Distinctively Catholic Healthcare

Protecting the Healthcare Right of ConscienceThrough Federal Legislation

This paper is being delivered on the heels of a Congressional victory on the legislation that serves as its topic. On Wednesday, the United States House of Representatives approved by a vote of 229-192, a federal health care right of conscience bill, H.R. 4691, the "Abortion Non-Discrimination Act." In this paper, I will provide an overview of existing conscience protections, discussing in some depth the current legislation and the threats to conscience that prompted its introduction in this Congress. I will conclude with a call for additional federal conscience legislation, addressing opportunities and challenges such legislation presents.

Let me begin with a source of Catholic teaching specifically on this topic. In *Evangelium Vitae*, John Paul II writes,

To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised. What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law. In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.

The right of which the Holy Father speaks right is protected by what are commonly

referred to as "conscience clauses." Some of these laws are true conscience laws in that they protect the rights of health care providers to decline involvement in procedures to which they have a moral or religious objection. But some of these protections take the form of non-discrimination laws. The non-discrimination provisions protect health care providers from forced involvement without restricting the kinds of objections they may have. The laws simply say, for example, that no one should be forced to get involved in abortion for any reason. I will refer to both of these as "health care right of conscience laws."

Respect for a health care right of conscience is recognized by a vast body of laws. The laws mostly date to the time immediately following the United States Supreme Court's decision in *Roe v. Wade*. One year after *Roe*, twenty-seven states enacted laws protecting health care providers from being forced to participate in abortion. On the federal level, in 1973, Congress passed the "Church amendment" known for its sponsor, Senator Frank Church. The amendment declares that the receipt of federal funds in various health programs will not require hospitals to participate in abortion and sterilization procedures, if they object based on moral or religious grounds. It also forbids hospitals in these programs to make willingness or unwillingness to perform these procedure a condition of employment.

In addition to the Church amendment, which remains in effect, a number of other federal laws protect a health care right of conscience. In the Treasury-Postal Appropriations bills in recent years, there has been a conscience clause protecting doctors, nurses, and pharmacists who decline to prescribe or provide contraceptives under the federal employee health benefits plan. Also, both Medicare and Medicaid protect health plans operating under those programs from being forced to provide, counsel, or refer for any service to which they have a moral or religious objection. The Foreign Operations Appropriations bills prohibit discrimination against natural

family planning programs. And federal law protects individuals who decline involvement, on the basis of moral or religious beliefs, in federal executions.

On the state level, the vast majority of states protect conscience rights. Brigham Young University law professor Lynn Wardle, an expert on conscience law, counts 49 states that protect a health care right of conscience in some context. Of these, 46 states protect health care providers in the abortion context. Some states protect providers who object to other kinds of procedures including euthanasia (for example, California and South Dakota), sterilization (for example, Kansas, Massachusetts, New Jersey, Pennsylvania), artificial insemination (Maryland), abortifacient drugs (South Dakota) and contraception.

The state of Illinois has adopted a comprehensive right of conscience law, under which the protection of physicians and other health care personnel extends to any procedure which "is contrary to the conscience of such physician or health care personnel." The state of Washington provides comprehensive conscience protection to individual health care providers and to religiously affiliated health care plans and facilities.

With the exception of the Illinois conscience statute, the existing laws are inadequate. The federal laws are deficient because they are limited to a narrow set of spending programs. Many of the state protections are really rules of statutory construction contained within the abortion statute. These laws say that nothing within the abortion code shall require a hospital or a physician to perform an abortion. But that does not rule out some other source of policy, another provision of the code or a court ruling that may be used to mandate abortion. Comprehensive conscience legislation is needed to fill the gaps in existing laws and to respond to challenges by abortion rights activists who in recent years have been employing novel means to circumvent and even overturn state protections.

The Abortion Non-Discrimination Act, which, as a serious piece of federal legislation requires a cute acronym, in this case, ANDA, responds to many of the current challenges. ANDA strengthens and clarifies an existing law, 42 U.S.C. § 238n. That law prohibits the federal government and state and local governments that receive federal financial assistance from discriminating against health care entities that decline to perform, train in, refer for, or make arrangements for abortion. ANDA simply amends the existing definition of "health care entity." That definition defines "health care entity" to include "an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." The definition explicitly included individual physicians, residents and residency training programs because at the time Congress was responding to a threat made by the Accreditation Council for Graduate Medical Education to mandate abortion training in all obstetrics and gynecology programs.

ANDA simply clarifies what is implicit in the law, namely that the full range of health care entities are protected. It is implicit because the definition says health care entity "includes" and "includes" is a word of illustration not a word of limitation. This may seem obvious and simple but on Wednesday, on the floor of the House, opponents of the bill said that it will "radically expand existing law." In fact, ANDA does the rather unremarkable thing of stating that "a health care entity includes a hospital." One footnote. The bill also contains two provisions protecting health care entities from being forced to pay for or provide coverage for abortions. But the one page bill is largely a clarification.

ANDA's passage is urgently needed. Let me cite a few examples to explain why:

In Alaska, after a private non-sectarian hospital, Valley Hospital adopted a new policy prohibiting elective abortions at the hospital, the Alaska-chapter of the American Civil Liberties

Union sued. The ACLU argued that because the hospital received federal, state and local subsidies, the hospital was a quasi-public hospital. Furthermore, as a quasi-public hospital, the ACLU argued, the hospital must grant access to abortion which is a fundamental right under the Alaska Constitution. The case made its way to the Alaska Supreme Court, which in 1997, accepted the ACLU argument and ordered the hospital to open its doors for elective late-term abortions. The court then struck down the Alaska conscience law as applied to Valley Hospital. But the court didn't stop there. It intimated in a footnote, that even if a religious hospital raised conscience rights, the court might strike down those conscience rights because showing any favoritism towards religious objections would be an impermissible establishment of religion.

A second example. In St. Petersburg, Florida, Bayfront Hospital, which leased land from the city at a subsidized rate, joined Baycare Health, a consortium of hospitals that follows the U.S. Conference of Catholic Bishops' Ethical and Religious Directives. By joining the consortium, Bayfront estimated that it saved ten million dollars per year. Prior to joining Baycare, Bayfront had been performing abortions in cases of fetal deformity, approximately ten abortions a year.

After an article appeared in the Tampa Tribune with the headline, "Baycare Hospitals Curtail Abortions," the city attorney wrote a memo to the hospital alleging that it was restricting access to medical care and violating "constitutional provisions" applicable to the use of public lands and funds. The city eventually sued Bayfront and Baycare. A few months later, the Florida-chapter of the ACLU sued Bayfront and the city. That suit alleged a violation of the establishment clause because 1) the city subsidized the hospital property, 2) the fact of the subsidy turned the hospital into a state actor and 3) the adoption of the pro-life policy amounted to an establishment of religion. In negotiations with the city, the hospital offered to purchase the land at fair market value–47 million dollars. The city actually rejected the offer. Under the pressure of the lawsuit

and mounting legal fees, Bayfront was forced to leave the consortium.

I want to take a moment to comment on the ACLU argument that was set forth in these lawsuits and elaborated on in a recent ACLU report, "Religious Refusals and Reproductive Rights." In the report, the ACLU argued, "when religiously affiliated organizations move into secular pursuits such as providing medical care or social services to the public or running a business—they should no longer be insulated from secular laws. In the public world, they should play by the public rules. The vast majority of health care institutions-- including those with religious affiliations–serve the general public. They employ a diverse work force. And they depend on government funds."

A few comments. First, the ACLU is well aware that not a single hospital would qualify for conscience protection under its test. In testimony before the House Energy and Commerce Health Subcommittee, ACLU lawyer, Catherine Weiss testified, "Among health care institutions, privately funded Christian Science sanatoria may exemplify those that should qualify for a religious exemption." Under the ACLU theory, in order for a Catholic hospital to invoke conscience protection, the hospital would have to reject government assistance, thereby abandoning Medicare and Medicaid patients, discriminate in employment and patient admissions, limiting both to Catholics, and engage solely in faith healing.

A second comment. The ACLU's argument assumes that abortion is the standard of care, that abortion is, in their words, "a public rule." In fact, it is not. The abortion right granted by the Court in *Roe v. Wade* is a right to be free from governmental interference in exercising the right. It is not an entitlement to have the government or anyone else deliver the means to obtain an abortion. It is not a right of unfettered access that places obligations on others. In fact, the Georgia statute that was under consideration in *Roe's* companion case, *Doe v. Bolton*, contained a

conscience clause. And the court relied on it in part in striking down another provision of Georgia law. In striking down a provision that required a hospital committee to review all abortions, the Court said, "the hospital itself is otherwise fully protected...the hospital is free not to admit a patient for an abortion. It is even free not to have an abortion committee. Further, a physician or any other employee has the right to refrain for moral or religious reasons, from participating in the abortion procedure."

The policies of the vast majority of hospitals also reflect the fact that health care providers do not regard abortion as standard medical care. 86% of all hospitals, including public and private non-sectarian hospitals, do not get involved in abortion.

Two more examples demonstrating the need for ANDA.

In Manchester, New Hampshire, Eliot Hospital, a non-profit, non-sectarian hospital merged with Catholic Medical Center to become Optima Health. As a condition of the merger, Eliot agreed to cease performing abortions. After abortion rights groups learned this, they approached the New Hampshire attorney general to challenge the merger using a novel theory of law. They argued that charitable trust law applied to the merger and that Eliot Hospital and the Catholic Medical Center illegally changed their charitable missions when they agreed to merge. The attorney general accepted the argument and concluded that the merger must be reviewed in probate court. Under this pressure, the merger dissolved.

One more example. After the Catholic dioceses in New York created Fidelis Care, a managed care plan, Family Planning Advocates of New York began pressuring the state health department to force the Catholic plan to provide abortion referrals. Family Planning advocates said, "Fidelis' ability to serve women of childbearing age is severely compromised by its refusal to cover. . .abortions." The state comptroller has since recommended that Fidelis no longer be

assigned state health contracts for women of childbearing age.

Fidelis Health, as well as the other health care providers cited above, would be protected by ANDA, should it become law. We remain hopeful that it will pass the Senate, however difficult that may be in light of the current political climate.

But unfortunately, even with ANDA's passage, health care providers will not be sufficiently protected as new threats to conscience arise. These other threats include mandated contraceptive and infertility insurance coverage and mandated provision of emergency contraception to rape victims in all cases, even when that regimen may be abortifacient. On these issues, the Catholic Church has been in a defensive position, attempting to defeat these measures and doing so with limited success. Pro-active protective federal legislation is needed.

Twenty states have now adopted laws requiring all employee health benefit plans that include prescriptive drug coverage to include contraceptive drugs. According to Planned Parenthood, bills are currently pending in thirteen states. A federal bill is also pending. These mandates pose obvious difficulties for the Catholic Church insofar as the mandates apply to the Church as an employer.

Virtually all the mandates enacted thus far provide either no conscience protection or totally inadequate "protection." Five states provide no conscience protection. Of the remaining fifteen that do, only one protects moral and religious beliefs. Seven that purport to protect "religious employers" follow an ACLU style "conscience clause" which transforms religious organizations such as Catholic charities and Catholic grade schools into secular ones with no conscience rights. These laws define "religious employers" as entities for which the following is true:

the inculcation of religious values is the purpose of the entity

the entity primarily employs and serves persons who share the religious tenets of the entity.

This language is currently being challenged by Catholic Charities of California which does not qualify for the protection under California law. The lawsuit is pending before the California Supreme Court.

These conscience protections in the contraceptive mandates, as inadequate as they are, would actually be overridden by a clause in the pending federal contraceptive mandate.

Two other federal bills that we are monitoring are an infertility mandate and an emergency contraception mandate. The infertility mandate requires all health plans that provide obstetrical services to include infertility treatments, including in vitro fertilization. The emergency contraception mandate requires all hospitals that receive federal financial assistance (which is a description that applies to all hospitals) to provide emergency contraception to rape victims. Catholic teaching does allow for the provision of emergency contraception to rape victims so long as it does not interfere with implantation of a newly conceived human embryo. One of our panelists, Joe Piccione, has done cutting edge work on both the science and morality of emergency contraception treatment. I direct you to his writings for more information on a protocol that implements the Bishops' health care directive on this issue.

As you may have noticed, I have now entered into an area of especially controversial issues and one in which the positions of the Catholic Church are unique. But fortunately, in Washington, we have friends of other denominations who have been assisting us in advocating for our right of conscience. For example, Concerned Women for America, a Protestant women's organization, submitted written testimony against the federal contraceptive mandate. And the Christian Medical Society, another Protestant organization has been actively involved in these issues. The Seventh Day Adventists support passage of ANDA.

The fact of the involvement of these organizations of other denominations suggests that what is at stake in this debate is not strictly a Catholic issue. The positions on these underlying issues may be mostly Catholic positions. But there is nothing distinctively Catholic about the interest in securing protection for the right to object to participating in these elective treatments and procedures.

Possibilities for coalition building in this area offer great hope for securing additional federal protections in these more controversial areas. That coalition building, coupled with grassroots education and lobbying make a victory in this area possible. When I began work in this area two years ago, my first inclination was to seek the assistance of those great traditional peace-churches, the Quakers and the Mennonites who have lived-experience as conscientious objectors. They are not on record either supporting or opposing our efforts. It is my sincere hope that they will join us.