referral or licensure requirements.⁴³⁵ Not only would this alternative be financially unrealistic, but it would legislatively eliminate the possibility for local communities to acquire quality health care in most other areas of medicine. The acquisitions may go forward, as many of the cases cited

433. No. 7062-94 (N.Y. Sup. Ct., filed Jan. 20, 1995).

434. See Ikemoto, *supra* note 6, at 1127.

435. To this extent I differ with the solutions proposed by Professor Katherine Boozang, *supra* note 6: “When the sectarian facility continues to adhere to religious beliefs that interfere with patient access to care, however, the state should require the religious hospital to provide the care, deny licensure, or the refuse regulatory approval for the category of services that raise potential conflicts.” (at 1509) State power cannot force the conscience of health care providers to act against their sincerely-held beliefs. This will simply destroy the system of private health care rather than change it, as the experience of this decade has borne out.

indicate, simply to continue acute care coverage. The religious hospital cannot, however, be forced to finance and provide services it finds morally reprehensible. That is the task of the state, as clearly intimated in federal Medicaid instructions.⁴³⁶

2. Where Health Care Organizations Disguise Their Religious Identity

The track record of mergers and acquisitions in this past decade has been marred by hidden negotiations and several notorious incidents of less than forthcoming publication to affected patient communities of the terms and conditions under which the transactions take place. When, after the fact, public scrutiny reveals the result in critically curtailed services, the response of the public is usually unmistakably negative.⁴³⁷

Whether negotiators for health care insurance coverage for patient bases are fully informed of the religious restraints upon hospital service providers or not is clearly the moral obligation of the hospitals themselves. The same is true of negotiations between religious hospital chains and rural or community hospitals. The hospitals must clearly and publicly identify themselves as religiously affiliated. Thus, the growing problem of the secularization of religious hospitals, with staff employment decisions and operating procedures becoming increasing the mirror of their commercial counterparts, becomes not only a question of the loss of religious relationship to the sponsoring churches. It becomes a question of justice once a religiously affiliated hospital is no more than a facade behind which ethical decisions are made formally and without the sincere convictions of staff and employees.

To retain the protected right of religious autonomy in ethical judgments in the sensitive balance of patients' rights and institutional protections it is necessary for religious hospitals to regain their religious missions, including, of course, the use of their resources for uncompensated service of the poor and uninsured. This may be achievable by careful training and management decisions. If not, since neither the government nor the churches themselves have an essential interest in maintaining secular businesses as tax-exempt and affiliated organizations, these hospitals should simply become secular, private non-profit health care organizations rather than perpetuate the false image of religious conviction. The integrity of religious ministry to the sick cannot be allowed to become so diluted by entrepreneurial goals that sensitive

436. See Section III.A., *supra*, and note 180, *supra*.

437. See, e.g., Shari Roan, *When the Church and Medicine Clash: More Hospitals are Merging with Catholic Facilities to Survive*, L.A. TIMES, Feb. 2, 1995, at A1, on the negotiations between Mercy Healthcare Sacramento and Sierra Nevada Memorial Hospital in Nevada County, California.

moral choices in reproductive medicine are made, not out of theological conviction, but rather to continue a pathway of ecclesiastical conformity at the cost of patients' otherwise reasonable expectations for the delivery of comprehensive health care services.

3. Where Restricted Services Are Not Clearly Disclosed and Discounted In Participatory Health Care Payment Plans

Payment for individual health care services in provider hospitals through group insurance or health maintenance organization plans is an evolving complexity. For example, St. Joseph's Hospital in Syracuse, New York, is a preferred provider of in-patient and out-patient hospital services with twenty-seven managed care companies, including the following: Aetna US Healthcare, Anheuser Busch EAP, Beech Street, Blue Cross Blue Shield of Central New York (Blue Point & Orange Point), CIGNA, Community Care Network, Fidelis Health Care, GHI (Hospital Benefits Only), HealthNow New York, HMO-CNY, Independent Living Services, Integra, MagnaCare, MediChoice, MultiPlan, MVP Health Plan, North American Administrators, North Medical Community Health Plan, Partners Health Plan, PHP/UNIVERA, Plumbers & Fitters Local #79 Welfare Fund, POMCO, Private Health Care Systems, RMSCO, Statewide Independent PPO, Inc., UNITED HealthCare, and United Payors & United Providers.⁴³⁸ These are employee benefits plans, professional group plans, as well as group plans providing for single purchasers. Some are nonprofit, others for-profit health care management organizations. The recent wave of state mandated Medicaid managed care involves a large number of provider-sponsored health maintenance organizations using Medicaid disbursements, that is, hospitals, community health centers or physicians that sponsor and manage the plans.

Health maintenance organizations do not pay directly for individual services, but rather on a capitated basis upfront, usually monthly or quarterly. Thus, the gatekeepers of the management systems, the doctors, hospitals or ancillary providers, assure quality and cost effectiveness.

St. Joseph's also announced that it will accept fee-for-service payments from a list of a dozen traditional health insurance plans. These are all for-profit, commercial health insurance companies. State workers' compensation funds, Medicare, Medicaid, and Champus (medically necessary services provided military personnel) are also accepted by the Hospital directly, that is, outside organizational healthcare payment

438. St. Joseph's Healthcare, *St. Joseph's Hospital Managed Care*, available at <http://www.sjhsyr.org/managedcare> (last visited May 6, 2001).

systems.

St. Joseph's is a private 431-bed comprehensive medical center with a medical staff of more than 600, representing a broad spectrum of specialties. The Hospital has an annual operating budget of more than \$200 million.

By contrast, Cedars-Sinai Medical Center in Los Angeles, more than three times the size of St. Joseph's, lists as contract payors twenty-four PPO/POS/EPOs, fifteen HMOs, eight Senior HMOs, three Medi-Cal HMOs, and three federal government plans, Medicare, Medi-Cal (state equivalent of Medicaid) and Champus.

I mention these contrasting hospitals and their service payment sources to illustrate the variety and complexity of players in the individual medical finance markets surrounding hospital services. Hospitals, or more frequently now, hospital systems negotiate advance fees for their services with a staggering array of nonprofit and commercial organizations.⁴³⁹ Each has its own margins, bottom line and projected costs.

When the services of religious hospitals are put out to bid, there is no question that full disclosure of restricted services must be provided across the board. Any other strategy would be disastrous for all involved. The issue of disclosure to insurance carriers, HMOs, physician groups and governmental agencies is assured by the constraints of the market and the integrity of the participants.

The problems arise, however, in the role of intermediate managers in passing on that information to individual purchasers of the various systems. Employers are charged with informing employees of the exact coverage of the various packages they offer. Physicians and health care professionals, as well as administrators of HMOs, must fully inform prospective purchasers of their choices of hospital providers and the services offered by each. Anecdotal evidence suggests, however, two sources of dissatisfaction at this level. Neither directly involves the hospitals themselves, but peripherally taints their service missions.

The first is the unfortunate disappointment when patients seek acute care reproductive medical or surgical services that are denied them on ethical grounds by hospital administrators after they have enrolled in payment plans, or, in some cases, been admitted by their attending physicians.

The second derives from situations in which purchasers pay for

439. THE HMO/PPO DIRECTORY, (12th ed. 2000), lists 1200 HMO and PPOs this year.

comprehensive health care services, which, when sought, are not delivered. Since traditional health insurance policies are risk-sharing instrumentalities contracting to pay for services provided on an individual basis, these policies and their disclosure practices are not problematic. Most provide comprehensive coverage.

The current problem comes, however, from health management organizations which pay on a per person or capitated basis for comprehensive services and then contract with hospital providers who will not supply the services advertised. In some circumstances religiously affiliated HMOs, not easily apparent to potential subscribers, neither pay for reproductive health services, nor adequately inform subscribers of other providers, or, in the case of Medicaid recipients, tell them of state "access" laws enabling them to use other services.

As a result of the attempts of state and federal governmental agencies to lower Medicaid costs by forcing Medicaid recipients into managed care programs the need for clear disclosure of services has become even more acute.

New York, for example, is one of sixteen states which adopted mandatory Medicaid managed care programs for its recipients. This has resulted in a possible limitation of freedom of choice for such patients. Women who have been assigned to managed care plans which refuse on moral or religious grounds to provide comprehensive reproductive services or to inform patients where else they can go to receive them, are deprived of services available to all other residents of New York State.

State regulations requiring full disclosure of services by health service providers, insurance policies and Medicaid agencies for the information of beneficiaries, unobjectionable by religiously affiliated hospitals,⁴⁴⁰ should be enacted by state law.

4. Special Relationship--Where Life or Comparable Values Are Put Into Jeopardy By Custodial Choices

Religious hospitals providing trauma or emergency room services for victims of sexual assault assume a "special relationship" of trust over the injured patient. The legal liability arising out of a special hospital-client relationship is non-waivable.⁴⁴¹

The California Court of Appeals in *Brownfield v. Daniel Freeman Marina Hospital*,⁴⁴² suggested that a rape victim who was damaged by a hospital's refusal of treatment or referral might have a viable claim for

440. See Section III.B., *supra*.

441. See *Tunkl v. Regents of the Univ. of Calif.*, 383 P.2d 441 (Cal. 1963).

442. 208 Cal. App. 3d 405, 256 Cal. Rptr. 240 (1989).

medical malpractice against the hospital. The court found that the patient's common law right to receive information necessary to exercise her right to self-determination in medical treatment could be the basis of a malpractice claim.

There is a long and solid jurisprudence supporting the intervention of state authority to protect the health and well-being of children, as well as incompetent adults, placed in life-threatening situations by the religiously-motivated choices of others.⁴⁴³ In other words, emergency care for the developmentally disabled and minors--circumstances of unique vulnerability wherein the individual patient is unable to make personal, informed choices--is a special exception to custodial religious choice.

Special relationship jurisprudence falls along three lines: 1) The right of children to receive adequate health care where the religious faith of the parents prompt them to neglect it, as in the blood transfusion, inoculation and faith-healing line of cases;⁴⁴⁴ 2) the right of children to be protected against exposure to dangerous or hazardous activities motivated by their parents' religious beliefs;⁴⁴⁵ and 3) the right of persons to be protected when they are involuntarily committed to the custody of others in special relationships of trust.⁴⁴⁶ In each situation, the religious freedom of the custodian must cede to the right of the incompetent person in need of medical attention to receive the care necessary to sustain life or achieve a value comparable to that of life itself.

This line of jurisprudence would allow the state to intervene in abridging the institutional religious freedom of church-related hospitals in four cases: 1) In the medical care of child and handicapped victims of rape or incest;⁴⁴⁷ 2) in the medical and forensic treatment of adult female victims of sexual crimes; 3) in the provision of blood transfusions, organ transplants or medically routinized and standard care procedures, such as dialysis, or to save or prolong the life of mentally incompetent adults

443. See Ann M. Massie, *The Religion Clauses and Parental Health Care Decisionmaking for Children: Suggestions For a New Approach*, 21 HASTINGS CONST. L. Q. 725 (1994); L. Greenberg, 'In God We Trust': Faith Healing Subject to Liability, 14 J. CONTEMP. HEALTH L. & POL'Y 451 (1998).

444. Appl. of President and Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964); Walker v. Superior Ct., 763 P.2d 852 (Cal. 1988).

445. Prince v. Massachusetets, 321 U.S. 158 (1944).

446. See, e.g., Stropes v. Heritage House Childrens' Ctr., Inc., 547 N.E.2d 244 (Ind. 1989).

447. See C. Lewis Borders, *Rape and Incest Abortion Funding Under Medicaid--Can the Federal Government Force Unwilling States to Pick Up the Tab?*, 35 J. FAM. LAW 121(1996-97).

entrusted to the care of a hospital; and 4) in the care and counseling of sexually-active AIDS patients.⁴⁴⁸

Emergency services for adult victims of rape or sexual assault routinely indicate d & c (dilation and curetage of uterus) procedures, etc., to protect the victim from pregnancy, infection and further injury from disease-causing pathogens, such as HIV or sexually-transmitted diseases, preserve DNA evidence of the perpetrator for prosecution, and promote rapid healing and restoration of health. Emergency hospitals, working with social service agencies and the criminal justice system, provide physical treatment as well as counseling, and/or, referral services for the victim's well-being.⁴⁴⁹ In today's health care market it is almost inconceivable that a victim can exercise choice among emergency facilities available to her and a knowledgeable decision regarding her own treatment in the short window of time in which treatment has to be given to achieve all the above purposes.⁴⁵⁰

The paradigm for religious exemption is the exemption of parents from the demands of the state in the religious education and training of their children. Forty-three states have statutes protecting parents who choose spiritual healing for their minor children, from the reach of regulatory or criminal statutes pertaining to dependent, abused, or neglected children.⁴⁵¹ While these statutes are extremely controversial⁴⁵² and have been set aside

448. See Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients*, 3 HEALTH MATRIX 31 (1993); Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 919 (1997); Shirley A. Padmore, *California's Limits On the Right to Refuse Life Saving Treatment--No Holds Barred?* (*Thor v. Sup. Ct.*, 855 P. 2d 375 (1993)), 46 WASH. U. J. URB. & CONTEMP. L. 369-380 (1994); Barbara Radford & Gina Shaw, *Beyond Roe and Abstract Rights: American Public Health and the Imperative for Abortion As a Part of Mainstream Medical Care*, 13 ST. LOUIS U. PUB. L. REV. 207-20; Margaret S. Russell, *A Taxing Tale: Unconstitutional Conditions and Abortion Subsidy*, 3 HEALTH MATRIX 459-484 (1993).

449. Jose Gonzalez, *A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World*, 35 HOUS. L. REV. 715 (1998).

450. See Frances Lexcen & N. Dickon Reppucci, *Effects of Psychopathology On Adolescent Medical Decision-Making*, 5 U. CHI. L. SCH. ROUNDTABLE 63 (1998).

451. See *Prayer-Treatment Exemptions to Child Abuse and Neglect Statutes, Manslaughter Prosecutions and Due Process of Law*, 30 HARV. J. LEGIS. 135, 140 (1993).

452. The "prayer treatment" exemption in the federal Child Abuse Prevention and Treatment Act of 1979 was eliminated in 1983. 45 C.F.R. § 1390 (1991).

by state courts with some regularity in recent years,⁴⁵³ the jurisprudence justifying the intervention of the state to protect children from dangerous and unhealthy conditions or medical neglect, is entirely consistent. Where state prosecutions of parents for neglect of adequate medical care leading to death or the permanent injury of the child are challenged, those prosecutions have been set aside, for the most part, only on due process grounds, that is, where parents lacked notice.⁴⁵⁴ Defenses based on the free exercise of religion have been unsuccessful. Indeed, six states specifically allow courts to order medical treatment over religious objections.⁴⁵⁵ If parents are limited in their ability to impose their religious norms upon their children, can such an exemption exist for institutions sought out specifically by public authorities for the emergency care of traumatized victims of rape or sexual abuse?

Children and the developmentally disabled, as Lawrence Tribe notes, in this society are a politically powerless minority.⁴⁵⁶ The common law concept of the government as *parens patriae*, however, has been repeatedly upheld where states have intervened for the welfare and protection of the rights of children.⁴⁵⁷ Since children cannot give consent to their own treatment, the guardianship role of parents may be superseded by the government when detrimental decisions are made for them.⁴⁵⁸

The Supreme Court in 1944 in *Prince v. Massachusetts*⁴⁵⁹ recognized the state's right to restrict otherwise constitutionally protected parental decision-making when a child's welfare is at stake. Characterizing the state's powers, the Court specifically stated that "[t]he right to practice

453. See, e.g., *Commonwealth v. Twitchell*, 617 N.E.2d 609 (1993); *Hermanson v. State*, 604 So. 2d 775 (Fla. 1992); *Newmark v. Williams*, 588 A.2d 1108 (Del. 1991).

454. See, e.g., *State v. McKown*, 475 N.W. 2d 63 (Minn. 1993), *cert. den.*, 503 U.S. 1036 (1992).

455. Florida, Iowa, Michigan, Missouri, North Dakota and Rhode Island.

456. Lawrence Tribe, *AMERICAN CONSTITUTIONAL LAW*, § 16-31 at 1588-89 (2d 3d. 1988).

457. See Samuel Davis & Mortimer Schwartz, *CHILDREN'S RIGHTS AND THE LAW*, 51-78 (1987).

458. See Angela Holder, *Special Categories of Consent: Minors and Handicapped Newborns*, in 3 *TREATISE ON HEALTH CARE LAW* §§ 19.01, 19.05 (Michael MacDonald et al. eds. 1991); Karen Rothenberg, *Medical Decision Making for Children*, 1 *BIOETHICS: A LEGAL AND ETHICAL REPORTER ON MEDICINE, HEALTH CARE, AND BIOENGINEERING*, § 8-2.1 (James Childress et al. eds. 1989).

459. 321 U.S. 158 (1944).

religion does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.”⁴⁶⁰ The Court sustained the applicability of state child labor laws against a woman whose niece helped her distribute religious literature, holding:

Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.⁴⁶¹

In 1972, the Supreme Court reiterated the rule of permissible state intervention in *Wisconsin v. Yoder*,⁴⁶² stating that “the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child.”⁴⁶³

Both *Prince* and *Yoder* cite a 1905 Supreme Court decision confirming the goal of universal immunization of children, even over the objections of parents, *Jacobson v. Massachusetts*.⁴⁶⁴

The states have consistently rejected parental free exercise claims to prevent governmental intervention in behalf of children. The California Supreme Court, for example, citing *Prince*, characterized the lives and health of children as “an interest of unparalleled significance.”⁴⁶⁵ “Regardless of the severity of the religious imposition,” the Court stated, “the governmental interest is plainly adequate to justify its restrictive effect.”⁴⁶⁶ The Court, on that basis, affirmed denial of a motion to dismiss charges of involuntary manslaughter and felony child endangerment against a Christian Science mother under circumstances where her four-year-old daughter died of acute meningitis after having been treated solely with prayer. The Court held that neither the federal Constitution nor the state’s own religious exemptions for Christian Scientists protected parents whose children’s lives were threatened by serious illness. Similar reasoning has been used in other state court decisions ordering medical intervention for children over the objections of parents.⁴⁶⁷

The Supreme Court’s strong assertion of state powers to protect

460. *Id.* at 166-67.

461. *Id.* at 170.

462. 406 U.S. 205 (1972).

463. *Id.* at 233-34.

464. 197 U.S. 11 (1905).

465. *Walker v. Superior Court*, 763 P. 2d 852, 869 (Cal. 1988).

466. *Id.* at 870.

467. See cases cited in note 396, *supra*.

children, with the concurrence of the state courts, enables us to conclude that the interest of the state in protecting children is a "compelling state interest."

The Child Abuse Prevention and Treatment and Adoption Reform Act of 1978,⁴⁶⁸ amending the previous legislation of the same name adopted by Congress in 1974,⁴⁶⁹ was followed by new Regulations issued by the Department of Health and Human Services in 1983. These regulations enlarged the definition of "negligent treatment or maltreatment" of children to include "failure to provide adequate medical care,"⁴⁷⁰ and now reads:

Nothing in this Part should be construed as requiring or prohibiting a finding of negligent treatment or maltreatment when a parent practicing his or her religious beliefs does not, for that reason alone, provide medical treatment for a child; provided, however, that if such a finding is prohibited, the prohibition shall not limit the administrative or judicial authority of the State to insure that medical services are provided to the child when his health requires it.⁴⁷¹

There is a parallel line of state cases holding hospitals, sanatoria and protective institutions liable for injuries to patients resulting from the negligence of the custodial institution. A "custodial" or "protective" role is assumed by law in the hospital-patient relationship as one of almost strict liability, posited upon entrustment by the patient to the care of a hospital and powerlessness in that situation of the patient to protect herself.

The Supreme Court itself has not ruled on the constitutionality or scope of religious exemptions for health care organizations in patient care. In general, however, the Court has affirmed in other contexts that the limits upon religious accommodation in the face of generally applicable and neutral state laws is the requirement that non-beneficiaries not be markedly burdened by the accommodation to the religious actor.⁴⁷²

468. 42 U.S.C. § 1501.

469. *Id.*

470. 48 Fed. Reg. 3,698 (1983), codified at 45 C.F.R. § 1340.2(d)(3).

471. *Id.* at 3702 (codified at 45 C.F.R. § 1340.2 (d)3)(ii)).

472. *Sherbert v. Verner*, 374 U.S. 398, 398 (1963). See also, Michael McConnell, *Accommodation of Religion: An Update and a Response to the Critics*, 60 GEO. WASH. L. REV. 685, 692, n.28 (1992) ("Of course, the [religious exercise] right is limited by the rights of others. . ."). *Id.*, *Accommodation of Religion*, 1985 SUP. CT. REV. 1, at 31 ("Where the government determines that it can make an exception without unacceptable damages to its policies, there is no reason for a court to second-guess that conclusion unless the constitutional rights of other

“The right to religious exemptions from regulation cannot be absolute; the state must be able to override it for sufficiently compelling reasons,” as Professor Douglas Laycock says.⁴⁷³

5. *Where a Private Nonprofit Hospital Is Sold to a Commercial Enterprise*

Non-profit hospitals may choose to abandon noncommercial status in order to improve their access to capital money markets. Instead of community obligations, they assume duties to provide profits by way of dividends for private and corporate purchasers of their stock.⁴⁷⁴ Without profits, of course, there is no capital marketability to attract investors. Commercial health care providers, in turn, purchase the assets of converting nonprofit providers in order to increase market share of local service areas, which in turn strengthens their ability to compete, negotiate medical plans and contracts, and set prices to produce additional levels of profit. There is, of course, neither altruism nor disinterest in this scenario.⁴⁷⁵

Church law generally provides hierarchical authorities the right to review, approve or disapprove, or, indeed, sanction the outright sale of ecclesiastical properties to commercial entities.⁴⁷⁶

In 1999 St. Louis University Medical Center, affiliated with the Jesuit University, on vote of the University's Board of Trustees, without consultation with the Archbishop of St. Louis, and then over his subsequent objection, was sold to Tenet Healthcare, Inc.⁴⁷⁷ The Board's vote to approve sale of the Catholic hospital, the original anchor health care facility of the Catholic Health Association, to Tenet Healthcare, Inc., secularized the hospital, while retaining its relationship as the teaching hospital for the medical faculty of the University. Under Catholic Health Association rules, the hospital is no longer a member and no longer may

persons are adversely affected.”).

473. “The Remnants of Free Exercise,” 1990 SUP. CT. REV. 1, 30.

474. David W. Young, *Ownership Conversions In Health Care Organizations: Who Should Benefit?* 10 J. HEALTH POL., POL'Y & L., 765, 767 (1986).

475. Shelley A. Sackett, *Conversion of Non-For-Profit Health Care Providers: A Proposal For Federal Guidelines On Mandated Charitable Foundations*, 10 STAN. L. & POL'Y REV. 247 (1999).

476. See, e.g., Directive 68 of the ETHICAL AND RELIGIOUS DIRECTIVES, note 50, *supra*, reflecting Canons 1295 *et seq.* of the Code of Canon Law. JOHN BOYLE, THE STERILIZATION CONTROVERSY: A NEW CRISIS FOR THE CATHOLIC HOSPITAL? 73 (1977).

477. See *supra* note 35.

identify itself as Catholic.⁴⁷⁸

Where a religious hospital has been sold to a for-profit commercial health-care corporation there have been instances in which either the public relations bulletins, or an actual contractual arrangement has been made to retain the religious character of the hospital. Essentially, of course, this would mean that the hospital retains its dedication to below-cost service of the poor, the mission of special care and concern for the community, advocacy of the rights of the poor and uninsured to social provision of health-related welfare rights, and the right to restrict otherwise legally permissible medical services by exercise of religiously-motivated moral choices.⁴⁷⁹

Such arrangements, I believe, are legally unenforceable, thus temporary, cosmetic and chimerical.⁴⁸⁰ Serving the poor is incompatible with board directors' duties to shareholders to produce dividends.⁴⁸¹ Where full disclosure of ethical restrictions made in negotiating for patient bases causes contractual losses, directors will be made liable to shareholders for squandering assets. Contracts to deprive persons of constitutionally-protected reproductive rights are against public policy and to that extent void.⁴⁸² The only statutory exemptions for religious choice are for religious hospitals. The administration of publicly-funded

478. Catholic Health Association rules are explained by J. Stuart Showalter and John H. Miles, *Restructuring Health Care Organizations While Retaining Recognition As a Catholic Hospital*, 32 ST. LOUIS U. L. J. 1111, 1121-28 (1988). Tenet Healthcare, Inc., now owns and operates six St. Louis area hospitals.

479. See Mark Krause, *First, Do No Harm: An Analysis of the Nonprofit Sales Acts*, 45 UCLA L. REV. 503-568 (1997).

480. See Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Changes In Charitable Status*, 23 AM. J. L. & MED. 221-250 (1997).

481. Glenn Wilson, a professor of Social Medicine at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, said it was unrealistic to expect market forces to provide for the poor because a free market economy does not redistribute money:

"The market may make hospitals and health care more efficient, but it will not provide for the poor," Mr. Wilson said. "At some point, we will do without care or we will raise the money. The hospitals can't give it away."

He added: "Whether the hospital is public or private, someone is going to have to pay for the people who have no money. Until we quit fantasizing that that is not true, we are not going to make any progress."

Preston, *supra* note 33.

482. See *supra* note 118, discussing *Bob Jones University v. United States*, 461 U.S. 574 (1983).

programs, such as Medicare and Medicaid; for example, which must continue if the hospital is to remain financially viable, contains exemptions under federal law only for religious hospitals or religious conscientious objection.⁴⁸³ Institutions organized and operated for profit are the antithesis of tax-exempt organizations under I.R.C. § 501(c)(3). Indeed, sale to for-profit enterprises radically shifts the governance and control of religious nonprofit organizations from the sponsoring church to individual shareholders. This is a radical departure from the rights of the public, exercised through the states' attorney generals, over public benefit charities and their financing.

The Supreme Court itself has acknowledged the incompatibility of the for-profit model of enterprise with religious exercise protected under the free exercise clause and exemptions statutorily granted in federal law. For example, the Tony and Susan Alamo Foundation was a nonprofit religious organization incorporated under the laws of California. Among its primary purposes, as stated in its Articles of Incorporation, were to "establish, conduct and maintain an Evangelistic Church; to conduct religious services, to minister to the sick and needy, to care for the fatherless and to rescue the fallen, and generally to do those things needful for the promotion of Christian faith, virtue, and charity."⁴⁸⁴

The Alamo Foundation derived its income, not from contributions or public benefit services, but, rather, from the operation of commercial businesses staffed by the Foundation's "associates", most of whom were drug addicts, derelicts, or criminals before their rehabilitation by the Foundation.⁴⁸⁵ These workers received no salaries, but, instead, were provided by the Foundation with food, clothing, shelter, and other benefits. The Secretary of Labor filed an action against the Foundation, alleging violations of the minimum wage, overtime, and recordkeeping provisions of the Fair Labor Standards Act.⁴⁸⁶

On appeal from an adverse decision in the federal district court, the Foundation argued religious exemption from the provisions of the Act. The Supreme Court affirmed. The Court held the commercial businesses operated by the Foundation in competition with ordinary commercial enterprises made the Foundation itself an "enterprise" within the

483. *See supra* note 123.

484. *Tony and Susan Alamo Foundation v. Secretary of Labor*, 471 U.S. 290, 292 (1985).

485. The Alamo Foundation operated four businesses in California, thirty businesses in Arkansas, three businesses in Tennessee, and a motel in Tempe, Arizona. It received additional income from the donations of its "associates."

486. 29 U.S.C. §§ 201 *et seq.*

meaning of 29 U.S.C. § 203(r),⁴⁸⁷ and gave its employees protection under the Act. The “economic reality” test of employment used by the Court under the Act divested the Foundation of its religious identity for purposes of federal law, despite the motivation of both its founders and associates to use its resources for religious and public benefit purposes. The Foundation, thus, lost its right to use religious exemptions to employment law, by its operation as a commercial enterprise. Citing dicta in the district court opinion, that “by entering the economic arena and trafficking in the marketplace,”⁴⁸⁸ the Foundation lost its religious exemptions to federal employment law, the Court concluded:

The Foundation’s commercial activities, undertaken with a ‘common business purpose’, are not beyond the reach of the Fair Labor Standards Act because of the Foundation’s religious character, and its associates are ‘employees’ within the meaning of the Act because they work in contemplation of compensation. Like other employees covered by the Act, the associates are entitled to its full protection.⁴⁸⁹

Statutory exemptions, granted to nonprofit and religious organizations for the common benefit of society, are lost by commercialization. The law is entirely consistent in this regard.⁴⁹⁰ The New Jersey Supreme Court, for example, in *Doe v. Bridgeton Hospital Association*⁴⁹¹ in direct response to the question, held that a nonsectarian hospital may not limit access to medical treatments based upon the religious views of its board members and administrators. In this case, the issue was nontherapeutic abortion requested by a patient. The court stated that a nonsectarian hospital, even with nonprofit status, is licensed to serve the public. It is operated for the public, rather than private ends.⁴⁹² Thus, the court concluded,

487. 29 U.S.C. §203 (r)(1) defines “enterprise” in pertinent part as the related activities performed (either through unified operation or common control) by any person or persons for a common business purpose, and includes all such activities whether performed in one or more establishments or by one or more corporate or other organizational units including departments of an establishment operated through leasing arrangements, but shall not include the related activities performed for such enterprise by an independent contractor.

Id.

488. *Tony and Susan Alamo Foundation v. Sec. of Labor*, 471 U.S 289, 294 (1988).

489. *Id.* at 306.

490. *See De La Salle Institute v. U.S.*, 195 F. Supp. 891 (N.D. Cal. 1961).

491. 366 A.2d 641 (N.J. 1976).

492. *Id.* at 646.

secular hospitals may not adopt policies based upon religion or morality that interfere with the otherwise legitimate use of their facilities by the general public.

There has been a suggestion by some that religious health care ministries, in the canon law, can continue their institutionalized existence in the for-profit, as well as the nonprofit corporational form.⁴⁹³ The suggestion is based upon the absence of such an express prohibition in the general canon law, as well as the fact that many nonprofit corporations, particularly in the health care fields, have created and manage for-profit subsidiaries, such as technical, research and diagnostic facilities, on the income of which they pay unrelated income taxes.⁴⁹⁴ This suggestion rests upon a fundamental misunderstanding.

The canon law requirements for the dedication and uses of ecclesiastical properties,⁴⁹⁵ the prohibitions against secular occupations for priests and members of religious orders⁴⁹⁶ and the control exercised by church officials over sponsored ministries are totally incompatible with the notion of a corporation organized and operated primarily to pay dividends to its shareholders. Religion and religious organizations are definitionally nonprofit.⁴⁹⁷ The churches, in general, are not dedicated to competing in their ministries with secular commercial entities for profit.

Nonprofit does not mean that an organization cannot be operated in a financially sound and solvent way, paying comparable compensation to staff and employees. It means, rather, that the primary motive for which it is organized and operated as a corporation is not to produce dividends for its owner-shareholders, but to serve the public by performing an acknowledged charitable service.

In the canon law, to maintain its religious identity, a sponsored health care organization must have an institutional formation and operation in which, at least, six elements are operative: (1) It must be under the direction of competent ecclesiastical authority and acknowledged as a constituent part of the church;⁴⁹⁸ (2) the principles of moral theology and medical ethics adopted officially by the church must be observed in all

493. See JOHN R. AMOS ET AL., *THE SEARCH FOR IDENTITY: CANONICAL SPONSORSHIP OF CATHOLIC HEALTHCARE* 61 (1993).

494. I.R.C. §§ 511-513 (West 2000). See, generally, I.R.S. Publication 598; *Queen of Angels Hospital v. Younger*, 66 Cal. App. 3d 359, 136 Cal. Rptr. 36 (1977); *Mutual Aid Ass'n v. United States*, 759 F.2d 792 (10th Cir. 1989).

495. 1983 Code C. 1254, CODE OF CANON LAW.

496. 1983 Code C. 285, 286.

497. I.R.C. § 501 (c)(3).

498. 1983 Code C. 300, 803 § 1 (1983).

activities of the hospital;⁴⁹⁹ (3) the sponsoring organization within the church must be recognized by the church itself as authentic, or clearly identified religiously with the church;⁵⁰⁰ (4) proper church authorities must have what is called the right of visitation, that is, the right to monitor, investigate and receive an accounting of the organization's books and activities;⁵⁰¹ (5) the pastoral care of patients and practices within the institution must be subject to the canonical discipline of the sponsoring church;⁵⁰² and (6) the organization's temporal assets must be administered according to applicable canonical principles.⁵⁰³

This is not an exhaustive list. It does not require ownership of properties, nor direct involvement of the local bishop, nor adoption of specific rules and regulations. It does, however, comprise the minimal standards for official affiliation of a health care organization as religious, that is, sponsored by a church or religious organization. The quantum of outside control and accountability, as well as the dedication of assets to non-lucrative, disinterested service, are both incompatible with the organizational structure and administration of a for-profit commercial entity. Thus, creation of a for-profit hospital or conversion of a religious hospital to for-profit status, whether independently or by transfer or merger into a commercial health management organization is, per se, a renunciation of its religious identity. With the loss of religious status comes the loss of all federal and state protected religious exemptions and privileges. This transformation is irrespective of the exigencies or religious motives that may have persuaded the decision initially. In all cases, the "economic reality test," affirmed by the Supreme Court in the Alamo Foundation case enables the court to look beyond religious facades into the reality of the day-to-day operations of health care institutions.

CONCLUSION

"Conscience clauses," protecting the free exercise of religion in ethical decision-making by religiously affiliated hospitals, I believe, should continue to be absolute in reproductive medicine where the hospitals are clearly and unmistakably religious and patient choices of providers are free and fully informed. This conclusion is compelled by the free exercise clause of the First Amendment, as well as by the national interest in preserving and promoting diversity in the voluntary health care sector.

499. 1983 Code C. 298, 326 (1983).

500. 1983 Code C. 803 § 3; *see also* 1983 Code C. 300, 305, 313, 325 (1983).

501. 1983 Code C. 804 § 1 (1983).

502. 1983 Code C. 804 § 1 (1983).

503. 1983 Code C. 12 (1983).

Religious hospitals waive the right to ethical autonomy in the area of reproductive medicine, however, to the extent that otherwise medically indicated and legally permissible treatments are concerned, by engaging in monopolistic practices, disguising their religious identity to garner larger patient bases, in emergency services licensed for the care of children, handicapped adults, in cases of traumatic intervention for victims of sexual assault, or when the hospitals cease to be nonprofit corporations.

The terribly difficult problem of access to reproductive health care in all its dimensions, in my judgment, will not be solved by state legislative mandates forcing private religious hospitals into ever more stringent "creative accommodations." The key is full disclosure, and the play of voluntary organizations in markets where ultimate purchasers are the final, free arbiters of their own health care needs. The constitutional mandate to provide for the health, safety and welfare of society, and its individual members, is primarily a burden upon the state. The state can meet this burden in respect to patients' constitutionally guaranteed rights of privacy by itself accommodating to the challenges of the managed care system by funding alternative facilities, while protecting the integrity of free institutional choices in the religious ministry to the sick.

