GOD AND WOMAN IN THE CATHOLIC HOSPITAL

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I. INTRODUCTION

Women's religious orders founded and fostered the development of most Catholic hospitals in the United States. Ironically, issues related to a woman's reproductive rights may provide the most difficult challenges to their ongoing struggles to preserve Catholic identity. Catholic hospitals in the United States currently endure vigorous attacks from well-organized liberal pro-choice groups[1] that seek to force such hospitals to provide access to a full range of "reproductive health services."[2] Articles in popular magazines contend that the Catholic character of particular hospitals prevents them from adequately serving the reproductive needs of their communities.[3] In response to

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1. *Cf.* WILLIAM SALETAN, BEARING RIGHT: HOW CONSERVATIVES WON THE ABORTION WARS (2003). Saletan distinguishes between liberal pro-choice activists, who advocate public funds for abortion and oppose parental consent laws, from more conservative pro-choice supporters, who support access to abortion but not the use of public funds and favor parental consent laws. He concludes that the position of conservative pro-choice supporters prevails in the political arena.

2. The term "reproductive health services" remains as a controversial and tendentious term. In the international law context, people use this term to promote increased access to abortion, contraception, and sterilization. *See* Father Robert Araujo, *Sovereignty, Human Rights, and Self Determination: The Meaning of International Law*, 24 FORDHAM INT'L. L. J. 1477, 1508 (2001). Generally, those working in the Catholic natural law tradition would not consider abortion, contraception and sterilization as "reproductive health services" because they prevent reproduction. In January of 2003, the Vatican announced plans to publish a "Lexicon of the Family and Life" that would include a glossary of terms intended to clarify sexual and reproductive issues. In an interview concerning the glossary, Cardinal Trujillo particularly "took issue with the term 'reproductive rights,' which he said is not used to promote right of reproduction, but the right of abortion." Jennifer Harper, *Vatican Writes 'Glossary' on Sex Terminology*, WASHINGTON TIMES, January 17, 2003, at A1.

3. *See,* e.g., Leslie Laurence, *The Hidden Health Threat That Puts Every Woman at Risk*, REDBOOK, July 1, 2000, *available at* 2000 WL 18879371. This article states:

> Abortion isn't the only procedure banned by hospitals under Catholic control. Prescribing birth control (even to treat endometriosis and ovarian cysts), performing surgery to sterilize men and women who've completed their families, treating infertility with in vitro fertilization and artificial insemination—all these procedures can become off-limits. Medical schools affiliated with Catholic hospitals can't train students to perform abortions or do research on fetal tissue. Doctors

intense lobbying by liberal pro-choice groups, several states adopted laws that require Catholic hospitals to provide emergency contraception for rape victims.[4] These same groups also lobby to promote state legislation that would mandate employers to include contraceptive coverage in health insurance policies with limits on the ability of religious organizations to avoid the mandate.[5] Some Catholic leaders believe the "true goal [of the contraceptive coverage mandate] is to set the stage for mandated coverage of all so-called reproductive services, including abortion."[6]

In a report issued in 2002, the American Civil Liberties Union's Reproductive Freedom Project called for legislation that would require Catholic hospitals to provide access to a full range of reproductive services.[7] In 1997, Senator Boxer and Representative Pelosi introduced legislation in Congress to require all hospitals that receive federal monies to provide a full range of reproductive health services.[8] Some states considered legislation to force Catholic hospitals to provide either abortion referrals or abortions.[9]

Politicians, especially Democrats, increasingly welcome demands for legislation that would require Catholic hospitals to provide reproductive health services to their patients and coverage of such services to their employees. While the Catholic Church typically disagrees with the Democratic Party over issues such as abortion, they agree on many other social justice issues.[10] Traditionally, Catholic voters formed an important part of the New Deal Democrat coalition, and leading Democrats had a close relationship with Church leaders. Now the Democratic Party is a party of abortion rights, and Democrat politicians appear willing to confront the Catholic Church through

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treating patients who have refused "extraordinary measures" at the end of their lives can't withdraw feeding tubes.

Id. The unwillingness of Catholic hospitals to provide certain services, as well as the mixture of religion and health care, concerns the author of this *Redbook* article. She quotes a psychiatrist who practices at a clinic in Minnesota that considered a merger with the prestigious St. Mary's Medical. That hospital's customs of offering prayers over the loudspeaker and placing crucifixes in the patient rooms offended the psychiatrist, and the psychiatrist further states: "Thoughtful Catholics recognize that it is not hospitable or charitable to use the vulnerability of an illness as an occasion to proselytize for a religious viewpoint." *Id.*

4. *See, e.g.*, 2002 Cal. Legis. Serv. Ch. 382 (A.B. 1860) (West); N.Y. PUB. HEALTH LAW § 2805–p (McKinney 2004); WASH. REV. CODE ANN. § 70.41.350 (West 2004).

5. John Burger, *Mandatory Contraceptive Coverage: Is Abortion Next?*, NAT'L CATH. REG., February 17, 2002, *available at* http://www.ncregister.com/Register_New/02202con.htm.

6. *Id.* (quoting Cathleen Cleaver, Director of Planning and Information for the Pro-Life Secretariat of the United States Conference of Catholic Bishops).

7. RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS, ACLU REPRODUCTIVE FREEDOM PROJECT (2002), *available at* http://www.aclu.org/Files/OpenFile.cfm?id=10943.

8. William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455, 516 (2001). This bill carried the title "The Family Planning and Choice Protection Act," H.R. 2525; S. 1208 (103rd Congress).

9. Jim Holman, *GOP and Latino Dems to the Rescue*, SAN FRANCISCO FAITH, July/August 1999, *available at* http://www.sffaith.com/ed/articles/1999/0799an.htm. In 1999, the California State Assembly defeated by a vote of 31 to 39 a bill proposed by Assemblywoman Sheila Kuhl (D–Santa Monica) that would require Catholic hospitals to provide abortions or abortion referrals. If they failed to do so, then the hospitals would not receive public bond financing or Cal-Mortgage loan insurance. Five Latino Democrats voted against the bill, and defeated it.

10. Remarks of Rev. Brian Hehir, Th.D., Professor, Harvard Divinity School, in *Finding Common Ground in a Pluralist Society: Catholic Providers Seek Ways to Maintain Catholic Identity in the Face of Opposition to their Stands on Reproduction and Physician-Assisted Suicide,* SPECIAL REPORT: THE 83RD CATHOLIC HEALTH ASSEMBLY, HEALTH PROGRES, July-Aug. 1998, *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9807&ARTICLE=AI.

legislation that requires Catholic institutions to provide reproductive health services in violation of Catholic ethical norms.[11] It may appear difficult for Church leaders to accept that Democrats, and in some instances Catholic Democrat politicians, support legislation that could directly force Church agencies to violate Church teaching.

Abortion is widely available in specialized clinics and some non-Catholic hospitals. However, this is insufficient for liberal pro-choice activists who seek to make abortion services available in Catholic hospitals.[12] As Professor Lynn Wardle noted, there exists a shift in tactics by liberal pro-choice activists. Originally they "argued that they merely desired to give women the private choice to select abortion," but now, "they try to compel hospitals, clinics, provider groups, and health care insurers to provide facilities, personnel, and funding for abortion."[13] In a 1998 panel discussion on Catholic Identity, sponsored by the Catholic Health Association, Father Brian Hehir, then a Professor at Harvard Divinity School, noted, "A fundamental disagreement between Catholic providers and their opponents is whether reproductive choices should be public or private issues."[14] Mary Healey-Sedutto, Director of Health and Hospitals, Archdiocese of New York, another participant in this panel discussion, articulated her comments more specifically. In referring to bills pending at the time in the New York legislature that would have required Catholic hospitals to provide a full range of reproductive health services in violation of Catholic teachings, she stated:

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11. Tony Quinn, *Democrats: A Loyal Constituency Is Restless*, LOS ANGELES TIMES, January 6, 2002, *available at* 2002 WL 2444130. This article notes:

> But the real political damage for Democrats may lie in Church leaders' accusations that the legislation smacks of officially endorsed bigotry against Catholics. They assert the pope was ridiculed and the church compared to a witch's coven as the bill moved through the Legislature. Church leaders also worry that the bill is part of a larger effort by feminist groups and their Democratic allies to force Catholic hospitals to provide abortion on demand, a matter of growing public debate as the number of Catholic-owned hospitals increases in California...Is there any room left in the Democratic Party for the traditionalist Catholic viewpoint? David Carlin, the former Democratic majority leader of the Rhode Island Senate, doesn't think so. In an article titled "How Can a Catholic Be a Democrat?", Carlin complains that his party is not only pro-abortion, but also in favor of same-sex marriage, physician-assisted suicide, stem-cell research and even cloning embryos. "If you're a Catholic," he writes, "how can you possibly continue to be a Democrat when the Democratic Party can be relied on to support the rejection of Christian values and their replacement by un-Christian or anti-Christian values?"

Id.

12. *See, e.g.*, *Abortion Non-Discrimination Act, H.R. 4691, Before the House Energy and Commerce Subcommittee on Health*, July 11, 2002, *available at* 2002 WL 20318916, statement of Catherine Weiss, Director of the ACLU Reproductive Freedom Project. Weiss stated:

> When, however, religiously affiliated organizations move into secular pursuits—such a providing medical care or social services to the public or running a business—they should no longer be insulated from secular laws that apply to these secular pursuits. In the public world, they should play by public rules. The vast majority of health care institutions—including those with religious affiliations—serve the general public. They employ a diverse workforce. And they depend on government funds. A recent study found that Medicare and Medicaid accounted for 46% of total revenues to religiously affiliated hospitals in California in 1998, while unrestricted contributions, including charitable donations from church members, accounted for only .0015% (or $15 in every $10,000) of total revenues. These institutions ought to abide by the same standards of care and reproductive health mandates that apply to other health care institutions.

Id.

13. *Abortion Non-Discrimination Act, H.R. 4691, Before the House Energy and Commerce Subcommittee on Health*, July 11, 2002, *available at* 2002 WL 20318915 (Statement of Professor Lyn Wardle, J. Reuben Clark Law School, Brigham Young University).

14. Remarks of Rev. Brian Hehir, *Finding Common Ground in a Pluralistic Society*, *supra* note 10.

> I am in shock at the rapidity with which these issues have developed. In the past months, five bills have moved through the assembly into the senate that will fundamentally challenge our ability to remain in healthcare . . . Our opponents have a frightening and insidious strategy . . . They have learned how to use our own strengths against us . . . They speak of their mission, of their core values, their ministry. They attend our meetings and participate in the discussion. They praise us with great flourish, but then move on to the one deficit: that we are preventing society from having access to what they see as societal rights. [15]

Under federal and state conscience clause legislation, individuals and institutions enjoy protection from a requirement to perform medical procedures that they object to such as abortion.[16] However, groups such as the ACLU contend that conscience clause legislation gives institutions too much protection and that this results in unwarranted restrictions in the availability of reproductive health services.[17] The groups argue that Catholic hospitals operate in the public sector and receive public funds; therefore, they should not impose restrictions on the availability of reproductive health services.[18] In addition, Professor William Bassett, a canon lawyer and professor at the University of San Francisco School of Law, argues that federal and state conscience clauses should be reconsidered in light of the fact that many of those covered by managed care plans are limited in their choices of hospitals.[19] Accordingly, under Professor Bassett's approach, patients' rights of access to reproductive services trumps the rights of religiously affiliated hospitals to refuse services unless the patient has ready access to other facilities, and the religious hospital fully discloses in advance its ethical restrictions.[20]

Catholic hospitals are governed by the *Ethical and Religious Directives for Catholic Hospitals*[21] ("*ERD*"), a set of norms adopted by the National Conference of Catholic Bishops ("NCCB") and most recently updated in 2001. Those procedures judged morally wrong include contraception,[22] direct sterilization,[23] and direct abortion.[24] In recent years, a number of laws have been proposed at the federal level that would deny federal funds to Catholic hospitals that refuse to provide certain reproductive health services.[25] Catholic health care leaders acknowledge that linking

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15. Remarks of Mary Healey-Sedutto, Ph.D., Director of Health and Hospitals, Archdiocese of New York, *Finding Common Ground in a Pluralistic Society*, *supra* note 10.

16. RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS, *supra* note 7, at 1.

17. *Id.* at 2.

18. *Id.* at 5.

19. Bassett, *Private Religious Hospitals*, *supra* note 8, at 455.

20. *Id.* at 456 – 57.

21. United States Conference of Catholic Bishops, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed. 2001). *See also* Kenneth R. White, *Hospitals Sponsored by the Roman Catholic Church: Separate, Equal and Distinct*, 78 MILBANK QUARTERLY 213, 216 (2000) ("The moral responsibility of Catholic health care is outlined in the Ethical and Religious Directives for Catholic Health Care Services.").

22. United States Conference for Catholic Bishops, *supra* note 21, at 25.

23. *Id.* at 28.

24. *Id.* at 26.

25. *See, e.g.*, H.R. 4113, 107th Cong. (2002), at 2001 Cong. US HR 4113 (cutting off federal funds to hospitals that fail to provide emergency contraception to victims of sexual assault).

the receipt of federal funds to the provision of reproductive services could effectively destroy Catholic health care.[26] Simultaneously, allegations exist that Catholic hospitals remain insincere about their commitment to provide health care to the poor and provide less indigent care than non-Catholic facilities.[27] It remains possible that groups could threaten Catholic hospitals with the loss of their tax-exempt status if they refuse to provide abortions.

Liberal pro-choice groups already gained success in state legislatures. Recently, several states passed laws that require all hospitals, including Catholic hospitals, to provide emergency contraception to rape victims.[28] These laws could be interpreted to require hospitals to provide services in violation of their bishop's interpretation of the *ERD*. Some laws even require most Catholic organizations to provide contraceptive coverage as part of their employee's health care plans.[29] These laws could pave the way for more sweeping legislation. If legislation can require Catholic hospitals to provide emergency contraception for rape victims and contraceptive coverage for employees, it might also require them to provide sterilizations and abortions to patients.

The distinctive mission of Catholic hospitals may be extinguished due to "a confluence of powerful environmental forces."[30] Indeed, cultural, religious, economic, and political forces seem to work in tandem to erode the religious mission of Catholic hospitals. Internal and external forces place the future of a distinctive Catholic health care at risk. The interaction of these forces is particularly apparent in the attacks on Catholic hospitals for their refusal to provide reproductive health services. This article will focus on the ongoing struggle to preserve a distinctively Catholic health care system in the United States in light of the increasing demands upon Catholic hospitals to provide a full range of reproductive health services.

Part I will discuss the spate of recent laws that require Catholic hospitals to provide contraceptive coverage to employees and emergency contraception to victims of sexual assaults. It will review the impact of United States Supreme Court precedents that undermined constitutional protection for Catholic hospitals and the controversy over conscience clause legislation. It will discuss the controversy over mandated

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26. Bonar Menninger, *Mission & Margin*, HEALTH LEADERS (Dec. 2003) *available at* http://www.healthleaders.com/magazine/2003/dec/cover.php?month=dec&year=2003 (quoting Sister Mary Roch Rocklage, chairwoman of the St. Louis based Sisters of Mercy Health System and the immediate past chairwoman of the American Hospital Association).

27. *See Catholic Hospitals and the Charity Myth*, The Abortion Access Project, *available at* http://www.abortionaccess.org/viewpages/php?id=168 (asserting "that Catholic hospitals actually provide lower levels of charity care than most other hospitals").

28. *See, e.g.*, 29 CAL. PENAL CODE § 13823.11(e)(1) (West 2002).

29. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1367.25 (West 2003); N.Y. INS. LAW § 3221 (1) (16) (McKinney 2003).

30. White, *Hospitals Sponsored by the Roman Catholic Church*, *supra* note 21, at 233 noting:

> A confluence of powerful environmental forces at the beginning of the twenty-first century is threatening the future of Catholic health care. A review of the research that defines, differentiates, and describes the performance and identity measures of Catholic hospitals reveals them to be a *separate* case of private, nonprofit hospital. They have experienced environmental pressures to become isomorphic with other hospital ownership types and are *equal* on some dimensions. To keep pace with the changing demands of religious sponsorship and the social role of the hospital, Catholic hospitals continue to redefine themselves. To justify a *distinct* and legitimate social role, they must begin to emphasize organizational commitments to a "Catholic" way of doing things. Without a palpable and routinely noticeable distinctiveness, the institutions fail the "identity challenge" of what makes them Catholic. . . . (citations omitted).

contraceptive coverage. It will review a recent California Supreme Court decision dealing with the constitutionality of a contraceptive coverage mandate, as applied to employee health plans sponsored by Catholic institutions. Part I will also discuss a Washington State Attorney General's Opinion that interprets Washington State and federal law to require Catholic institutions to provide contraceptive coverage to their employees. It will review recent legislation requiring Catholic hospitals to provide emergency contraception, and studies on the current practices in Catholic hospitals with respect to emergency contraception. Finally, it will review protocols on emergency contraception developed by Catholic health care systems.

Part II will discuss the moral foundation of Catholic health care. It will review the Catholic natural law tradition and challenges to that tradition. It will examine the controversy among Catholic theologians over the proper role of Catholic hospitals and the influence of the secular bioethics movement on Catholic health care. Various versions of the *ERD* will be reviewed with particular attention being paid to their treatment of abortion, contraception, and sterilization. Catholic identity will also be discussed, with a particular focus on the threat posed to such identity by laws that may require Catholic hospitals to violate the *ERD*. The current threat to the religious identity of Catholic hospitals in the United States is perhaps the greatest in the history of these institutions. If, ultimately, Catholic hospitals succumb to these pressures, lose their Catholic identity, and become indistinguishable from secular institutions, health care in the United States will become increasingly dominated by a business model that subordinates the spiritual and moral dimensions of health care to the profit motive.

II. EXTERNAL THREATS TO CATHOLIC IDENTITY: MANDATED CONTRACEPTIVE COVERAGE AND EMERGENCY CONTRACEPTION LAWS

Catholic hospitals experience increasing governmental pressures to provide services in violation of their core beliefs. These pressures may result from new conditions placed on access to government funding, limitations on participation in government programs, or extensions of state or federal regulatory authority. United States Supreme Court precedents also make it difficult for Catholic institutions to claim protection from such laws under the First Amendment's Free Exercise clause. In *Employment Division, Dep't of Human Resources v. Smith*,[31] the court refused to apply strict scrutiny to neutral laws of general applicability even if those laws carry the incidental effect of burdening a particular religious practice. Accordingly, states are no longer required to establish a compelling interest in support of laws that result in incidental burdens on religious practices. Subsequently, Congress adopted the Religious Freedom Restoration Act of 1993[32] ("RFRA") to overrule *Smith* and restore the compelling state interest test. However, in *City of Boerne v. Flores*,[33] the United States Supreme Court held RFRA unconstitutional as applied to state and local legislation. The gutting of RFRA by the United States Supreme Court removes a

31. Employment Div., Dep't of Human Res. v. Smith, 494 U.S. 872, 893 (1990).

32. Religious Freedom Restoration Act of 1993, Pub. L. 103-141, 107 Stat. 1489 (codified at 42 U.S.C.A. §§ 2000bb to 2000bb-4 (West 2003)).

33. 521 U.S. 507, 536 (1997).

potentially significant shield against generally applicable laws that arguably violate religious liberties. Some contend, however, that RFRA might still be valid with respect to federal laws.[34]

It remains possible that a state could pass a law that would require all hospitals to provide reproductive services in violation of the *ERD* as a condition of licensure. Indeed, as discussed *infra*, some states passed laws that require Catholic hospitals to provide emergency contraception without regard to limitations set out in the *ERD*, while other states passed laws that require Catholic organizations to provide contraceptive coverage to their employees if they provide them with prescription drug coverage. Under *Smith*, it may be very difficult to convince a court that such laws violate the First Amendment. On the other hand, if the law in question appears to be motivated by animus toward Catholics, or appears to single out Catholic institutions, then perhaps an argument could be made under *Church of Lukumi Babalu Aye v. City of Hialeah*.[35] This argument would show that such a law comes subject to strict scrutiny and may violate the First Amendment. Otherwise, these laws would most likely be upheld.

Similarly, the federal government could pass a law that requires all hospitals that receive Medicare funds to provide a full range of reproductive services. Generally, courts uphold this sort of conditional funding restriction. For example, in *Rust v. Sullivan*[36] the court upheld restrictions on the activities of Title X grantees with respect to the promotion of abortion as a family planning method. On the other hand, courts may view legislation that requires Catholic hospitals to provide reproductive services in violation of the *ERD*, in order to receive Medicare funds, as a more substantial intrusion into the activities of the grantees than the restrictions upheld by the court in *Rust*. In *Rust*, the grantees effectively avoided the impact of the law by segregating their abortion activities from their other activities. In the case of Catholic hospitals, however, the principles concerning material cooperation would still make such a mandate morally problematic and indeed might force the institution to close.

During the past forty years, state laws that restricted access to contraception and abortion supported by the Catholic Church on natural law grounds fared poorly before the United States Supreme Court. Indeed, it is possible to view the series of Supreme Court precedents that deal with issues such as contraception and abortion as motivated by an eagerness to endorse the sexual revolution and a desire to limit Catholic power in state legislatures. By the early 1950s, Connecticut and Massachusetts remained the only states that continued to enforce laws banning the sale and distribution of contraceptives.[37] Not coincidentally, both states had significant Catholic populations

34. *See, e.g.*, Thomas C. Berg, *Religious Liberty in America at the End of the Century*, 16 J. L & REL. 187, 193 (2001).

35. 508 U.S. 520, 524 (1993) (striking law down that prohibited sacrificial killing of animals for religious purposes where directed only at the Santeria religion).

36. 500 U.S. 173, 203 (1991).

37. In 1953, McFadden wrote:

> Only two states in the nation, Massachusetts and Connecticut, have had the courage to hold their ground against the powerful influences demanding the lifting of barriers (to the advertising, sale and distribution of contraceptives). In these two states, an adequate law exists and diligent effort is made to enforce it. In the November 1948 election the people of Massachusetts again voted to retain the law.

CHARLES J. MCFADDEN, MEDICAL ETHICS 81 (3d ed. 1953).

and an active lobby in the state legislature on behalf of Catholic interests, and thus Catholics had the ability to thwart attempts to repeal the bans on the sale and distribution of contraceptives.[38]

Indeed, in *Griswold v. Connecticut*,[39] rather than allow the state legislature to continue to deal with the issue of access to contraceptives, the Court even invented a new federal constitutional right of privacy to strike down Connecticut's ban on the sale of contraceptives to married persons. Likewise, in *Eisenstadt v. Baird*,[40] the Court, relying on the Equal Protection clause, struck down a Massachusetts law that prohibited the distribution of contraceptives to unmarried people. Similarly, at the time of *Roe v. Wade*,[41] people viewed support for restrictions on access to abortion as a Catholic issue. Even though many states had already liberalized their abortion laws, the Court seemed impatient with the rate of change. In a sweeping decision, the Court struck down all existing state abortion laws as too restrictive. *Roe* may be viewed primarily as a decision that removed the abortion issue from the state legislatures because of concern that there remained too much Catholic influence in those bodies.

Of course, the influence of Catholic interests in legislatures witnessed a sharp decline since the time of *Griswold*, *Eisenstadt*, and *Roe*, while the influence of the pro-choice lobby significantly increased. With the shift of cultural attitudes toward such issues among elites, the current United States Supreme Court appears unreceptive to arguments that state or federal laws requiring Catholic hospitals to provide reproductive services in violation of Catholic teachings violate the First Amendment. In this context, the Court will more than likely defer to the legislative branch because the outcomes will embrace values shared by many members of the Court. Indeed, sexual autonomy seems to enjoy a preferred constitutional status in the eyes of the current court.[42] Further, conservative justices gave us *Smith* and *Rust*. The combination of liberal, pro-sexual autonomy justices with conservative justices deferential to legislatures and hostile to unconstitutional condition arguments appear difficult to overcome.

Moreover, the judicial commitment to sexual autonomy as a favored right, when coupled with the de-emphasis of religious free exercise rights, does not bode well for Catholic hospitals that seek to follow the *ERD*. It appears clear that *Smith* diluted the Free Exercise Clause. The states remain free to pass neutral laws of general application that substantially restrict religious activity by individuals and groups as long as those laws contain some rational basis. Indeed, as Professor Hitchcock has noted, some influential commentators and Supreme Court justices have viewed religious liberty as a

38. DAVID J. GARROW, LIBERTY AND SEXUALITY 1–195 (1994) (discussing Catholic opposition to repeal or amend Massachusetts and Connecticut laws banning sale and distribution of contraceptives).

39. 381 U.S. 479, 485–86 (1965).

40. 405 U.S. 438, 454–55 (1972).

41. 410 U.S. 113 (1972). At the time of *Roe*, evangelical Protestant denominations remained uninvolved in the pro-life movement. In fact, the Southern Baptist Convention initially embraced the pro-choice position and only passed its first pro-life resolution in the early 1980s. In 1971 and 1974, the Southern Baptist Convention had adopted a resolution that endorsed the availability of abortion in cases of rape, incest, fetal deformity and potential damage to the physical or mental health of the mother. In 2003, the Southern Baptist Convention adopted a resolution expressly repudiating its earlier pro-choice stance. Tom Strode, *Resolution Repudiates Early Abortion Stance*, FLORIDA BAPTIST WITNESS (June 26, 2003), *available at* http://www.floridabaptistwitness.com/1104.article.print; Richard Land, *Thirty Years Later: Southern Baptists and Roe v. Wade*, *available at* http://www.nrlc.org/news/2003/NRL07/30_years_later.htm.

42. *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 578 (2003).

potential threat to secular liberal democracy.[43] It also appears that many members of the United States Supreme Court regard traditional Catholic views on human sexuality as primitive and perhaps even malicious. In any conflict between religious groups and persons who advocate personal autonomy in sexual matters, it remains probable that the Court favors advocates of sexual autonomy. Similarly, in the current context, it probably favors patient's rights in matters that pertain to sexuality, like access to reproductive services, over the interests of Catholic health care institutions in continuing to observe the religiously-based restrictions found in the *ERD*. Accordingly, it would not be surprising for the Court to uphold laws that require Catholic hospitals to provide reproductive services contrary to their core religious beliefs.

Currently, under federal and state conscience clause legislation, individuals and institutions are protected from performing medical procedures that they object to, such as abortion. In 1973, responding to *Roe v. Wade*, Congress passed the Church Amendment, the original federal conscience clause legislation.[44] According to Professor Bassett, the legacy of *Bradfield v. Roberts*[45] is one of federal and state governments that treat Catholic health care as an essentially secular enterprise eligible for the receipt of government funding.[46] This view of Catholic health care necessitated the enactment of conscience clause protections in the aftermath of *Roe v. Wade* in order to prevent the courts from using the receipt of federal funds as a basis for requiring Catholic hospitals to provide abortions.[47]

The Church Amendment prohibits courts and public officials from requiring recipients of federal funds under three specific programs to perform abortions or sterilizations, if that would be contrary to their religious or moral beliefs.[48] Its constitutionality has been upheld against an Establishment Clause claim.[49] In 1996, Congress passed the Coats Amendment, legislation that prohibits the government from discriminating against medical residency programs that lose accreditation because they fail to provide abortion training.[50] In 1997, Congress expanded conscience clause protection to Medicaid managed plans so that they could refuse to provide services or referrals for services they objected to on moral and religious grounds.[51] Notwithstanding these laws, Professor Wardle questions whether existing conscience

43. James Hitchcock, *The Enemies of Religious Liberty*, FIRST THINGS, February 2004, at 26. *See also* Lee v. Weisman, 505 U.S. 577, 599– 609 (1992) (Blackmun, J., concurring); Kathleen M. Sullivan, *Religion and Liberal Democracy*, 59 U. CHI. L. REV. 195, 195 (1992).

44. 42 U.S.C. A. § 300a-7 (West 2004).

45. 175 U.S. 291 (1899).

46. Bassett, *Private Religious Hospital, supra* note 8, at 548.

47. *Id.*

48. 42 U.S.C.A. § 300a-7 (West 2004).

49. Chrisman v. Sisters of St. Joseph of Peace, 506 F.2d 308, 312 (9th Cir. 1974) (relying on Church Amendment; dismissing civil rights lawsuit against Catholic hospital that received Hill-Burton funds brought by woman who was refused sterilization; rejecting establishment clause claim) *discussed in* Bassett, *Private Religious Hospitals*, *supra* note 8, at 554.

50. 42 U.S.C.A. § 238n (West 2004). This legislation passed in response to St. Agnes Hospital v. Riddick, 748 F. Supp. 319, 332 (D. Md. 1990) (upholding withdrawal by Accreditation Council for Graduate Medical Education of accreditation of Catholic hospital's residency program in obstetrics and gynecology because of failure to provide training in elective abortions, sterilizations and contraception; finding ACGME is state actor but rejecting free exercise claim after determining there is a compelling state interest in providing this type of training).

51. 42 U.S.C.A. § 1396u-2 (3) (B) (West 2004).

clause protections provide adequate protection for religiously affiliated health care institutions.[52]

In September of 2002, in anticipation of attempts to narrow the conscience clause exemptions, the House passed H.R. 4691, legislation designed to expand the Coats Amendment.[53] The United States Conference of Catholic Bishops ("USCCB") supported this legislation in order to make it clear "that the term 'health care entity' in existing law includes the full range of participants involved in providing health care, such as health care professionals, health plans, hospitals and other health facilities."[54] It did not pass in the Senate, and was reintroduced in both houses in 2003.[55] The USCCB deemed this legislation necessary in order to "counteract efforts to make all care providers perform abortions."[56] Under Supreme Court precedents, conscience clause legislation such as this is probably not constitutionally mandated. On the other hand, such legislation appears not to violate the Establishment Clause.

Groups such as the ACLU, however, contend that conscience clause legislation gives institutions too much protection resulting in unwarranted restrictions in the availability of reproductive services. In testifying against H.R. 4691, Catherine Weiss, Director of the ACLU's Reproductive Freedom Project, noted that the legislation could "thwart" the enforcement of state and local laws that require entities certified or licensed by the state to address the full range of health care needs in the communities they serve."[57] She continued by clarifying, "A state might be prevented... from denying a 'certificate of need'... to a newly merged hospital that refused to provide even lifesaving abortions...."[58] In an attempt to refute this argument, the USCCB issued a fact sheet that notes that approximately fourteen percent of hospitals currently provide a

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52. According to Professor Wardle:

> Existing conscience clause laws are inadequate as drafted for at least five major reasons. First, most are very narrow in terms of the practices, procedures or contexts in which they apply-most were drafted with abortion and sterilization in mind and go no further. Second, many of them are very narrow and restrictive, covering only a small group of health care providers, not workers in the health care industry generally. Third, the scope of protection (the discrimination forbidden) is limited. Fourth, the remedies and procedures for vindicating the rights are undeveloped and restricted. Fifth, most of the laws are outdated, having been written before many of the medical developments occurred that have created some of the most difficult moral dilemmas.

7/11/02 Cong. Testimony, *available at* 2002 WL 20318915.

53. H.R. 4691, 107th Cong. (2002) (passed the House September 25, 2002). As amended, it read:

> The Federal Government, and any State or local government that receives federal financial assistance, may not subject any health care entity to discrimination on the basis that – (1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform, provide coverage of, or pay for induced abortions, or to provide referrals for such training or such abortions; (c) Definitions: For purposes of this section:...(2) The term "health care entity" includes an individual physician or health professional, a postgraduate physician training program, a participant in a program of training in the health care professions, a hospital, a provider sponsored organization, a health insurance plan, or any other kind of health care facility, organization or plan.

Statement of Catherine Weiss, *supra* note 12.

54. Letter from Gail Quinn, Executive Director, Secretariat for Pro-Life Activities, United States Conference of Catholic Bishops (July 2, 2002) *available at* http://www.usccb.org/prolife/issues/abortion/andah.htm.

55. S. 1397, 108th Cong. (2003), 2003 US. S. 1397; H.R. 3664, 108th Cong. (2003).

56. Letter from Gail Quinn, *supra* note 54.

57. Statement of Catherine Weiss, *supra* note 12.

58. *Id.*

full range of abortion services and thus, "If states denied licenses and certification to all hospitals that fail to provide the 'full range' of abortions, our health care system would disappear."[59] The fact sheet further notes, "the vast majority of states already have their own conscience laws that would prevent the enforcement of such a coercive and harmful policy."[60]

Weiss further argued, "Because it does not define the term 'abortion', H.R. 4691 could permit health care entities to refuse to provide emergency contraception, even to victims of rape."[61] Again, the USCCB's fact sheet refutes this argument noting, "Because H.R. 4691 does not provide its own definition of 'abortion' or 'contraception,' it does not change the current federal policy of classifying the morning-after pill as 'postcoital emergency contraception.'"[62]

A. The Controversy over Mandated Contraceptive Coverage

Legislation proposed in Congress "would require prescription drug benefits in all health plans to cover the pill, IUD, diaphragm, Norplant, Deprovera and emergency contraception."[63] Gail Quinn, Executive Director of the USCCB's Secretariat for Pro-life Activities, in a letter to the Senate Health, Education, Labor and Pensions Committee, stated that such a bill would "force church entities to end all prescription drug benefits if they are to avoid violating their fundamental moral and religious teaching on the dignity of human procreation." [64]

In recent years, a number of states passed statutes or adopted regulations that require employers and insurers to provide contraceptive coverage.[65] Some states

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59. FACT SHEET: ACLU'S MISREPRESENTATIONS ABOUT THE ABORTION NON-DISCRIMINATION ACT, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, SECRETARIAT OF PRO-LIFE ACTIVITIES, June 3, 2003, *available at* http://www.usccb.org/prolife/issues/abortion/aclufact.htm.

60. *Id.*

61. STATEMENT OF CATHERINE WEISS, *supra* note 12.

62. FACT SHEET, *supra* note 59, *citing* 62 Fed. Reg. 8609 (Feb. 25, 1997).

63. Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), H.R. 2727, 108th Cong. (2003); S. 1396, 108th Cong. (2003); *see also Contraceptive Plans Threaten Right to Choose What's Right*, NATIONAL CATHOLIC REGISTER, Sept. 8, 2002, at 1,12.

64. *Contraceptive Plans Threaten Right to Choose, supra* note 63, at 12.

65. *See, e.g.*, ARIZ. REV. STAT. § 20-826 (2002); ARIZ. REV. STAT. § 20-1057.08 (2002); ARIZ. REV. STAT. § 20-1402 (2002); ARIZ. REV. STAT. § 20-1404 (2002); ARIZ. REV. STAT. § 20-2329 (2002); CAL. HEALTH & SAFETY CODE § 1367.25 (West 2003); CAL. INS. CODE § 10123.196 (West 2003); DEL. CODE ANN. tit. 18, § 3559 (2003); GA. CODE ANN. § 33-24-59.6 (Michie 2002); HAW. REV. STAT. ANN. § 431:10A-116.6 (Michie 2002); HAW. REV. STAT. ANN. 431:10A-116.7 (2002); IOWA CODE ANN. § 514C.19 (West 2001); ME. REV. STAT. ANN. tit. 24, § 2332-J (West 2002); ME. REV. STAT. ANN. tit. 24-A, § 2756 (West 2002); ME. REV. STAT. ANN. tit. 24-A, § 2847-G (West 2002); ME. REV. STAT. ANN. tit. 24-A, § 4247 (West 2002); MD. CODE ANN. INS. § 15-826 (2002); MASS. GEN. LAWS ANN. ch. 175, § 47W (West 2003); MASS. GEN. LAWS ANN. ch. 176A, § 8W (West 2003); MASS. GEN. LAWS ANN. ch. 176B, § 4W (West 2003); MO. ANN. STAT. § 376.1199 (West 2004); NEV. REV. STAT. ANN § 689A.0415 (Michie 2002); NEV. REV. STAT. ANN § 689A.0417 (MICHIE 2002); NEV. REV. STAT. ANN § 689B.0376 (Michie 2002); NEV. REV. STAT. ANN § 689B.0377 (Michie 2002); NEV. REV. STAT. ANN § 695B.1916 (Michie 2002); NEV. REV. STAT. ANN § 695B.1918 (Michie 2002); NEV. REV. STAT. ANN § 695C.1694 (Michie 2002); NEV. REV. STAT. ANN § 695C.1695 (Michie 2002); NEV. REV. STAT. ANN § 695C.1717 (Michie 2002); N.H. REV. STAT. ANN. § 415:18-i (2002); N.H. REV. STAT. ANN. § 420-A:17-c (2002); N.H. REV. STAT. ANN. § 420-B:8-gg (2002); N.M. STAT. ANN. § 59A-22-42 (Michie 2002); N.M. STAT. ANN. § 59A-46-44 (Michie 2002); N.Y. INS. LAW § 3221(l)(16) (McKinney 2003); N.Y. INS. LAW § 4303 (McKinney 2003); N.C. GEN. STAT. § 58-3-178 (2002); R.I. GEN. LAWS § 27-19-48 (2002); R.I. GEN. LAWS § 27-20-43 (2002); R.I. GEN. LAWS § 27-41-59 (2002); VT. STAT. ANN. tit. 8, § 4099c (2002); WASH. REV. CODE ANN. §48.43.065 (West 2003); *see also*

adopted mandates without any conscience clause limitations thereby requiring religious employers to provide coverage notwithstanding their religious objections.[66] *Smith* would probably consider these laws as neutral laws of general application and thus not vulnerable to constitutional challenge.[67] Other states provided "broad exemptions" that cover all religious organizations.[68] A few states passed legislation that requires employer health plans to provide coverage for prescription contraceptives with more narrowly drawn conscience clauses.[69] In some instances, the application of these laws to Catholic institutions is based upon a narrowing of protection under conscience clause legislation by distinguishing between secular activities and religious activities.[70] While a Catholic parish could satisfy these requirements, a Catholic hospital could not. Naturally, these laws remain problematic for Catholic hospitals.

Cathleen Cleaver, Director of Planning and Information for the USCCB's Committee on Pro-life Activities recently noted with respect to mandated contraceptive coverage laws, "There seems to be a nationwide push by groups like the American Civil Liberties Union and Planned Parenthood. We believe their true goal is to set the stage for mandated coverage of all so-called reproductive services, including abortion."[71] Indeed, if such acts are construed to include coverage for emergency contraceptives that could act as abortifacients, then the line between abortion and contraception becomes illusory. Moreover, if legislatures can force Catholic hospitals to provide contraceptive coverage for employees under their health plans, it comes easier to argue that they

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Inimal M. Chettiar, *Contraceptive Coverage Laws: Eliminating Gender Discrimination or Infringing on Religious Liberties*, 69 U. CHI. L. REV. 1867, 1877, fn. 68 (2002) (listing statutes from 19 states).

66. Chettiar lists four states with no religious exemption: Georgia: GA. CODE ANN. § 33-24-59.6 (2003); IOWA CODE ANN. § 514C.19 (West 2001); New Hampshire: N.H. REV. STAT. ANN. § 415:18-i (2002); N.H. REV. STAT. ANN. § 420-A:17-c (2002); N.H. REV. STAT. ANN. § 420-B:8-gg (2002); Vermont: VT. STAT. ANN. tit. 8, § 4099c (2002). Chettiar, *supra* note 65, at 1878 fns. 74 – 77.

67. Chettiar, *supra* note 65 , at 1882–84.

68. Chettiar lists the following states with laws of "broad exemptions": Delaware: DEL. CODE ANN. tit. 18, § 3559 (2003); Maryland: MD. CODE ANN. INS. § 15-826 (2002); Missouri: MO. ANN. STAT.§ 376.1199(4) (2004); Nevada: NEV. REV. STAT. ANN. § 689A.0415(5) (Michie 2002); NEV. REV. STAT. ANN § 689A.0417(5) (MICHIE 2002); NEV. REV. STAT. ANN § 689B.0377 (5) (Michie 2002).

69. Chettiar lists nine states that provide exemptions based on religiously based objections but further provide a "detailed definition of which employers qualify for the exemption." She further breaks these "selective exemption" into three categories: (1) four states (Rhode Island, Connecticut, Massachusetts and Maine) limiting the exemption to "churches as defined in Section 3121 (w) of the Internal Revenue Code"; (2) four states (North Carolina, Hawaii, California, and Arizona) focusing on "the purpose of the organization and the people involved in it"; and (3) Washington State's "unique"exemption. Chettiar, *supra* note 65, at 1880–81.

70. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1367.25 (West 2003); N.Y. INS. LAW § 3221 (l) (16) (McKinney 2003). For example, the New York law provides that "every group or blanket policy which provides coverage for prescription drugs shall include coverage for the cost of contraceptive drugs or devices . . . ." Although the law provides an exemption for religious employers, this exemption is narrowly drawn. It provides:

> For purposes of this subsection, a "religious employer" is an entity for which each of the following is true: (a) the inculcation of religious values is the purpose of the entity. (b) The entity primarily employs persons who share the religious tenets of the entity. (c) The entity serves primarily persons who share the religious tenets of the entity. (IV) The entity is a nonprofit organization as described in Section 6033(a)(2)(A) I or iii, of the Internal Revenue Code.

The exemption in the California law is identical to the New York law.

71. John Burger, *Mandatory Contraceptive Coverage—Is Abortion Next?*, NATL. CATH. REG., Feb. 17, 2002 – Feb. 23, 2002, *available at* http://www.ncregister.com/Register_News/022002con.htm *quoting* Cathleen Cleaver.

ought to be required to provide a full range of reproductive health services to the community.

1. The California Contraceptive Coverage Case

In *Catholic Charities of Sacramento, Inc. v. Superior Court*,[72] the Supreme Court of California upheld the constitutionality of the Women's Contraception Equity Act (WCEA), a law that requires most Catholic institutions, including Catholic hospitals, to provide their employees with contraceptive coverage if they provide prescription drug coverage. The California Supreme Court's decision is unprecedented insofar as it upholds a state law that requires Catholic organizations to choose between providing contraceptive coverage for their employees, an act that violates a longstanding Catholic moral teaching, or discontinuing a prescription drug benefit for its employees, a benefit that such organizations are obligated to provide under Catholic social justice teaching.[73] It remains a particularly portentous decision for Catholic hospitals because if the government can require Catholic hospitals to provide contraceptive coverage for their employees, including perhaps even coverage for abortifacient drugs, then only a relatively small step remains to require them to provide a full range of reproductive services for patients.

In its rejection of Catholic Charities' Free Exercise claims, the Court noted that *Smith* would ordinarily preclude such claims.[74] Indeed, this decision illustrates the difficulty for a religious organization in the post-*Smith* era in resisting a supposedly neutral law of general application that forces it to violate a core belief. The majority opinion of the California Supreme Court illustrates a generally dismissive attitude towards Catholic Charities' constitutional arguments. It relies on *Smith* in rejecting Catholic Charities' claims and focuses on what it views as the benign purpose of the law: reducing gender discrimination and extending contraceptive coverage to the ten percent of women not currently provided contraceptive coverage from commercial insurers.[75] Both the Court's decision and the legislative mandate evince disdain for traditional Catholic moral teaching on contraception. Unfortunately, the case sets a troubling precedent particularly for Catholic hospitals—under its reasoning a state law requiring all hospitals, including Catholic hospitals, to provide abortion services would probably withstand constitutional scrutiny.[76]

The WCEA requires that health and disability insurance policies that provide coverage for prescription drugs must also cover prescription contraceptive drugs.[77] The

72. 85 P.3d 67 (Cal. 2004), *cert. denied* 2004 WL 2050815 (2004).

73. Petitioner's brief notes: "In our examination of the legal history of the United States, we have found not a single instance in which courts have held it constitutional to compel a religious institution directly to fund, in its own internal operations for its own employees conduct that it condemns as sinful." Petitioner's Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700664, at *13.

74. *Catholic Charities*, 85 P.3d at 81.

75. *Id.* at 74.

76. *See* Petitioner's Reply Brief, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2002 WL 985448, at *1.

77. CAL. HEALTH & SAFETY CODE § 1367.25 (West 2004) (governing group health service plan contracts); CAL. INS. CODE § 10123.196 (West 2004) (governing individual and group disability insurance policies). These two statutes are virtually identical.

act includes a narrowly drawn religious exemption that permits a "religious employer" to avoid the mandate, but attempts to distinguish between Church activities that are essentially secular and those that are religious.[78] In order to qualify for the "religious employer" exemption, these laws require an organization to state as its purpose "the inculcation of religious values," to employ primarily persons who share its "religious tenets," to serve primarily persons who share its "religious tenets," and to be incorporated under the particular provisions of the Internal Revenue Code referenced in the statute.[79] Catholic Charities acknowledged that it did not meet any of these criteria.[80] Although the mandate could be avoided by not providing any prescription drug coverage for employees, Catholic Charities argued it had a moral obligation to provide such coverage under Catholic teaching.[81]

Although not expressly relied upon by the court and questioned by the appellant's brief, it is possible that portions of the legislative history indicating that many Catholic institutions in California, including several hospitals and the Diocese of Sacramento, were already providing contraceptive coverage to their employees may have seriously undermined the claim that this legislation significantly infringes the religious freedom of Catholic institutions.[82] It is also possible that in light of the pattern of widespread dissent on the issue of contraception within the Church, neither a majority of the Supreme Court of California nor the members of the California State Legislature who voted for the law believed that the objection to providing such benefits was sincere and well-founded. In addition, the court was undoubtedly influenced by the characterization in the State's brief of Catholic hospitals and universities as "secular" organizations that are only "loosely affiliated" with the Catholic Church thereby further undermining the argument that the contraceptive coverage mandate significantly impinged upon religious freedom.[83] Finally, the impact of Catholic Charities' First Amendment

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78. CAL. HEALTH & SAFETY CODE § 1367.25(b)(1) (West 2004) provides:

> b) Notwithstanding any other provision of this section, a religious employer may request a health service plan contract without coverage for federal Food and Drug Administration approved contraceptive methods that are contrary to the religious employers religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods.
>
> 1) For purposes of this section a 'religious employer' is an entity for which each of the following is true:
>
> A) The inculcation of religious values is the purpose of the entity.
>
> B) The entity primarily employs persons who share the religious tenets of the entity.
>
> C) The entity serves primarily persons who share the religious tenets of the entity.
>
> D) The entity is a nonprofit organization as described in Section 6033(a)(2)(A) i or iii, of the Internal Revenue Code of 1986, as amended.

See also CAL. INS. CODE § 10123.196(d) (West 2004).

79. CAL. HEALTH & SAFETY CODE § 1367.25(b)(1) (West 2004); CAL. INS. CODE § 10123.196(d) (West 2004).

80. *Catholic Charities*, 85 P.3d at 75.

81. *Id.* at 75.

82. *See, e.g.*, Petition for Review, *Catholic* Charities, 85 P.3d 67 (No. S099822), *available at* 2001 WL 170664 at *10 note 11 (summarizing legislative history). In its brief, Catholic Charities characterizes these assertions as incorrect, but fails to provide any specific data on the numbers of Catholic organization that provide such coverage for their employees. Petitioner's Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 170664, at *39.

83. Real Parties in Interest Answer Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2002 WL 985444, at *4. The State's brief further argues:

arguments was undoubtedly blunted by the counter-argument that the mandate could be avoided by simply dropping all prescription drug coverage for employees and increasing their compensation.[84]

In this case, the Superior Court rejected Catholic Charities' claim that the contraceptive mandate was unconstitutional and denied its motion for a preliminary injunction.[85] The Court of Appeals affirmed the Superior Court's holding that the challenged law violated neither the Free Exercise nor the Establishment Clauses of the First Amendment.[86] Subsequently, the California Supreme Court granted review.[87] Catholic Charities raised several issues in its Petition for Review including Free Exercise and Establishment Clause claims under the United States Constitution as well as a claim under the California State Constitution.[88]

> Although it claims that 'Catholic Charities is part of the Catholic Church,' and although it is affiliated with the Roman Catholic Bishop of Sacramento, Inc., Petitioner nevertheless is a separately incorporated and administered organization. It is a nonprofit public benefit corporation. Petitioner's secular legal status permits it to receive substantial public funding and to enter contracts with public agencies.
>
> Petitioner does not qualify for WCEA's religious employer exemption. Inculcation of religious values is not its purpose; it does not primarily employ or serve persons who share its religious tenets; and it is not a nonprofit religious organization within the terms of IRC section 6033(a)(2)(A) (i) or (iii). In fact, most of Petitioner's 183 employees are not Catholic, and the humanitarian services Petitioner provides are offered without regard to the religious affiliation of the recipients. In short, Petitioner is legally a secular organization.

Id. at 7 (footnotes omitted)

Professor Berg argues that the most troubling of these requirements is the service requirement. He states:

> An entity can be exempt only if it 'serves primarily persons who share the religious tenets on the entity.' Catholic Charities failed because it serves any needy person, Catholic, Christian or not. An entity can make its religious beliefs explicit, but only to people who already share the beliefs; evangelism is unprotected, because it proclaims to nonbelievers. And, according to this view, any social service that reaches out to the world loses its ability to maintain its religious identity. Teach and minister among yourselves in your insular community-in the catacombs. But once you serve the larger society, you no longer may draw lines of conscience on what you will and will not support.

Thomas C. Berg, *Religious Freedom in the Catacombs*, 190 AM. 17, 17–19 (2004).

84. Real Parties in Interest Answer Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2002 WL 98544, at *25.

85. *Catholic Charities*, 85 P.3d at 76.

86. Catholic Charities of Sacramento, Inc. v. Superior Court, 109 Cal. Rptr.2d 176 (Cal. App. 2001), *pet for rev granted*, 112 Cal. Rptr.2d 258 (Cal. 2001). The Court of Appeals concluded:

> [T]he prescription contraceptive coverage statutes, which were enacted to eliminate discriminatory insurance practices that had undermined the health and economic well-being of women, are otherwise valid laws that are generally applicable and neutral with respect to religion. Because the statutes have a secular purpose, do not advance or inhibit religion, and do not foster excessive entanglement with religion, the incidental effect of the statutes on religious belief does not violate the religious guarantees of the United States and California constitutions.

Catholic Charities, 109 Cal.Rptr.2d at 181.

87. Catholic Charities of Sacramento, Inc. v. Superior Court, 112 Cal. Rptr.2d 258 (Cal. 2001).

88. The following issues were set forth in the Petition for Review:

> 1) Whether the religious freedom guarantees enshrined in Article 1, Section 4 of the California Constitution continue to trigger "strict scrutiny," as a matter of independent state grounds, where the Legislature has imposed a substantial burden upon religious exercise by deliberately targeting certain religious institutions for coercion of conduct contrary to their religious beliefs.
>
> 2) Whether a statutory exemption provision, designed by its authors and sponsors to draw explicit and deliberate distinctions between different religious organizations for the stated purpose of denying the exemption to certain targeted religious organizations, violates the federal and State Establishment Clauses.

Catholic Charities made several arguments that the WCEA's mandate and its limited exemption were unconstitutional because of interference with religious autonomy.[89] The California Supreme Court rejected Catholic Charities' argument that the law unconstitutionally interferes with "matters of religious doctrine and internal church governance."[90] In this regard, it found the church property and ministerial exception cases inapposite.[91] Catholic Charities also argued that the legislature improperly took sides in an internal dispute over Church doctrine on contraception pointing to legislative history and particularly statements by Senator Speier, the primary sponsor of the bill, noting the widespread dissent by Catholics from the Church's teaching and urging legislators to "do the right thing" by lending their support to the dissenters.[92] The California Supreme Court rejected the contention by Catholic Charities that the legislature improperly took the side of Catholics who dissent from Church teaching on contraception and specifically rejected Catholic Charities' reliance on the comments by Senator Speier, by simply noting "the Legislature's motive cannot reliably be inferred from a single senator's remarks."[93] But this observation ignores the fact that Senator Speier was the moving force behind the bill in the California Senate.[94]

The California Supreme Court further rejected the contention that the exemption violates the First Amendment insofar as it distinguishes between religious and secular activities of the Church holding that it is perfectly proper for the government to make such a distinction for the purpose of providing an exemption designed to accommodate religious exercise.[95] Similarly, it rejected the argument that the exemption to the mandate violates the Establishment Clause by requiring a governmental inquiry into religious beliefs by noting that Catholic Charities acknowledged it does not fit any of the criteria set forth in the exemption.[96]

Catholic Charities also challenged the law under the Free Exercise Clause of the

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3) Whether a statutory exemption provision, which explicitly classifies eligible employers based upon religious criteria, such as the "inculcation of religious values" and the "sharing [of] religious tenets," and was designed by its authors and sponsors to target certain religious organizations that they viewed as holding "particularly objectionable" religious views on the perceived problem at issue, violates the federal Free Exercise Clause.

4) Whether a religious organization, bringing a Free Exercise Clause claim in California state court, may invoke the 'hybrid rights' exception to the general rule enunciated in Employment Division v. Smith, 494 U.S. 872, 110 S.Ct. 1595 (1990), and, if so, what standard should California courts apply in reviewing such 'hybrid rights' claims.

Petition for Review, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 34369289, at *1.

89. *Catholic Charities*, 85 P.3d at 76.

90. *Id.* at 77.

91. *Id.* at 76–78.

92. Petitioners Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700604, at *14–15.

93. *Catholic Charities*, 85 P.3d at 78. *But cf.* Edwards v. Agullard, 482 U.S. 578, 587 (1987) (holding Lousiana law requiring teaching of creationism in public schools if evolution is taught violates Establishment Clause; court focuses on statement of sponsor of bill in ascertaining its purpose); Wallace v. Jaffree, 472 U.S. 38, 43 (1985) (holding Alabama law authorizing a daily period of silence in public schools violates Establishment Clause; court focuses on remarks of prime sponsor of bill in ascertaining its purpose).

94. Petition for Review, *Catholic Charities*, 85 P.3d (No. S099822), *available at* 2001 WL 34369289, at *5.

95. *Catholic Charities*, 85 P.3d at 79 (citing Presiding Bishop v. Amos, 483 U.S. 327, 334–40 (1978).

96. *Id.* at 80; *but cf. id.* at 96 (concurring opinion by Kennard, J.) (expressing doubt as to whether it is permissible under the Establishment Clause for California to limit religious employer exemption to religious organizations engaged in inculcation of religious values).

United States Constitution.[97] It argued that the WCEA should be subjected to strict scrutiny notwithstanding *Smith*.[98] Catholic Charities challenged the limited exemption arguing that under *Lukumi* it lacked facial neutrality due to the use of religious terminology.[99] The Supreme Court rejected the *Lukumi* analogy on the basis that the purpose of these references in WCEA is to provide a religious exemption rather than to impose a burden.[100] Accordingly, the court held that *Lukumi* was distinguishable from the present case because it involved the use of religious language for the purpose of prohibiting religious activity.[101] But this seems disingenuous in light of the fact that the primary motivating factor behind both the contraceptive mandate and the narrowly crafted exemption was to force most Catholic institutions to provide contraceptive coverage. Moreover, legislation requiring a religious organization to violate its core beliefs in order to carry on a ministry that benefits the public is as burdensome as legislation restricting religious activity.

Catholic Charities also argued that strict scrutiny should apply here because in crafting this legislation and its narrow conscience clause, the California legislature deliberately targeted the Catholic Church based on general antipathy toward the Church and contempt for its position on contraception.[102] Catholic Charities contended that the mandate is not a neutral or generally applicable law insofar as it specifically targets Catholic institutions.[103] It characterized the mandate and exemption as a "religious gerrymander" specifically designed to deny the exemption to Catholic organizations engaged in charitable works rather than purely spiritual works.[104]

Catholic Charities argued that the exemption was crafted for the purpose of excluding Catholic hospitals and social service agencies.[105] In this regard, it argued that the purpose of the legislature in enacting the mandate and the limited exemption was "to close a 'Catholic gap' in insurance coverage for prescription contraceptives."[106] Catholic Charities focused on the legislative history to support its contention that the legislature had "deliberately" targeted the Catholic Church.[107] A consultant's study relied on by the legislature indicated that ninety percent of insured Californians already had contraceptive coverage at the time of the legislation.[108] The CEO of Planned Parenthood of California argued at a legislative hearing that a broadly crafted religious

97. *Id.* at 81.

98. *Id.* at 82.

99. Petitioner's Brief on the Merits, *Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700664, at *30.

100. *Catholic Charities*, 85 P.3d at 83.

101. *Id.* at 83.

102. Petitioner's Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700664, at *10–11, 35. (relying primarily on Larson v. Valente, 456 U.S. 228 (1982)). The Petition for Review states "what has occurred here is unworthy of a noble democratic institution like the California Legislature," Petition for Review, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 34369289, at *2.

103. *Catholic Charities*, 85 P.3d at 82.

104. Petitioner's Brief on the Merits, *Catholic Charities*, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700664, at *32.

105. *Id.* at *35.

106. *Id.* at *6–9.

107. *Id.*

108. *Id.* at *6.

exemption would undermine the purpose of the contraceptive mandate.[109] On this basis, Catholic Charities argued that the legislative history showed that the sponsors and authors of the bill crafted a religious exemption that was specifically designed not to cover most Catholic institutions, the only identifiable group of large employers with a religiously-based moral objection to contraceptive coverage.[110]

Moreover, Catholic Charities contended the legislative history is replete with evidence of antipathy to the Catholic Church and its position on contraception.[111] It pointed to statements by sponsors of the bill noting that Catholic teaching on contraception was archaic and not followed by most Catholics and Catholic institutions.[112] Catholic Charities also pointed to statements made by legislators comparing the Catholic Church to "a witches coven, a 'new age' bakery, and a chinchilla ranch" as providing further evidence of hostility toward the Catholic Church.[113]

Notwithstanding this legislative history, the California Supreme Court holds there is no evidentiary basis for the targeting claim.[114] Specifically, the court rejected Catholic Charities' reliance on the testimony of the Planned Parenthood representative referring to the necessity of closing the "gap" in coverage.[115] The court says the "gap" referred to here by the Planned Parenthood representative is the failure of some PPO and indemnity plans to provide contraceptive coverage rather than the failure of Catholic organizations to provide such coverage.[116] This observation by the court, however, seems disingenuous in light of the fact that the representative refers to the "gap" in the context of opposing an exemption that would have accommodated Catholic hospitals and universities.[117]

Catholic Charities argued that the law should be subject to strict scrutiny under the hybrid rights doctrine because the provision of contraceptive coverage by Catholic organizations could be viewed as an endorsement of the morality of contraception and accordingly the law effectively forces them to engage in symbolic speech that they find

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109. *Id.* at *7.

110. Petitioner's Brief on the Merits, *Catholic Charities*, 85 P.3d 67, *available at* 2001 WL 1700664, at *7–8. The Petitioner's Brief summarizes the legislative history as follows:

> The record establishes that the authors and sponsors of the bill principally wanted to "close the gap" left by Catholic religious institutions, which are a significant and easily identifiable group of employers with an institutional religious prohibition against offering contraceptive insurance coverage. For the authors and sponsors, Catholic religious institutional employers were viewed as the problem-a problem to be "dealt with" by imposing the contraceptive mandate upon them. If an exemption were needed for constitutional or political reasons, the authors and sponsors posited, that exemption must be deliberately fashioned to exclude Catholic hospitals, universities, and social service agencies. Indeed, if closing the Catholic gap were not the problem, then "granting an exemption" to Catholic employers could hardly be said to "defeat the original purpose of the bill."

Id. (footnotes omitted).

111. *Id.* at *10.

112. *Id.*

113. *Id.* at *11, n. 8.

114. *Catholic Charities*, 85 P.3d. at 87.

115. *Id.*

116. *Id.*

117. Petitioner's Brief on the Merits, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700664, at *7–8 (referring to testimony of Kathy Kneer, the CEO of Planned Parenthood of California, before the Senate Insurance Committee. Testimony *available at* 11 DocApp A003050 – 51.).

objectionable.[118] The Supreme Court of California summarily rejected this argument noting that Catholic Charities is still free to voice its disapproval while providing contraceptive coverage.[119] Nonetheless, the mandate remains problematic for Catholic organizations including Catholic hospitals. For example, with respect to Catholic health care institutions, Directive 70 provides, "Catholic health care institutions are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral. . . ."[120] Of course, under the Catholic natural law tradition, artificial contraception is judged to be intrinsically immoral.[121]

There is also the risk of scandal that would arise from a Catholic institution providing contraceptive coverage to its employees, and this, in and of itself, could be a basis for the moral condemnation of any institutional compliance with a contraceptive mandate.[122] This in turn presents Catholic organizations with a difficult dilemma — either cease providing coverage for outpatient prescription in its employee health plan, a violation of Catholic social teaching, or create the risk of scandal by complying with the state's mandate. The other suggested possibility of increasing compensation so that employees could pay for prescription drug coverage out-of-pocket may not be viable because it may not provide affordable coverage for employees who suffer catastrophic or chronic illnesses with very high drug costs.[123]

The California Supreme Court also rejected Catholic Charities' arguments that the mandate was unconstitutional under the California State Constitution.[124] The court holds that even if strict scrutiny was applicable under the California Constitution, the law serves a compelling state interest, i.e., gender equity, and is narrowly tailored because a broader exemption would increase those affected by discrimination.[125]

Finally, Catholic Charities argued that the WCEA's limited religious exemption could not even survive the rational basis test because its criteria is arbitrary: i.e., its exclusion from the exemption of Church bodies providing service or employing persons of other religions is unrelated to any state interest.[126] The Court rejected this argument noting that the criterion requiring employment of persons of the same religion

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118. *Id.* at *38.

119. *Catholic Charities*, 85 P.3d at 89.

120. United States Conference for Catholic Bishops, *supra* note 21, at 37. The Directive goes on to give specific examples of such intrinsically immoral acts including abortion and direct sterilization, but not contraception.

121. JANET E. SMITH, HUMANAE VITAE: A GENERATION LATER 84 (1991) ("Contraception is intrinsically immoral not because it violates the purpose of the reproductive organs but because it violates the procreative meaning of sexual acts; because it violates the nature of the sexual act.").

122. United States Conference for Catholic Bishops, *supra* note 21, at 37 ("The possibility of scandal must be considered when applying the principles governing cooperation").

123. *Cf.* Real Parties in Interest Answer Brief on the Merits, Catholic Charities, 85 P.3d 67 (No. S099822), *available at* 2002 WL 985444, at *25-26 ("Petitioner can avoid the conflict between law and beliefs by simply not offering any prescription drug coverage through insurance carriers and, instead, for example, paying a stipend to employees to enable them to obtain their own prescription drug coverage.").

124. *Catholic Charities*, 85 P.3d 67 at 81. The California Constitution provides: "Free exercise and enjoyment of religion without discrimination or preference are guaranteed. This liberty of conscience does not excuse acts that are licentious or inconsistent with the peace or safety of the State. The Legislature shall make no law respecting an establishment of religion." WEST'S ANN. CAL. CONST., art. 1, § 4 (2004).

125. *Id.* at 93–94.

126. Petitioner's Brief on the Merits, 85 P.3d 67 (No. S099822), *available at* 2001 WL 1700664. at *47-48.

substantially overlaps with the constitutionally required ministerial exception.[127] While it acknowledges that the requirement that the organization primarily serve those of the same religion is problematic, it concludes that it is irrelevant because Catholic Charities fails to satisfy any of the other criteria set forth in the exemption.[128]

Justice Brown is the sole dissenter from the Court's opinion in *Catholic Charities*.[129] While the majority opinion finds that the freedom of religious organizations to practice their religion is trumped by the demands of gender equity, Justice Brown would invalidate the law in light of its restrictions on religious freedom. She states the issue in the case as follows, "May the government impose a mandate on a religiously affiliated employer that requires the employer to pay for contraceptives—in violation of an acknowledged religious tenet—or to redefine what constitutes religious conduct."[130] She believes that *Smith* is not controlling in this case.[131] First, she notes that *Smith* involves "the denial of a benefit to an individual because of a violation of existing law."[132] On the other hand, *Catholic Charities* involves a "law that requires a religious organization to provide a benefit despite its theological objections."[133] Brown takes a much more positive view of the importance of religious liberty than does the majority.[134] She notes that while the church property and ministerial cases are inapposite here, they are merely examples of cases within a broader category of constitutional protection for religious organizations and not exhaustive.[135] She also states, "Some courts have reasoned that religious institutions are exempted entirely from the *Smith* analysis."[136]

Justice Brown is troubled by the exemption's distinction between religious and secular organizations within the Church and finds it to be problematic under Establishment Clause precedents.[137] She observes that in this case, the exemption provisions represent an "intentional, purposeful intrusion into a religious organization's expression of its religious tenets and sense of mission."[138] As compared with the majority opinion, Justice Brown gives more credence to the legislative history relied on by Catholic Charities indicating religious bias on the part of legislators. She refers to the tension between the traditional views of the Catholic Church on human sexuality and the predominant view that sexual autonomy is the preeminent value.[139] In this regard, she questions the religious neutrality of the contraceptive mandate noting that during the debates over it, the remarks of several legislators indicate that they believed

127. *Catholic Charities*, 85 P.3d at 94.

128. *Id.* at 95.

129. *Id.* at 98 (Justice Brown dissenting).

130. *Id.*

131. *Id.* at 99.

132. *Id.*

133. *Catholic Charities*, 85 P.3d at 99.

134. *Id.* at 100.

135. *Id.*

136. *Id.* at 99, *citing to* Gellington v. Christian Methodist Episcopal Church, 203 F.3d 1299, 1303 (11th Cir. 2000) (holding that ministerial exception under Title VII survives *Smith*).

137. *Catholic Charities*, 85 P.3d at 100 (Justice Brown dissenting).

138. *Id.* at 102.

139. *Id.* at 103.

that the Church's position was archaic.[140] Justice Brown found further evidence of the legislature's targeting of Catholic organizations in statements by Senator Speier that most Catholics believe that one can practice birth control and still be a good Catholic and that Speier agreed with that position.[141] She also notes that the harm caused by the state's imposition of the contraceptive mandate may greatly outweigh the benefits of the law in light of the relatively small number of employees actually affected.[142] She concludes that the attempt to distinguish between the religious and secular activities of the Catholic Church is "an impermissible government entanglement in religion" and a violation of the Establishment Clause.[143]

Moreover, if the law is determined not to be religiously neutral, Justice Brown questions whether it would pass the federal strict scrutiny test noting that the exemption takes "such a crabbed and constricted view of religion that it would define the ministry of Jesus Christ as a secular activity."[144] She also finds the narrow exemption "baffling" in light of the fact that religious employers can avoid the impact of the mandate by either dropping prescription drug coverage or self-insuring.[145] Finally, she would invalidate the narrow exemption under the California State Constitution because of the lack of a compelling state interest in light of evidence showing that ninety percent of commercially insured Californians already have contraceptive coverage and that only a small number of employees of Catholic organizations would be affected by the mandate.[146]

Justice Brown's views would of course be much more protective of religious institutions against state attempts to force them to violate their core religious beliefs. This seems more in keeping with the values underlying the First Amendment. But in this legal culture, if the views of the religious organization in question run counter to the prevailing orthodoxy on sexual autonomy, then they are likely to get short shrift in the courts. It seems clear from the legislative history that the contraceptive mandate and its narrow conscience clause were deliberately aimed at forcing Catholic institutions such as hospitals to provide contraceptive coverage. This is particularly troubling in light of the fact that the mandate could be construed to also include coverage of RU-486, a drug used for the purpose of causing abortions.[147]

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140. *Id.*

141. *Id.* at n.3.

142. *Id.* at 104.

143. *Catholic Charities*, 85 P.3d at 105.

144. *Id.* (footnote omitted).

145. *Id.*

146. *Id.* at 108.

147. *See* Petition for Review, 2001 WL 34369289 at *12, n.13, stating:

> Catholic Charities timely filed a Motion for Reconsideration in the trial court, arguing that the approval of RU-486 and Kaiser's intention to add it to the formulary placed the Catholic Church in jeopardy of being complicit in pharmaceutical abortions, masquerading in 'post-coital' contraception. . . . In Catholic Charities view, this expands the issue to include what Catholic Charities regards as abortion. On October 31, 2000, the trial court granted Catholic Charities Motion for Reconsideration, finding that the approval of RU-486 should have been considered by the trial court, and again denied the Motion for Preliminary Injunction.

2. The Washington State Attorney General's Opinion

On December 14, 2001, the EEOC interpreted the Pregnancy Discrimination Act to require employers to provide contraceptive coverage when they provide prescription drug coverage.[148] Subsequently, in *Erickson v. Bartell Drug Co.*,[149] a federal district court in the state of Washington held that the exclusion of prescription contraceptives from a prescription drug plan provided by an employer violated the Pregnancy Discrimination Act. This decision was appealed to the Ninth Circuit, but later settled and the appeal dropped.[150] Neither the EEOC ruling nor the *Erickson* case, however, considered claims for exemption on the basis of religion. A 2002 Washington State Attorney General's opinion, however, does consider the application of a contraceptive coverage mandate to Catholic organizations and provides another example of an anti-discrimination law trumping religious freedom.

The Washington State Attorney General Opinion relies on *Erickson* and the EEOC decision in determining that "under state and federal law, offering a generally comprehensive prescription drug plan that excludes prescription contraceptives would constitute an unfair labor practice and is not an option for either insurance carriers or employers."[151] Citing the strong public policy against sex discrimination, the opinion concludes that the failure to provide contraceptive coverage where the employer otherwise provides prescription drug coverage is sex discrimination.[152] On this basis, it opines that it would be an unfair labor practice for an employer to offer prescription drug coverage, but require employees to pay an additional amount out-of-pocket for contraceptive coverage.[153] The opinion also notes that prescription contraceptive coverage by employers is mandated as a part of Washington State's Basic Health Plan.[154]

In the same opinion, Washington State's conscientious objection statute is narrowly interpreted as applied to employers with a religious or moral objection to providing contraceptive coverage.[155] Paradoxically, the opinion concludes that objecting employers can be required to provide, but not to purchase, contraceptive coverage.[156] Thus it suggests that the objecting employer can classify its cost as an overhead expense to be included by the actuary in the calculation of the carrier's rates.[157]

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148. Commission Decision on Coverage of Contraception, Dec. 14, 2000, 2000 WL 33407187 (E.E.O.C. Guidance) at *5.

149. 141 F.Supp.2d 1266 (W.D. Wash. 2001); *but cf.* Glaubach V. Regence Blueshield, 74 P.3d 115 (Wash. 2003) (answering a certified question by holding that the failure of a health insurer to provide coverage for all methods of contraception did not violate Washington insurance reform act).

150. The *Erickson* case was subsequently appealed to the 9th Circuit, but the appeal was dropped when the Bartell Drug Company settled with a class of its female employees. Under the terms of the settlement, Bartell agreed to provide contraceptive coverage to its employees. Sally Roberts, *Plan Agrees to Cover Contraceptive Drugs: Bartell Case was Closely Watched*, BUSINESS INSURANCE, March 17, 2003, at 2003 *available at* WL 9137929.

151. WASH. STATE ATTY. GEN. OP. 2002, No. 5, Aug. 8, 2002, 2002 WL 31936085 (Wash. A.G.), at *7.

152. *Id.* at *4.

153. *Id.* at *1.

154. *Id. referring to* 2002 Basic Health Member Handbook, Appendix A, p. 26, 32.

155. *Id.*

156. *Id.*

157. Wash. State Atty. Gen. Op. 2002, No. 5, Aug. 8, 2002, 2002 WL 31936085 (Wash. A.G.), at *8. In an interesting exercise in legal hairsplitting, the Attorney General Opinion goes on to conclude:

The Washington State Attorney General Opinion was issued in response to a request from the Insurance Commissioner for guidance on whether the statute requiring contraceptive coverage applies to employers with a religious objection.[158] The statute mandating contraceptive coverage contains a "conscientious objection" clause providing that individuals or organizations with a religious or moral objection to particular coverage may not be required to "purchase it."[159] The Washington State Attorney General Opinion concludes that notwithstanding the "conscientious objector" statute, a religiously affiliated employer would commit an "unfair practice" in violation of state law if it provided prescription drug coverage without contraceptive coverage.[160] It further states:

> Before closing the discussion, we note that the "conscience clause" statute... protects an employer exercising the option from 'purchasing' for its employees coverage to which the employer has a conscientious objection. . . . [S]tate and/or federal law prohibits charging the employees themselves for prescription contraceptive coverage, even if such coverage is the subject of the employer's conscientious objection. So long as the employer is not required to 'purchase' the coverage, however, there might be lawful ways of covering these costs.[161]

Subsequently, in an article in the *Spokesman-Review*, a Spokane, Washington newspaper, a spokeswoman for the state insurance commissioner's office stated that under this ruling, Sacred Heart Medical Center must provide prescription birth control coverage for its employees. The article went on to note that the "ruling did provide a bit

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> Inclusion of the cost of prescription drug coverage as a component (such as administrative, overhead, contingency, or other expense allowance) in the actuarial analysis of a carrier's rates is therefore permissible under RCW 48.43.065 if it does not require employers to directly purchase the health service that is objected to; ensures enrollees will not be denied coverage of, and timely access to, any service or services excluded from their benefits package; does not require extra payments by the enrollee to receive coverage; and does not require carriers to provide services without "appropriate payment of premium or fee."

Id.

158. *Id.*

159. WASH. REV. CODE ANN. § 48.43.065(3) (West 2004) provides:

> (a) No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for the service or services if they object to doing so for reason of conscience or religion.
>
> (b) The provisions of this section shall not result in an enrollee being denied coverage of, and timely access to, any service or services excluded from their benefits package as a result of their employer's or another individual's exercise of the conscience clause in (a) of this subsection.
>
> (c) The insurance commissioner shall define by rule the process through which health carriers may offer the basic health plan services to individuals and organizations identified in (a) and (b) of this subsection in accordance with provisions of subsection (2)(c) of this section.

In apparent response to the attorney general opinion, legislation was introduced in the Washington State Senate in February 2003 to amend § (1)(b) to read: "No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase *or otherwise provide* coverage for the service or services if they object to doing so for reason of conscience or religion." 2003 WA. S.B. 5887 (SN) (emphasis added).

160. WASH. STATE ATTY. GEN. OP. 2002, No. 5, Aug. 8, 2002, 2002 WL 31936085 (Wash. A.G.), at *1.

161. *Id.* at *7.

of a fig leaf for employers who find contraceptives objectionable: They can ask their insurer to wrap the costs of such coverage into overall policy costs, perhaps as an administrative or overhead cost."[162] In an editorial, the *Spokesman-Review* commented favorably on the new ruling:

> Surely, when the Sisters of Providence founded the hospital in the 19th century, they saw their mission as repairing body and soul. But Sacred Heart has become a modern health care conglomerate, forging partnerships with for-profit companies, accepting government money, hiring employees without a Catholic litmus test and taking all patients regardless of creed.
>
> Its makeup and mission are largely secular. Therefore, its employees have the same rights as anyone else.[163]

B. Emergency Contraception

1. State Laws Mandating Emergency Contraception and Studies on its Availability in Catholic Hospitals

The administration of emergency contraception methods has become the standard of care for the treatment of female sexual assault victims.[164] The two most widely used methods "are the combined estrogen-progestin . . . and progestin only methods."[165] "Both regimes consist of two doses of contraceptive steroids taken 12 hours apart after intercourse."[166] Under Directive 36 of the 2001 *ERD,* the bishops permit the administration of emergency contraception by Catholic institutions where the woman is a victim of sexual assault and "if, after appropriate testing there is no evidence that conception has occurred already. . . ."[167] In effect, Directive 36 provides for an exception to the traditional prohibition on the use of artificial contraception. While in accordance with Catholic teaching, a married woman who engaged in consensual sexual intercourse would not be permitted to resort to contraception to prevent pregnancy, a sexual assault victim is permitted to prevent conception.[168] The basis for this exception

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162. Richard Roesler, *Contraceptive Coverage Goes for Hospital Too*, SPOKESMAN-REVIEW, Aug. 12, 2002, at A1.

163. Gary Crooks, *Medical Center Can Find Right Balance*, SPOKESMAN-REVIEW, Aug. 18, 2002, at B6.

164. Reza Keshavarz, Roland C. Merchant & John McGreal, *Emergency Contraception Provision: A Survey of Emergency Department Practitioners*, 9 ACADEMIC EMERGENCY MED. 69 (2002) *available at* http://www.aemj.org/cgi/content/full/9/1/69; *see also* Brownfield v. Daniel Freeman Marina Hospital, 208 Cal.App.3d 405 (Cal. Ct. App. 1989) (dismissing an action for declaratory relief brought by rape victim against Catholic hospital for failing to provide emergency contraception medication to her or refer her, suggesting that she might have a malpractice action).

165. David A. Grimes & Elizabeth G. Raymond, *Emergency Contraception*, 137 ANN. OF INT. MED. E-180-81 (Aug. 6, 2002).

166. *Id.*

167. United States Conference for Catholic Bishops, *supra* note 21, at 21.

168. Kevin D. O'Rourke, *Applying the Directives*, 79 HEALTH PROGRESS 64 (July-Aug. 1998), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9807&ARTICLE=E.

is the right of the rape victim to self-defense.[169] The Directive further provides, however, that it is not morally permissible "to initiate or recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."[170]

Federal legislation without any conscience clause limitations has been proposed that would cut off federal funds to hospitals that do not provide emergency contraception to female sexual assault victims.[171] California recently passed a bill that requires physicians and other health care providers to provide female victims of sexual assaults with "postcoital contraception."[172] This legislation does not contain a conscience clause. Similarly, Washington State law requires every hospital that treats rape victims, including Catholic hospitals, to: (1) provide the victim accurate and unbiased information about emergency contraception; (2) orally inform the victim that she has the option to receive emergency contraception at the hospital, and (3) provide emergency contraception to every victim who requests it, unless there is a medical reason not to do so.[173] This law also requires printed informational materials to be distributed and used in all emergency rooms in the state.[174] In addition, there is a specific requirement that the Washington State Department of Health respond to complaints about the failure of hospitals to comply with the emergency contraception mandate.[175] New York has now also adopted law requiring all hospitals to provide emergency contraception to rape victims without any conscience clause protection.[176] It does, however, provide that emergency contraception need not be provided to rape victims who are pregnant.[177]

State laws mandating provision of emergency contraception without conscience clause limitations may be problematic for Catholic hospitals. As discussed, *infra,* some argue that it is not morally permissible for a Catholic hospital to provide emergency contraception to a rape victim who is ovulating because of the potential abortifacient effect of emergency contraceptive medications. But state laws mandating provision of emergency contraception to all rape victims without any conscience clause limitations would not permit denial of emergency contraceptive based on moral considerations. Moreover, laws of this type that may require Catholic hospitals to disregard their local bishop's interpretation of the *ERD.* Catholic teaching could establish a dangerous precedent—if such laws come to be generally accepted, then the next step might be to require Catholic hospitals to provide abortions. The assumption of policy makers may be that Catholic hospitals are not all that serious about maintaining compliance with the *ERD* if they go along with laws of this type without protest.

The adoption of these laws has been fostered by studies claiming that many Catholic hospitals do not provide emergency contraception to rape victims, even within

169. *Id.*
170. United States Conference for Catholic Bishops, *supra* note 21, at 21.
171. H.R. 4113, 107th Cong. (2002).
172. 2002 Cal. Legis. Serv. Ch. 382 (A.B. 1860) (West).
173. WASH. REV. CODE ANN. § 70.41.350 (1) (West 2004).
174. WASH. REV. CODE ANN. § 70.41.350 (2) (West 2004).
175. WASH. REV. CODE ANN. § 70.41.360 (West 2004).
176. N.Y. PUB. HEALTH LAW § 2805-P(2c) (McKinney 2004).
177. *Id.* at 2 I.

the parameters set forth in Directive 36. In a small pilot study of the actual practices of hospitals published in 2000, the authors telephoned the emergency departments of seventy-eight large hospitals located in urban areas to ask a series of questions on the availability of emergency contraception to rape victims.[178] The questions focused on whether the hospitals permitted the discussing or dispensing of emergency contraception, whether the hospital made referrals for emergency contraception, and the number of rape cases treated.[179] Staff at nine of the hospitals refused to answer the questions and staff at another eleven indicated they did not provide treatment for rape victims.[180] The final pool for the study consisted of fifty-eight hospitals, and twenty-seven of the hospitals surveyed were Catholic hospitals.[181] The study found that seven of the Catholic hospitals had policies prohibiting physicians from prescribing contraceptives, and five of these seven also prohibited physicians from discussing contraceptives with patients.[182] Twelve of the Catholic hospitals had policies prohibiting discussion of emergency contraception with rape victims.[183] Notwithstanding these policies, respondents at eight of the twelve hospitals indicated "that relevant information would likely be provided to rape victims."[184] Seventeen of the Catholic hospitals prohibited the dispensing of emergency contraception in their hospital pharmacies.[185] It was also noted that several Catholic hospitals had no restrictions on the availability of emergency contraception, but the issue was considered to be controversial even at these institutions.[186]

As to the morality of providing emergency contraception in Catholic hospitals, the study notes, "The proscription on the use of contraception does not apply in cases of rape."[187] It also notes that provision of emergency contraception may be impermissible under Catholic teaching where it prevents implantation of an embryo in the endometrium.[188] However, it states, "Testing a rape victim to determine whether conception has occurred as a result of rape is not feasible, and the most that can be accomplished is an extremely rough judgment of probabilities."[189] Nonetheless, it opines that under the principle of double effect, it is morally permissible for providers in Catholic hospitals to provide rape victims with emergency contraception where their intent is to prevent ovulation or conception even though they realize that the effect could be abortifacient.[190]

A 2002 study conducted by Ibis Reproductive Health for Catholics for a Free Choice targeted the practices of Catholic hospitals with respect to Emergency

178. Steven S. Smugar, *Informed Consent for Emergency Contraception: Variability in Hospital of Rape Victims*, 90 AM. J. PUB. H. 1372 (2000).

179. *Id.* at 1372.

180. *Id.* at 1373.

181. *Id.*

182. *Id.*

183. *Id.*

184. Smugar, *supra* note 178, at 1373.

185. *Id.* at 1374.

186. *Id.*

187. *Id.*

188. *Id.*

189. Smugar, *supra* note 178, at 1374.

190. *Id.*

Contraception ("EC") and identified the *ERD* as "a potential obstacle to the provision of EC in hospital emergency rooms."[191] Notwithstanding Directive 36, the Catholics for a Free Choice study opines, "[I]n spite of ample medical evidence to the contrary, the dominant view among the US bishops is that EC can work to cause an abortion and, therefore, must be forbidden in all circumstances."[192] The Catholics for a Free Choice study was conducted in late August 2002. Its surveyors called virtually all of the Catholic hospital emergency rooms in the U.S. to question "the triage nurse or whoever else answered the phone about the availability of emergency contraception in the emergency room."[193] The study concludes:

> Only five percent of the emergency rooms provided EC on request. An additional 23% of Catholic emergency rooms provide EC to rape victims only. Thus, only 28% of Catholic ERs will provide women who have been raped with EC. Among those hospitals that do provide EC to rape victims, the majority set up unnecessary barriers, such as pregnancy tests or police reports. These hospitals also do not volunteer information over the phone, but admit to dispensing EC to rape victims only after repeated questioning, which could deter some victims. Some hospitals (6%) indicated that the decision about providing EC was left to the attending physician. Presumably, with good luck, a woman who had been raped might be seen by an attending physician who would provide EC, but there were no guarantees.[194]

The results of the Catholics for a Free Choice study have been widely reported, and the study has been used to promote popular support for legislation mandating the provision of emergency contraception and to place greater pressure on public agencies to enforce existing legislation. For example, a 2003 article in the *Spokesman-Review* focused on emergency contraception policies in hospitals operated by Providence Services of Eastern Washington.[195] The article focused on that portion of the Catholics for a Free Choice study claiming that six hospitals in Washington State, including Sacred Heart Medical Center in Spokane, were in violation of a Washington State law mandating provision of emergency contraception to sexual assault victims.[196] The article reports that the study claims that triage nurses at some hospitals in the Providence Services system, including Sacred Heart, told "mystery callers" posing as rape victims that they do not provide emergency contraception.[197] A spokeswoman for Sacred Heart, however, denied this and stated, "Sacred Heart has a written policy on this issue which explicitly states that in cases of sexual assault, we provide emergency contraception after tests indicate the patient is not currently pregnant."[198]

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191. SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS, *available at* http://www.catholicsforchoice.org/PDF/EC%20Study.pdf.

192. *Id.* at 5.

193. *Id.* at 5.

194. *Id.*

195. Carla K. Johnson, *Catholic Hospitals Violate State Law, Pro-Choice Group Claims*, SPOKESMAN-REVIEW, January 3, 2003, *available at* 2003 WL 4552117 (2003).

196. *Id.*

197. *Id.*

198. *Id.*

2. Sexual Assault Protocols Developed by Catholic Hospitals

State laws that require Catholic hospitals to provide emergency contraception to rape victims may at times conflict with the *ERD*. There is a divergence of approaches among bioethicists employed by Catholic hospitals over the application of Directive 36. The primary basis for these divergent approaches is the uncertainty over whether emergency contraceptive medications could have an abortifacient effect. Some bioethicists are extremely skeptical as to whether emergency contraception treatments can have an abortifacient effect.[199] Others, however, believe that the medication may have an abortifacient effect.[200] Directive 36 seems to recognize the possibility of an abortifacient effect insofar as it prohibits any treatments that would interfere with implantation of a fertilized ovum.[201] Directive 36 permits the treatment with emergency contraception medications "[i]f, after appropriate testing, there is no evidence that conception has occurred already." But since Directive 36 "does not spell out precisely what constitutes 'appropriate testing' and 'evidence that conception has occurred,'" variability exists in the interpretation of these phrases.[202]

Two approaches to the issue have emerged: the ovulation approach and the pregnancy approach.[203] The ovulation approach relies on testing to determine whether the victim is ovulating in order to avoid providing emergency contraceptive medications that could have an abortifacient effect. The pregnancy approach discounts the possibility of an abortifacient effect and focuses on testing to determine whether the victim has some preexisting pregnancy.[204] If the victim is pregnant, then no emergency contraception would be provided. Of course, in this case, no emergency contraception would be needed since the pregnancy would not have resulted from the rape and the medication would not interfere with an existing pregnancy.[205]

The arguments in favor of the pregnancy approach are based on the assumption that emergency contraceptive medications do not have an abortifacient effect.[206] But proponents of the pregnancy method may "have overstated the case against the

199. Telephone Interview with Jan Heller, Ph.D., Staff Ethicist for Providence Health System, and Sister Karin Dufault, S.P., Ph.D., R.N, Chair of the Board, Providence Health System (Sept. 23, 2003).

200. Telephone Interview with Joseph J. Piccione, J.D., Mission Integration and Corporate Ethicist and Attorney, OSF Healthcare, Peoria, Ill. (May 5, 2003).

201. Directive 36 provides:

> Compassionate and understanding care should be given to a person who is the victim of sexual assault. ...A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with a fertilized ovum.

United States Conference for Catholic Bishops, *supra* note 21, at 21.

202. Ronald P. Hamel & Michael R. Panicola, *Emergency Contraception and Sexual Assault: Assessing the Moral Approaches in Catholic Teaching*, 83 HEALTH PROGRESS 12 (Sept.-Oct. 2002), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0209&ARTICLE=I.

203. *Id.*

204. SECOND CHANCE DENIED, *supra* note 191, at 9.

205. *Id.*

206. Hamel & Panicola, *supra* note 202, at 13.

abortifacient effects of high-dose estrogen-progestin pills."[207] There are several studies indicating that emergency contraception methods "may impair endometrial receptivity to the implantation of a fertilized egg."[208] In a 2001 article reviewing the literature on the mechanism of action for various emergency contraception medications, the authors conclude there is "no clearcut answer to the question" of how emergency contraception medications prevent pregnancy.[209] And more specifically, they state:

> The most difficult parameter to assess with certainty is endometrial receptivity. Endometrial markers of receptivity have been established so far with certainty only in rodents. Even if endometrial receptivity is shown to be altered by EC, other steps that precede implantation may also be altered enough to interrupt the process at an earlier stage.[210]

Although it is not clear at this time whether the changes to endometrial receptivity are sufficient to inhibit implantation,[211] some physicians argue that since it potentially prevents implantation, emergency contraception could act as an abortifacient.[212] Kevin O'Rourke, a Catholic moral theologian who favors the ovulation approach, argues; "Although impregnating a woman through rape would be a great injustice, it would not be so great an injustice as killing an infant whom rape had brought into being."[213]

Proponents of the ovulation approach point to the possibility of an abortifacient effect as the basis for their concerns. Thus even if science has not at this time authoritatively determined that emergency contraceptives have an abortifacient effect,

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207. Daniel P. Sulmasy, *A Reasonable, Realistic and Ethical Protocol*, 83 HEALTH PROGRESS 15 (Sept.-Oct. 2002) *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0209&ARTICLE=K (nonetheless, Sulmasy, a physician and a Catholic priest, endorses the pregnancy approach in light of the delays in treatment that may result from use of the tests called for under the ovulatory approach).

208. David A. Grimes & Elizabeth G. Raymond, *Emergency Contraception*, 137 ANN. OF INT. MED. (3) E-180, E-182 (Aug. 6, 2002).

209. Horacio B. Croxatto, et. al., *Mechanism of Action of Hormonal Preparations Used for Emergency Contraception: A Review of the Literature*, 63 CONTRACEPTION 111 (2001).

210. *Id.* at 119.

211. Grimes & Raymond, *supra* note 208, at E-182.

212. Correspondence, Letter from Douglas P. Miller, M.D., Catawba Memorial Medical Center, Hickory, N.C., 138 ANN. OF INT. MED. 237, *available at* 237http://www.annals.org/issues/v138n3/full/200302004000024.html. The letter is a response to Grimes & Raymond, *Emergency Contraception*, *supra* note 208, and states in part:

> Hormonally mediated contraception, whether pre- or postcoital, is well recognized as having a dual mechanism of action. Sometimes conception itself is prevented and sometimes implantation of an already conceived embryo is prevented, thus precipitating an early abortion. The use of the term *abortion* is appropriate for this type of procedure because a human embryo is genetically a distinct individual from the moment of conception.

Id. The response by the authors is interesting in that it disagrees on the point of when a pregnancy begins but does not take issue with the statement that the effect of emergency contraception may be to prevent implantation. It states in part:

> Dr. Miller apparently disagrees with the internationally accepted definition of the beginning of pregnancy that we used in our review. Major medical organizations as well as the federal government concur that implantation defines the beginning of pregnancy. Fertilization is a necessary but insufficient step toward establishing pregnancy.

Correspondence, Letter from David A. Grimes, M.D. & Elizabeth G. Raymond, M.D., M.P.H., Family Health International, Research Triangle Park, N.C., 138 ANN. OF INT. MED. 237-38, *available at* http://www.annals.org/issues/v138n3/full/200302004000024.html (footnotes omitted).

213. O'Rourke, *supra* note 168, at 67.

neither has that possibility been authoritatively rejected. Accordingly, they use the analogy of the hunter in the woods who sees movement behind a bush, but cannot discern whether it is a deer or a human behind the bush. Under these circumstances, it would not be morally permissible for the hunter to shoot whatever is behind the bush. Proponents of the pregnancy approach reject this analogy arguing that it is inapposite. While the hunter's intention is to kill what is behind the bush, the intention of the provider administering emergency contraceptive medication is to prevent conception.[214] Nonetheless, more typically the intention of the provider is to prevent pregnancy by any means necessary including the prevention of implantation. Proponents of the pregnancy approach also point to the lack of absolute proof of an abortifacient effect, but this merely increases the level of uncertainty. Certainly, it would still be morally impermissible for the hunter to shoot even if he was some distance from the target and a poor shot.

The most prominent example of the ovulation approach is seen in the protocol developed in 1995 by Joseph Piccione and Gerard McShane for use at St. Francis Hospital in Peoria, Illinois, now known as the "Peoria Protocol."[215] Directive 36 requires the hospital to conduct tests to determine whether conception has already occurred and permits administration of emergency contraception if the test is negative.[216] But as noted by Father Kevin O'Rourke, the requirement of pregnancy testing seems a bit peculiar since any detectable conception would have had to result prior to the rape in light of the fact that such tests are not reliable until ten days after conception has occurred.[217] In addition, according to O'Rourke, the second requirement is also problematic since Ovral, an emergency contraceptive provided to suppress ovulation, also acts as an abortifacient by preventing implantation.[218] Thus O'Rourke argues that the timing of ovulation is the critical determination in preventing an abortion induced by taking Ovral.[219] The Peoria Protocol uses a progesterone test and a urine dip-stick test to ascertain the presence of leutinizing hormones (LH).[220] O' Rourke summarizes:

> If the LH test is negative and supported by progesterone level findings, ovulation is not occurring and Ovral may be used. If the LH test is positive, the process of ovulation is under way and Ovral should not be used. The method seems to obviate the quandary that occurs when a rape victim is unsure whether she has ovulated.[221]

The Peoria Protocol specifically notes that it provides for "contraceptive intervention" only where "there is a clinical indication that the effect of the intervention

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214. *Id.*

215. *Id.* at 66.

216. United States Conference for Catholic Bishops, *supra* note 21, at 20; *see also* O'Rourke, *Applying the Directives*, *supra* note 168, at 66.

217. O'Rourke, *supra* note 168, at 66.

218. *Id.*

219. *Id.*

220. Interim Protocol Sexual Assault: Contraceptive Treatment Component, OSF Health Care System, Peoria, Illinois, Oct. 1995 (on file with author).

221. O'Rourke, *supra* note 168, at 66-67.

will be truly contraceptive and not abortifacient."[222] The clinical determination that the contraceptive intervention would not be abortifacient is based on the following: (1) the menstrual history of the victim; (2) a blood test to determine hormone levels in order to determine the timing of the ovulatory cycle; and (3) an OvuKit urine test to determine whether ovulation has begun.[223] By requiring both the urine dip-stick test and the progesterone level test, the Peoria Protocol goes beyond other ovulation approach protocols.[224]

The Peoria Protocol has been approved by the Illinois State Department of Public Health.[225] Under Illinois law, hospitals that care for sexual assault victims are required to develop a protocol to ensure that victims will receive information on emergency contraception.[226] The protocol must be submitted to the state Department of Public Health for approval.[227] Under the Illinois law, the information provided to sexual assault victims must include:

> [M]edically and factually accurate and written and oral information about emergency contraception; the indications and counter-indications and risks associated with the use of emergency contraception; and a description of how and when

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222. Interim Protocol Sexual Assault: Contraceptive Treatment Component, OSF Health Care System, Peoria, Illinois, October, 1995 (on file with author).

223. *Id.*

224. Hamel & Panicola, *supra* note 202, at 13.

225. Telephone Interview with Joseph J. Piccione, J.D., Mission Integration and Corporate Ethicist, OSF Health Care System, Peoria, Ill. (May 5, 2003).

226. 410 ILL. COMP. STAT. ANN. § 70/2-2 (West 2004). The Department of Public Health has also adopted regulations to implement this statute. ILL. ADMIN. CODE tit. 77, § 545.95 (West 2004) provides:

> (a) By April 30, 2002, every hospital providing services to alleged sexual assault survivors in accordance with a plan approved under Section 545.35 of this Part must develop a protocol for providing emergency contraception information and treatment to alleged sexual assault survivors. (Section 2.2(b) of the Act)
>
> (b) The Department shall request a plan that complies with the requirements of this Section by April 1, 2002. The Department will approve the protocol if it finds that the implementation of the protocol would provide sufficient protection for survivors of an alleged sexual assault and if the protocol provides for the following as soon as possible and, in any event, no later than 12 hours after the alleged sexual assault survivor presents herself/himself at the hospital for emergency care:
>
> 1) medically and factually accurate written and oral information about emergency contraception;
>
> 2) the indications and counter-indications and risks associated with the use of emergency contraception;
>
> 3) a description of how and when victims may be provided emergency contraception upon the written order of a physician (Section 2.2(b) of the Act);
>
> 4) appropriate referral to a physician licensed to practice medicine in all its branches as provided in the Medical Practice Act of 1987.
>
> (c) The hospital shall implement the protocol upon approval by the Department. (Section 2.2(b) of the Act)
>
> (d) The Department shall produce medically and factually accurate written materials that all treatment hospitals shall provide to each female sexual assault survivor of childbearing age.

227. 410 ILL. COMP. STAT. ANN. § 70/2.2 (West 2004)

> victims may be provided emergency contraception upon the written order of a physician licensed to practice medicine in all its branches.[228]

The implementing regulations adopted by the Illinois Department of Public Health also set forth sample protocols including one developed by the Catholic Hospital Association.[229] Under the Catholic Hospital Association protocol, a sexual assault victim who tests negative for pregnancy on the blood test and also has a negative result on the urine dip-stick test is to be offered Ovral. On the other hand, if she tests positive on either of the tests, the emergency department will not provide Ovral.[230] Moreover, if the woman is determined to be in her mid-cycle LH surge or in the early post-ovulatory stage, Ovral or its equivalent will not be provided.[231]

Another example of the ovulatory approach is the *Guidelines for Catholic Hospitals Treating Victims of Sexual Assault* as approved by the Board of Governors of the Pennsylvania Catholic Conference.[232] These guidelines provide that no anti-ovulant drugs may be used if the pregnancy test is positive.[233] They emphasize that medical interventions are permitted "as long as there is no anticipated effect of an abortifacient."[234] Thus it is permissible to "use medications which prevent ovulation, sperm capacitation, or fertilization."[235] If the pregnancy test is negative, then clinical determinations would be based on: "a menstrual history provided by the victim," "hormonal levels as determined by a blood test to categorize the timing of a woman's ovulatory cycle," and "results of a urine test which is a reliable guide to the prediction of ovulation."[236] The Pennsylvania guidelines go on to state, "If the urine test is positive, this would indicate the hormonal shift to ovulation has begun. The use of a contraceptive steroid intervention could be abortifacient and is therefore not permitted, even though there might be no evidence that conception has occurred."[237]

The ovulatory approach has been criticized as imposing unacceptable limitations on the moral options available under Directive 36 insofar as the directive itself does not explicitly prohibit the use of emergency contraceptive medications in women who have recently ovulated or are about to ovulate.[238] This criticism, however, seems a bit disingenuous because Directive 36 does prohibit use of treatments that have as "their purpose or direct effect... interference with the implantation of a fertilized ovum."[239] And in addition, Directive 45 clearly prohibits "[e]very procedure whose sole immediate effect is the termination of pregnancy before viability . . . which . . . includes

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228. *Id.*

229. *See* ILL. ADMIN. CODE tit. 77, §545. APP. C Emergency Contraception Protocols (West 2004).

230. *Id.*

231. *Id.*

232. Bd. of Governors of the Pennsylvania Catholic Conference, Guidelines for Catholic Hospitals Treating Victims of Sexual Assault, Sept. 23, 1998, *available at* http://www.ewtn.com/library/BISHOPS/HOSPSEX.HTM (last visited Sept. 15, 2004).

233. *Id.*

234. *Id.*

235. *Id.*

236. *Id.*

237. *Id.*

238. Hamel & Panicola, *supra* note 202, at 12-13.

239. United States Conference for Catholic Bishops, *supra* note 21, at 21.

the interval between conception and implantation of the embryo."[240]

Perhaps more persuasively, critics of the ovulatory approach also point out that conception only occurs when fertilization is complete, and fertilization is a process that occurs over a twenty-four hour period.[241] Accordingly, they argue that it is morally permissible to administer emergency contraception to any sexual assault victim who comes to the emergency treatment within that twenty-four hour period.[242] They bolster their argument by noting that it is very unlikely that a conception will occur as a result of rape.[243] They further argue that the weight of medical evidence at this time does not support the notion that emergency contraception medications act as an abortifacient by preventing implantation.[244] And they criticize the Peoria Protocol as seeking absolute certainty. again emphasizing "the extremely small" risk of destruction of a conceptus.[245] Finally, they argue that proponents of the ovulation approach have distorted the moral object of administering the emergency contraception medication to a woman who is ovulating in light of the small risk of preventing implantation.[246]

In contrast to the ovulation approach, the pregnancy approach tests only for an existing pregnancy. If the test result is negative, then the victim would be offered emergency contraception.[247] Of course, as noted by O'Rourke, the problem with this approach is that a pregnancy resulting from the rape would not show up for at least ten days following the incident.[248] Nonetheless, proponents of the pregnancy approach argue that it is morally preferable for several reasons. They argue that no tests can provide evidence of conception from recent sexual assault and prior pregnancy is ruled out so as to protect a developing embryo.[249] And further that the ruling out of a prior pregnancy provides sufficient moral certainty in light of the relatively unlikely chance of a conception occurring because of rape and the lack of scientific studies establishing an abortifacient effect for emergency contraceptive medications. In this regard, they characterize the moral object of the administration of the medication as the prevention of conception rather than the prevention of implantation. They also refer to a proportionate justification for the act, i.e., "the prevention of pregnancy resulting from the sexual assault and its subsequent impact on the overall well-being of the woman."[250] Finally, they argue that the Catholic moral tradition does not always require taking the safest approach. In this regard, they point to the principle of double effect as applied in the cases of administering morphine to patients in severe pain even if that may hasten death, and the allowance for the bombing of military targets in wartime even if there is some risk of collateral damage to civilian targets.[251]

240. *Id.* at 26.
241. Hamel & Panicola, *supra* note 202, at 15.
242. *Id.* at 15-16.
243. *Id.* at 16.
244. *Id.*
245. *Id.* at 17.
246. *Id.*
247. Hamel & Panicola, *supra* note 203, at 17.
248. O'Rourke, *supra* note 168, at 66.
249. Hamel & Panicola, *supra* note 202, at 17.
250. *Id.*
251. *Id.* at 18.

III. THE MORAL FOUNDATION OF CATHOLIC HEALTH CARE : THE CATHOLIC NATURAL LAW TRADITION, THE ETHICAL AND RELIGIOUS DIRECTIVES, AND CATHOLIC IDENTITY

The trend toward the adoption of legislation requiring Catholic hospitals to provide reproductive services that may violate Catholic teaching has undoubtedly been fostered by the perception among policymakers that the leaders of these institutions may not be serious about preserving their distinctive mission insofar as it requires them to refrain from providing or cooperating in the provision of access to reproductive services. This perception is perhaps not surprising in light of continuing assaults on the Catholic natural law tradition by revisionist theologians. Changes in the cultural and religious environment have had a significant impact on Catholic health care as traditional Catholic teachings on human sexuality and reproduction have become increasingly counter-cultural. Notwithstanding these changes, the teaching of the Church as derived from the Catholic natural law tradition and expressed in Papal documents and the *ERD* have remained remarkably constant in their rejection of artificial contraception, direct sterilization, and direct abortion.

Since the Second Vatican Council, there has been substantial controversy among Catholic theologians over the morality of contraception, sterilization, and even abortion under certain circumstances. Through the 1950s, many priests relied on manuals on medical moral issues written by such authors as Gerald Kelly, Charles J. McFadden, and Thomas J. O'Donnell, all scholars working in the Catholic natural law tradition.[252] In the 1960s, however, a fundamental split arose between Catholic moral theologians who relied on traditional natural law methodology, and those who advocated a more contextual, practical approach and eschewed reliance on transcendent, pre-existing absolute norms. Revisionist theologians working in the latter school, typically referred to as proportionalists or consequentialists, sought an accommodation between Church teaching and the secular culture. The secular movement of bioethics also has had an impact on Catholic health care. Notwithstanding their widespread influence, the Vatican repudiated the approach taken by the revisionists and secular bioethicists.

A. The Catholic Natural Law Tradition

The Church traditionally adopted a natural law framework for addressing medico-moral issues. In the Catholic natural law tradition, certain actions are deemed intrinsically immoral notwithstanding potentially beneficial consequences.[253] William May, drawing on the writings of St. Thomas Aquinas, summarizes the traditional approach by noting that there are three levels of natural law precepts: 1) self-evident first principles (e.g., good is to be pursued and evil avoided); 2) a second set of more specific precepts that can be readily derived from first principles through the use of natural reason; and 3) more "remote conclusions," i.e., specific moral norms, known

252. George P. Graham, *Bioethics: An Orphan Discipline*, HOMILETIC & PASTORAL REV. 10, May 2001, at 10, *available at* http://www.catholicculture.org/usertools/print.cfm?id=4126&itemtype=Library%20Document (last visited Sept. 15, 2004).

253. WILLIAM E. MAY, AN INTRODUCTION TO MORAL THEOLOGY 282 (2d ed. 2003).

only to the "wise, or those perfected in the virtue of prudence."[254] Traditional Catholic theologians, such as Professor May, argue that the *Magisterium* of the Church has infallibly taught certain core moral precepts such as those summarized in the Decalogue, "precisely *as these precepts have been traditionally understood within the Church.*"[255] This would include the traditional proscription of abortion.[256] In addition, there are specific moral norms, e.g., the proscription on artificial contraception, that have been authoritatively proposed by the *Magisterium* but may not be infallibly proclaimed.[257] Traditionalists, such as May, argue that dissent among Catholic theologians is not permissible even as to these latter, more specific norms.[258]

Albert Jonsen notes that the approach taken by Catholic moral theologians through the middle of the twentieth century was typified by "an exposition of fundamental moral principles derived from natural law and divine revelations, followed by a casuistic analysis of specific topics."[259] It was also characterized by deference to the *Magisterium*.[260] This approach may be seen in *Medical Ethics*, a work by Charles J. McFadden that was originally designed for teaching Catholic nurses but later modified for use in teaching ethics to pre-medical students, nurses, medical students, and physicians.[261] In the introduction to McFadden's work, Fulton J. Sheen emphasizes the importance of doctors and nurses having "a moral sense of oughtness."[262]

McFadden's discussion of ethics is based on natural law. Indeed, he clearly explicates his belief in "absolute" moral norms that are "immutable" and "universal," i.e., binding at all times and in all places on all people.[263] Natural law, in the Thomistic tradition, is humanity's participation in the eternal law through the use of reason.[264] He also emphasizes the importance of "true conscience," a conscience that is properly formed and directs actions in accordance with the precepts of the natural law.[265] Noting the difficulty in ascertaining the precepts of the natural law, McFadden also refers to "[t]he Moral Law" that "is to be found in tradition, in Sacred Scripture, and in the teaching of Christ's infallible Church."[266] He concludes, "[i]t is this law known both by reason and Divine Revelation which should be cherished by doctor and nurse alike as the source and basis of their moral ideals."[267]

The principle of double effect also plays a significant role in the traditional

254. *Id.* at 77–78.

255. *Id.* at 250 (emphasis added).

256. *Id.* at 252.

257. There is an ongoing debate over whether the teaching of *Humanae Vitae* is infallible. Most consider it to be authoritative, but not infallible. Others have argued that the document itself was infallibly proclaimed *ex cathedra* by Pope Paul VI, or that even if it wasn't proclaimed *ex cathedra*, the teaching is infallible because it has been continuously proclaimed by the universal ordinary *Magisterium*. JANET E. SMITH, HUMANAE VITAE: A GENERATION LATER 155–60 (1991).

258. *Id.* at 215–23.

259. ALBERT R. JONSEN, THE BIRTH OF BIOETHICS 36 (1998).

260. *Id.*

261. MCFADDEN, *supra* note 37, at xiii (3d ed. 1953).

262. *Id.* at xii.

263. *Id.* at 18.

264. *Id.*

265. *Id.* at 20–21.

266. *Id.* at 18.

267. MCFADDEN, *supra* note 37, at 18.

Catholic natural law approach. The principle of double effect treats as morally licit indirect abortions or sterilizations, i.e., abortions or sterilizations that result as unintentional byproducts of medical treatments for serious pathological conditions. Gerald Kelly notes that under the principle of double effect, an action is deemed morally licit if the following requirements are met:

> 1) The action, considered by itself and independently of its effect, must not be morally evil . . . 2) The evil effect must not be the means of producing the good effect. The principle underlying this condition is that good end cannot justify the use of an evil means . . . 3) The evil effect is sincerely not intended, but merely tolerated . . . 4) There must be a proportionate reason for performing the action, in spite of its evil consequences. In practice, this means that there must be a sort of balance between the total good and the total evil produced by an action. Or, to put it another way, it means that, according to a sound prudential estimate, the good to be obtained is of sufficient value to compensate for the evil that must be tolerated.[268]

As to contraception, McFadden notes that by the 1940s, the use of contraception was already widespread even among Catholics.[269] Nonetheless, he states that "[i]n contraception, man completely perverts the order of nature and acts contrary to the will of the Creator."[270] He concludes with the following instruction to Catholic nurses and doctors: "No instruction on the methods of using contraceptives of any type may be given to any person, regardless of religion, by a doctor or nurse."[271] Not surprisingly, McFadden also condemns all direct sterilizations, i.e. surgical sterilizations of a man or woman for the purpose of preventing future pregnancies, as "mutilation[s]" that are not morally licit.[272] On the other hand, in accordance with the principle of double effect, he recognizes that "therapeutic sterilizations," i.e. procedures resulting in sterility where "the primary objective is the removal of a diseased organ and the preservation of the health and life of the patient" rather than where the "[d]esire to effect sterilization" is the motive, may be morally licit.[273]

As to abortion, in conformity with Catholic tradition, McFadden condemns all "direct abortions," defined as procedures "employed to procure the expulsion of fetus."[274] This condemnation would include "therapeutic abortion" defined as abortions that are "directly induced as a means of safeguarding the health and life of the mother."[275] On the other hand, in accordance with the principle of double effect, "indirect abortion[s]," defined as "any instance in which a treatment or operative procedure is performed for some other purpose but incidentally and secondarily does cause the expulsion of the fetus," are deemed morally licit.[276]

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268. GERALD KELLY, MEDICO-MORAL PROBLEMS 13–14 (1958); *see also* MCFADDEN, MEDICAL ETHICS, *supra* note 37, at 33.

269. MCFADDEN, *supra* note 37, at 77–80.

270. *Id.* at 93.

271. *Id.* at 99.

272. *Id.* at 282.

273. *Id.* at 294–95.

274. *Id.* at 162.

275. MCFADDEN, *supra* note 37, at 162.

276. *Id.*

B. The Challenge of Revisionist Theologians

Revisionist Catholic theologians (sometimes referred to as proportionalists or consequentialists) generally reject the notion that the violation of specific norms such as the prohibition on direct abortions, direct sterilizations or artificial contraception may be considered intrinsically immoral acts notwithstanding their consequences and context.[277] Many revisionists acknowledge that there are some absolute principles, i.e., the obligation to always "act in conformity with love of God and neighbor."[278] They would also generally acknowledge that norms using "morally evaluative language" may be absolute, e.g. a prohibition on murder rather than a prohibition on direct killing.[279] Professor May, who coined the term proportionalism to describe the approach taken by revisionist theologians, summarizes the major principles underlying their arguments as follows: "(1) the requirements of the 'preference principle' or 'principle of proportionate good;' (2) the existence of a human act as a totality; and (3) the historicity of human existence."[280]

As to the "principle of proportionate good," revisionist theologians argue that in articulating norms it is necessary to take into account the effect of the norms on "human goods or values."[281] Under this approach, acts such as direct abortion, direct sterilization and contraception could be considered moral if "done for the sake of a proportionally greater good."[282] The totality argument is closely related to the proportionality argument and proposes that the morality of an act can only be appraised by taking account of the totality of its effect.[283] This also requires an appraisal of the actor's intention.[284] Thus under this view, contraceptive sterilization when undertaken because a future pregnancy could endanger a mother's life could be viewed as appropriate for the purpose of stabilizing the marriage.[285] Finally, the historicity argument is that specific moral norms develop in particular historical contexts and are subject to revision based on continuing human experience.[286]

The controversy between Catholic traditionalists and revisionists parallels the divide in moral theology between deontologists and teleologists. In appraising the morality of particular acts, deontologists, focusing on pre-existing transcendent norms, accept the notion that certain acts are intrinsically evil notwithstanding their seemingly beneficial consequences. Teleologists, on the other hand, focus on whether a

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277. *See, e.g.*, CHARLES E. CURRAN, MEDICINE AND MORALS 29 (1970), stating:
> Since the experience of Christian people and all men of good will is a source of moral knowledge, an ethician cannot simply spell out in advance everything that must be done by the doctor. And generally speaking, in other complicated areas of human life, the theologian cannot say that this or that action must always be performed. In many matters of medicine the ethician can merely tell the doctor to exercise his own prudent moral judgment. The patient and the doctor together must decide the feasibility of performing an operation by weighing the advantages against the risk.

278. MAY, *supra* note 253, at 104.
279. *Id.*
280. *Id.* at 105.
281. *Id.*
282. *Id.* at 106.
283. *Id.* at 107.
284. MAY, *supra* note 253, at 108.
285. *Id.*
286. *Id.* at 109.

proportionate good is brought about by the act in question.[287] The traditional Catholic natural law position is conventionally viewed as deontological, although some revisionist theologians argue that it is for the most part teleological.[288] Indeed, it is argued by revisionist theologians that with the exception of norms such as the prohibition of artificial contraception and direct killing, most norms in the Catholic tradition have been "teleologically parsed."[289] Nonetheless, while some revisionists argue that their position is neither strictly deontological or teleological, the primary focus of their activity has been the rejection of the deontological approach taken by the traditionalists.[290]

Revisionists also contend that it is permissible for Catholic theologians to publicly dissent from non-infallible teachings proposing specific moral norms, such as the proscription of artificial contraception.[291] Following the Second Vatican Council this controversy over the nature of moral reasoning within the Catholic tradition became public as seen in the reaction to *Humanae Vitae*,[292] the Papal encyclical rejecting artificial contraception. William May argues that the "roots of the rejection of moral absolutes" by revisionist theologians may be found in the Majority Report on the issue of contraception issued by the Papal Commission for the Study of Population, the Family and Natality.[293] Clearly, although revisionist theologians may be a disparate group, virtually all of them reject the Catholic Church's ban on artificial contraception and it is difficult to understand the movement apart from the controversy over this issue.[294] Eventually, those who dissented from *Humanae Vitae* realized that the traditional natural law approach did not provide a satisfactory basis for their dissent and began to develop alternative approaches.[295] Instead, building on the principle of double effect, they developed a new approach to medical ethical issues that resisted the application of absolute moral norms.[296]

For example, in a 1970 book, Charles Curran, a leading revisionist theologian, outlines the "Points of Dissatisfaction" with the Catholic natural law tradition.[297] His basic position is that the Catholic natural law tradition is untenable because it is based on the existence of pre-existing, absolute medico-moral norms.[298] Curran begins by noting that the Catholic natural law tradition had been a major point of disagreement between Protestant and Catholic theologians and calls for a "critical appraisal of natural law theory" noting that the questioning of the Church's position on contraception had led to a questioning of the entire system of natural law on which it was based.[299] He

287. CHRISTOPHER KACZOR, PROPORTIONALISM AND THE NATURAL LAW TRADITION 10–11 (2002).

288. *Id.* at 13–14.

289. *Id.* at 14–15.

290. *Id.* at 12.

291. MAY, *supra* note 253, at 215.

292. POPE PAUL VI, HUMANAE VITAE (1968), *available at* http://www.ewtn.com/library/ENCYC/P6HUMANA.HTM.

293. MAY, *supra* note 253, at 101.

294. KACZOR, *supra* note 287, at 4–5.

295. CURRAN, *supra* note 277, at 29.

296. JONSEN, *supra* note 259, at 54 (discussing the work of Richard McCormick).

297. CURRAN, *supra* note 277, at 2-8.

298. *Id.* at 43.

299. *Id.* at 1.

notes that while Catholic natural law theory has received wide support "from many men of goodwill" in the area of social justice, in the area of medical morals it had not been well received.[300] According to Curran, the primary defect in regard to the Catholic natural law tradition's approach to issues such as abortion, contraception, sterilization, and artificial insemination is its unfortunate focus on "the physical structure of the act itself."[301] He argues that it is preferable to view an act in its "total human context" rather than just focusing on its physical attributes.[302]

Curran also criticizes traditional law theory as embracing an archaic "classicist world view" that focused on the immutable instead of an "historical worldview" that focuses on change and evolution.[303] These two worldviews in turn create two different theological methodologies: the classicist focuses on preexisting abstract principles while the historicist focuses on the context of the act.[304] Although he acknowledges that Vatican II does not officially adopt either view, he sees the primary thrust of Vatican II to be tilted toward the historicist view noting its emphasis on the importance of entering into dialogue with the modern world.[305] On the statements of the *Magisterium* of the Church, he notes that, unfortunately, many Catholics still accept them "in a somewhat fundamentalist manner."[306] Instead, he suggests that they should be viewed "in light of the historical, cultural, and scientific circumstances of the time in which they were composed."[307]

Curran treats contraception and sterilization as related questions noting that once one accepts the notion that reproduction may be prevented that, other than the permanence of the procedure, there was little basis for distinguishing between "interfering with the act of sexual intercourse (contraception) or interfering with the reproductive faculty (anovulant pills, sterilizing operations)."[308] He thus concludes that a rejection of the natural law basis on the use of contraception by married couples, as advocated by the majority of the Papal commission, also necessitates a rejection of any limitation on direct sterilization.[309] Curran also questions the traditional absolute prohibition on direct abortions.[310] He suggests that the traditional teaching should be modified to permit an abortion where it is necessary to save the life of the mother.[311]

Curran also criticizes the use of the principle of double effect in traditional Catholic natural law teaching noting that it has been typically used to distinguish between situations where the evil effect is merely permitted for proportionate reasons (deemed morally licit) rather than intended (deemed morally illicit).[312] Curran is critical of the traditional use of the principle of double effect insofar as it has focused on the "sole

300. *Id.* at 2.
301. *Id.* at 16.
302. CURRAN, *supra* note 277, at 17.
303. *Id.* at 19-20.
304. *Id.* at 20-21.
305. *Id.* at 22-24.
306. *Id.* at 31.
307. CURRAN, *supra* note 277, at 31-32.
308. *Id.*
309. *Id.* at 3.
310. *Id.* at 5.
311. *Id.* at 7.
312. CURRAN, *supra* note 277, at 7.

immediate effect" of the procedure in question without reference to other values.[313] Thus although it would permit termination of an ectopic pregnancy by removal of the fallopian tube where the purpose of the procedure is to prevent the rupture of the tube, it would not permit removal of the fetus alone.[314] Curran would extend this principle so as to permit removal of the fetus without removal of the tube in order to preserve the woman's fertility.[315]

Clearly the influence of the revisionists has been significant: in 1977, the Catholic Theological Society of America published a study stating that artificial contraception, sterilization and masturbation could not be considered intrinsically immoral acts.[316] The issuance of *Humanae Vitae* marked the beginning of an era of public dissent where large numbers of people remained in the Church despite their rejection of its teaching on matters related to human sexuality.[317] There were also well known Catholic theologians who argued that Catholic hospitals operating in a pluralistic society should provide procedures such as contraceptive sterilizations that are considered morally permissible by large segments of the population.[318] These same theologians argued that an obligation to provide sterilizations and contraception also flowed from the receipt of public funds.[319]

The ongoing abortion controversy has placed additional pressure on Catholic hospitals. Abortion was legalized throughout the United States by judicial fiat in 1973.[320] In 1973, the pro-choice group Catholics for a Free Choice was founded "as an offshoot of the National Organization for Women."[321] In addition, many high-profile

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313. *Id.*

314. *Id.* at 6.

315. *Id.* The 1971 *ERD* appear to require removal of the tube itself rather than permitting removal of the fetus alone. Directive 16, Ethical and Religious Directives for Catholic Health Facilities, *reprinted in* THOMAS J. O'DONNELL, S.J., MEDICINE AND CHRISTIAN MORALITY 311, 315 (1976).

316. *Cf.* PHILIP JENKINS, THE NEW ANTI-CATHOLICISM: THE LAST ACCEPTABLE PREJUDICE 59–60 (2003):

> The dispute over *Humanae Vitae* also dissolved traditional constraints about openly challenging Church authorities. Very shortly after the encyclical was issued, prominent Catholic theologian Charles Curran announced to a press conference that Catholics were not bound to obey the papal pronouncement, and his doubts were publicly echoed by hundreds of other priests and Catholic educators. This was an early manifestation of what would be a continuing theme over the next thirty years: the repeated clashes between Church authorities and liberal theologians, especially on the issues of sexuality. In 1977, the once dependably orthodox Catholic Theological Society of America (CTSA) published the study *Human Sexuality*, which stated that no definitive grounds existed to condemn practices such as contraception, sterilization, and masturbation.

317. *Id.* at 59. According to Professor Jenkins:

> [F]rom the late 1960s, the contraception debate made the issue of obedience crucially important. For most Catholic families, to accept the official Church position meant pursuing a course that would profoundly affect one's everyday life and prosperity. Many families chose to disregard Church teaching on this vital issue, though without feeling the need to abandon the Church. By 1992, a Gallup poll found that 80 percent of U.S. Catholics disagreed with the statement 'Using artificial means of birth control is wrong.'

Id. at 58-59. (footnotes omitted).

318. CHRISTOPHER J. KAUFFMAN, MINISTRY AND MEANING: A RELIGIOUS HISTORY OF CATHOLIC HEALTH CARE IN THE UNITED STATES 290-91 (1995).

319. *Id.* at 291 (quoting from Richard A. McCormick, S.J., *Not What Catholic Hospitals Ordered*, 39 LINACRE Q. 21 (May 1972)).

320. Roe v. Wade, 410 U.S. 113 (1973).

321. JENKINS, *supra* note 316, at 60.

Catholic politicians are avowedly pro-choice.[322] And Professor Charles Curran, a well-known Catholic moral theologian, priest, and one time faculty member at Catholic University, even suggested that direct abortion could be considered a moral option to be provided by Catholic hospitals under some circumstances.[323]

C. The Challenge of the Secular Discipline of Bioethics

Beginning in the 1960s, the secular discipline of bioethics began to emerge and to some extent supplant the traditional Catholic natural law approach to medico-moral issues even in Catholic institutions. Albert Jonsen, a pioneer in the bioethics movement, a laicized Jesuit priest and former theology professor at the University of San Francisco, traces the beginning of bioethics as a discrete discipline to the development of a shunt by Belding Scribner at the University of Washington that permitted persons with kidney failure to receive long-term dialysis.[324] In the case of the development of dialysis, the Seattle Artificial Kidney Center had more patients than it could possibly treat, and a committee was formed to determine, out of those determined to be medically suitable, "who shall live and who shall die."[325] The committee made its determination through the use of "social worth criteria."[326] The activities of the Seattle committee occasioned significant controversy and discussion among prominent ethicists and theologians.[327] Eventually, the new secular discipline of bioethics was organized through several conferences in the 1960s and the emergence of centers such as the Kennedy Institute at Georgetown, the Hastings Center and the Society of Health and Human Values.[328]

Later the *Belmont Report,* a government-commissioned study that focused on human subjects research, identified three governing principles of secular bioethics: "respect for persons, beneficence and justice."[329] Ultimately, these "principles found

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322. William Lobdell & Teresa Watanabe, *Church May Penalize Politicians; Bishops Are Exploring Requiring Officeholders Who Are Catholic to Back Official Doctrine*, L.A. TIMES, November 29, 2003, 2003 WL 68901157. The prominent pro-choice Catholic politicians mentioned in this article are Senator Edward Kennedy (D-Mass.), Governor George Pataki (R,-New York), Governor Arnold Schwarzenegger (R. Cal.), and Rep. Nancy Pelosi (D-Cal.). *Id.* The article also refers to statistics from the American Life League, a pro-life group, indicating that voters have elected 412 politicians to state and federal offices who are both Catholic and pro-choice. *Id.*

323. CURRAN, *supra* note 277, at 29. He states:

> Perhaps in other matters now spelled out in the hospital code, more room should be left for conscientious decision by the doctor. The problem seems to reside in a system of theory that attaches exclusive moral importance to the physical structure of an act. At the very least, theologians must listen when doctors of good will are listening to them. In fact, theologians must ask doctors to reveal their moral experience. The doctor must at least be listened to with respect when he honestly says that he thinks a raped 15-year-old girl who is a patient in a mental hospital should be aborted.

324. *Id.* JONSEN, *supra* note 259, at X-XI.

325. *Id.* at 212.

326. *Id.*; *see also* Graham, *Bioethics: An Orphan Discipline*, *supra* note 252, at 11-12.

327. JONSEN, *supra* note 259, at 214-15.

328. *Id.* at 13-26.

329. *Id.* at 103 (discussing THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (Washington, D.C.: Government Printing Office, 1979)); *see also* Dianne N. Irving, *The Impact of International Bioethics on the 'Sanctity of Life Ethics', and the Ability of OB Gyn's to Practice According to*

their way into the general literature of the field, and, in the process, grew from the principles underlying the conduct of research into the basic principles of bioethics."[330] Accordingly, ethical decisions in particular situations are to be arrived at by balancing these competing ethical principles; no one principle trumps the others.[331] Thus the philosophical underpinnings of the secular discipline of bioethics are essentially pragmatic and teleological. Indeed, some argue that bioethics is morally and philosophically incoherent.[332]

The discipline of secular bioethics has influenced Catholic hospitals and particularly their ethics committees, as well as the professional bioethicists employed by them.[333] In the wake of *Humanae Vitae*, a number of Catholic moral theologians, including Jonsen, decided that they could no longer defend the Church's traditional positions on abortion and contraception.[334] According to Jonsen, the debate within the Catholic Church on the morality of contraception "inadvertently promoted the growth of bioethics by increasing the ranks of the new bioethicists."[335] Moreover, "it drove others away from their original home in Catholic moral theology into the new field of bioethics."[336] And questions as to the morality of abortion, sterilization and contraception eventually disappeared altogether from the agenda of the new bioethicists.[337]

Not surprisingly, therefore, within the world of Catholic health care compliance with the *ERD* has been, at times, problematic. One observer has noted, "[t]he provision of abortion and other reproductive-altering services prohibited by the religious directives would violate its moral commitments and thus would not be offered by Catholic hospitals."[338] But, nonetheless, a few Catholic hospitals have been accused of attempting to circumvent the *ERD* by cooperating with non-Catholic health care providers to offer sterilization services.[339] In some instances Catholic hospitals have provided surgical sterilization procedures through unrelated organizations or at a separately operated clinic within the hospital itself.[340] Typically, obstetrician-gynecologists who practice in Catholic hospitals and in physician office buildings owned by Catholic hospitals provide prescriptions for contraceptives to their patients.[341]

Conscience (paper presented at International Conference: The Future of Obstetrics and Gynaecology, International Federation of Catholic Medical Associations and MaterCare International, Rome, Italy, June 18, 2001), *available at* http://www.lifeissues.net/writers/irv/irv_40bioandconscience01.html.

330. JONSEN, *supra* note 259, at 104 (footnote omitted).

331. Irving, *supra* note 329.

332. *Id.*

333. Irving, *supra* note 329.

334. JONSEN, *supra* note 260, at 300.

335. *Id.*

336. *Id.*

337. *Id.* at 296, 303.

338. White, *supra* note 21, at 220-21.

339. *See* Christopher Zehnder, *What's Ailing Catholic Hospitals,* CRISIS, Nov. 2001, *available at* http://www.crisismagazine.com/november2001/feature8.htm.

340. At least one Catholic Hospital announced that it would perform medically-indicated sterilizations in the hospital rather than in a related facility. The hospital is St. Louise Regional Hospital, a facility operated by Catholic Healthcare West in Gilroy, California. Ron Shrinkman, *Survival v. Directives,* MODERN HEALTHCARE, Nov. 20, 2000, at 12.

341. The results of a 1975 survey conducted by anonymous mail questionnaires on the sterilization and contraceptive practices in United States Catholic hospitals revealed that even at that time 20% of the 348

And abortion referrals have been provided in community health care facilities that have been merged with Catholic hospitals. [342]

D. The Vatican's Rejection of the Revisionist Attack on Absolute Moral Norms

As noted previously, revisionist theologians reject the notion that there are absolute moral norms, i.e., norms that are always true, that authoritatively determine such matters as the immorality of artificial contraception, direct sterilization and direct abortion. Revisionists contend that these sort of "specific moral absolutes defended in the Catholic tradition and affirmed by the *Magisterium* isolate partial aspects of human acts and, on the basis of such isolated aspects, render decisive moral judgments about them."[343] Instead, revisionists propose that the morality of such acts should be judged based on the totality of the circumstances and in light of the potential for further "self-development" of the moral actor.[344]

Revisionist theologians also embrace a principle of "proportionate good" whereby "some acts of direct abortion . . . [and] contraception . . . can be morally right acts if . . . done for the sake of a proportionately greater good."[345] From this viewpoint, acts such as direct sterilization to preserve the health of the mother against the threat of future pregnancies and the use of artificial contraception could be justified as enhancing or preserving family stability.[346] Finally, revisionist theologians argue that moral norms are the product of human experience and particular historical circumstance and as such must be subject to revision as civilization advances.[347]

Notwithstanding the widespread influence of the revisionists, the *Catechism of the Catholic Church*[348] and two papal encyclicals issued in the 1990s reject the arguments put forth by revisionist theologians and reaffirm traditional Catholic teaching on the existence of absolute moral norms. In *Veritatis Splendor* (1993)[349] and *Evangelium*

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facilities responding to the survey permitted medically-indicated sterilizations. Of the fifty-three residency hospitals responding, seventeen provided oral contraceptives, thirteen provided diaphragms, five provided IUDs and six provided all methods of contraceptives. Of the 283 non-residency hospitals responding, forty-one provided oral contraceptives, twenty-two provided diaphragms, seventeen provided IUDs, and thirty-eight provided all methods of contraceptives. John M. O'Lane, *Sterilization and Contraception Services in Catholic Hospitals,* 133 AM. J. OBSTETRICS & GYNECOLOGY 355, 356 (1979).

342. The Daughters of Charity, with the approval of the local bishop, agreed to continue to provide abortion referrals, at least on a temporary basis, at Niagara Falls Memorial Hospital, a community hospital that was merged with St. Mary's, a hospital owned by the Daughters. Lucette Lugnado, *Religious Practice: Their Role Growing, Catholic Hospitals Juggle Doctrine and Medicine,* WALL ST. J., Feb. 4, 1999 at A1, *available at* 1999 WL-WSJ 5439555. In addition, Brackenridge Hospital, a city-owned hospital that is managed by Ascension Health, provided abortion referrals in a city-operated clinic set aside within the hospital to provide contraceptives and sterilizations. Kim Sue Lia Perkes, *Bishops to Weigh Tighter Controls at Catholic Hospitals,* AUSTIN-AM. STATESMAN, October 26, 2000, *available at* http://www.cath4choice.org/new/inthenews/102600BishopsWeighControls.htm.

343. MAY, *supra* note 253, at 103.

344. *Id.*

345. *Id.* at 106.

346. *Id.* at 108.

347. *Id.* at 109.

348. CATECHISM OF THE CATHOLIC CHURCH (English trans., 1994) [hereinafter CATECHISM].

349. POPE JOHN PAUL II, VERITATIS SPLENDOR (1993), *available at* http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc06081993_veritatis-splendor_en.html [hereinafter VERITATIS SPLENDOR].

Vitae (1995),[350] Pope John Paul II condemns the approach taken by revisionist theologians and reasserts the Catholic natural law tradition. These developments have in turn had an influence on the 1994 and 2001 versions of the *ERD*, discussed *infra*.

The *Catechism* embraces the traditional Catholic natural law approach stating: "There are concrete acts that it is always wrong to choose, because their choice entails a disorder of the will, i.e., a moral evil. One may not do evil so that good may result from it."[351] The *Catechism* also reasserts traditional Church teaching on abortion, sterilization, and contraception. Paragraph 22 states that "[h]uman life must be respected and protected absolutely from the moment of conception."[352] Paragraph 2271 further states: "Since the first century the Church has affirmed the moral evil of every procured abortion. This teaching has not changed and remains unchangeable. Direct abortion, that is to say, abortion willed either as an end or a means, is gravely contrary to the moral law."[353] Under Paragraph 2272 of the *Catechism,* the penalty for formal cooperation in the procurement of an abortion is automatic excommunication.[354] Paragraph 2366 condemns both artificial contraception and contraceptive sterilization by providing that "it is necessary that each and every marriage act remain ordered *per se* to the procreation of life."[355] It further notes: "This particular doctrine, expounded on numerous occasions by the *Magisterium*, is based on the inseparable connection, established by God, which man on his own initiative may not break, between the unitive significance and the procreative significance which are both inherent to the marriage act."[356]

Veritatis Splendor was issued for the purpose of responding to the claims of revisionists and "with the intention of clearly setting forth certain aspects of doctrine which are of crucial importance in facing what is certainly a genuine crisis."[357] The encyclical was occasioned by the need to restate "certain fundamental truths of Catholic doctrine which in the present circumstances, risk being distorted or denied."[358] Specifically, it was occasioned by the phenomenon of public dissent within the Church that rejected the "Church's moral teachings" and the authoritative role of the Magisterium.[359]

Veritatis Splendor affirms the authority of the *Magisterium* to establish absolute norms governing moral conduct.[360] Part II of the encyclical directly confronts the

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350. POPE JOHN PAUL II, EVANGELIUM VITAE (1995) [hereinafter EVANGELIUM VITAE].

351. CATECHISM, *supra* note 348, at para. 1761.

352. *Id.* at para. 2270.

353. *Id.* at para. 2271.

354. *Id.* at para. 2366.

355. *Id.* (quoting HUMANAE VITAE, *supra* note 76).

356. CATECHISM, *supra* note 348 (quoting HUMANAE VITAE, *supra* note 76).

357. VERITATIS SPLENDOR, *supra* note 349, at para. 5 (emphasis in original).

358. *Id.* at para. 4.

359. *Id.*

360. *Id.* at para. 25, stating:

> The moral prescriptions which God imparted in the Old Covenant, and which attained their perfection in the New and Eternal Covenant in the very person of the Son of God made man, must be *faithfully and continually put into practice* in the various different cultures throughout the course of history. The task of interpreting these prescriptions was entrusted by Jesus to the Apostles and their successors, with the special assistance of the Spirit of truth. . . .

Paragraph 26 continues: "In the moral catechesis of the Apostles, besides exhortations and directions

claims of the revisionist theologians, noting that since Vatican II, "there have developed *certain interpretations of Christian morality which are not consistent with 'sound teaching.*"[361] After referring to the extravagant emphasis on individual autonomy in contemporary moral discourse, the encyclical condemns the work of moral theologians who reject the existence of absolute moral norms.[362] It states: "No one can fail to see that such an interpretation of the autonomy of human reason involves positions incompatible with Catholic teaching."[363]

Veritatis Splendor restates the traditional Thomistic definition of the natural law as the participation in the eternal law by the use of reason.[364] It rejects arguments by revisionists contending that the traditional approach focuses too much on physicalism, i.e. the biological nature of acts such as contraception and direct sterilization, rather than on the historical and social context of such acts.[365] In rebuttal, it states: "*A doctrine which dissociates the moral act from the bodily dimensions of its exercise is contrary to the teaching of Scripture and Tradition.*"[366] It also reaffirms the existence of moral absolutes, "*negative precepts* of the natural law," governing human conduct that are valid always and everywhere.[367] Noting that some moral theologians have emphasized the cultural context in order to question the immutability of specific moral norms, it responds: "There is something in man that transcends those cultures."[368] It condemns an approach that legitimizes departures from moral norms as so-called "pastoral solutions."[369] While acknowledging the important role of conscience, it emphasizes the role of the teachings of the Church in forming the consciences of Christians.[370]

Veritatis Splendor emphatically rejects the arguments of moral theologians who would judge the morality of acts "on the basis of a technical calculation between the 'premoral' or 'physical' goods and evils which actually result from the action."[371] Likewise, it rejects teleological ethical approaches, such as proportionalism, that emphasize the maximization of goods and the minimization of evils.[372] It notes that while the foreseeable consequences of an act may mitigate its gravity, it can never "alter its moral species."[373] It rejects the proportionalist argument that the morality of an act cannot be determined solely by its object and must take account of the "*totality of the foreseeable consequences of that act for all persons concerned.*"[374] Instead, *Veritatis Splendor* reemphasizes the continuing validity of the traditional Thomistic teaching that

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connected to specific historical and cultural situations, we find an ethical teaching with precise rules of behaviour." *Id.*

361. *Id.* para. 29 (emphasis in original).
362. VERITATIS SPLENDOR, *supra* note 349, para. 35–37.
363. *Id.* at para. 37.
364. *Id.* at para. 43.
365. *Id.* at para. 47.
366. *Id.* at para. 49 (emphasis in original).
367. VERITATIS SPLENDOR, *supra* note 349, para. 52.
368. *Id.* at para. 53.
369. *Id.* at para. 56.
370. *Id.* at para. 64.
371. *Id.* at para. 65.
372. VERITATIS SPLENDOR, *supra* note 349, at para. 74–75.
373. *Id.* at para. 77.
374. *Id.* at para. 79.

"*the morality of the human act depends primarily and fundamentally on the 'object' rationally chosen by the deliberate will.*"[375] It reiterates that acts such as contraception and direct abortion are acts that are intrinsically evil regardless of circumstances.[376] Finally, as to the phenomenon of public dissent from the *Magisterium* by moral theologians, it states: "Moral theologians are to set forth the Church's teaching and to give, in the exercise of their ministry, the example of loyal assent, both internal and external, to the *Magisterium's teaching in the areas of both dogma and morality.*"[377]

Evangelium Vitae was written to combat the prevalence of a "culture of death" that is "excessively concerned with efficiency" and accordingly devalues the lives of those who impose burdens on others.[378] The encyclical even refers to the unleashing of a "*conspiracy against life*" that has undermined the family as well as "relations between peoples and States."[379] Specific mention is made of the expenditure of large sums of money to produce pharmaceuticals designed to accomplish abortions without medical assistance.[380]

Evangelium Vitae reasserts the traditional teaching on the immorality of contraception, and condemns a "contraceptive mentality" that strengthens the temptation to resort to abortion when an unwanted life is conceived.[381] While acknowledging that abortion and contraception are distinctly different, the latter undermining the procreative nature of sexual act and the former destroying human life, it refers to them "as fruits of the same tree" that are "rooted in a hedonistic mentality."[382] It expresses alarm at the fact that "attacks on life are spreading" and receive widespread and powerful support from a broad consensus on the part of society" as well as "widespread legal approval and the involvement of certain sectors of health care personnel."[383]

Evangelium Vitae traces the current attacks on human life to a concept of freedom that places an excessive emphasis on individual autonomy and "emancipation from all forms of tradition and authority."[384] It refers to an ongoing struggle between a "culture of life" and a "culture of death."[385] Furthermore, referring to the "unspeakable crime of abortion," it condemns all direct abortions.[386] It further emphasizes that human life is to be protected from the time of fertilization of the ovum.[387] As to abortion, the Holy Father, speaking infallibly, concludes: "Therefore by the authority which Christ conferred upon Peter and his Successors, in communion with the Bishops... *I declare that direct abortion, that is abortion willed as an end or as means, always constitutes a*

375. *Id.* at para. 78.
376. *Id.* at para. 80.
377. VERITATIS SPLENDOR, *supra* note 349, at para. 110.
378. EVANGELIUM VITAE, *supra* note 350, at para. 12.
379. *Id.*
380. *Id.* at para. 13.
381. *Id.*
382. *Id.*
383. VERITATIS SPLENDOR, *supra* note 349, at para. 17.
384. *Id.* at para. 19–20.
385. *Id.* at para. 21.
386. *Id.* at para. 58.
387. *Id.* at para. 60.

grave moral disorder, since it is the deliberate killing of an innocent human being."[388] Finally, as to dissenting theologians, the encyclical enjoins them "never be so grievously irresponsible as to betray the truth and their own mission by proposing personal ideas contrary to the *Gospel of Life* as faithfully presented and interpreted by the Magisterium."[389]

E. The Ethical and Religious Directives

The traditional Catholic natural law approach is reflected in the *Ethical and Religious Directives for Catholic Hospitals* [*ERD*], a set of norms adopted by the NCCB and updated in 2001.[390] "The directives describe procedures that are judged morally wrong by the [NCCB] and the United States Catholic Conference."[391] Those procedures judged morally wrong include contraception,[392] direct sterilization[393] and direct abortion.[394] Thus artificial contraception is deemed immoral notwithstanding compelling reasons for limiting fertility. Direct surgical sterilizations are forbidden notwithstanding substantial clinical reasons for permanently curtailing the capacity of particular patients to become pregnant. And direct abortions are forbidden notwithstanding the potential effect of the pregnancy on the life or health of the mother. This traditional natural law approach may be seen in all versions of the *ERD*.

The *ERD* apply to Catholic hospitals within a particular diocese upon their adoption and promulgation by the local bishop.[395] In the United States, conformity with the *ERD* may provide a litmus test for determining the degree to which a hospital is serious about preserving its Catholic mission.[396] Indeed, the thrust of the *ERD* is to require Catholic hospitals to preserve their distinctively Catholic mission.[397] If the *ERD* are not observed by a particular Catholic health care facility, then the local bishop could withdraw recognition of the hospital's identity as a Catholic institution.[398] This

388. VERITATIS SPLENDOR, *supra* note 349, at para. 62.

389. *Id.* at para. 82.

390. United States Conference for Catholic Bishops, *supra* note 21. *See also* White, *Hospitals Sponsored by the Roman Catholic Church*, *supra* note 21, at 216 noting: "The moral responsibility of Catholic health care is outlined in the Ethical and Religious Directives for Catholic Health Care Services."

391. *Id.* at 216. In 2002, the National Conference of Catholic Bishops and the United States Catholic Conference merged to become the United States Catholic Bishops Conference.

392. United States Conference for Catholic Bishops, *supra* note 21, at 28.

393. *Id.*

394. *Id.* at 26.

395. "[T]he diocesan bishop is responsible for applying the *Ethical and Religious Directives* in his diocese." Francis Morrisey, *Toward Juridic Personality*, HEALTH PROGRESS, July-Aug. 2001, *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0107&ARTICLE=J.

396. Maida and Cafardi state:

> In the field of health care, the U.S. Bishops, exercising this faith authority, have approved the *Ethical and Religious Directives for Catholic Health Facilities*. These directives . . . are applied to specific situations under the guidance of each diocesan bishop with that bishop's diocese. It is a person's acceptance of the Catholic faith that makes these *Directives* binding. A health care facility could not call itself "Catholic" and ignore these *Directives*. They have been defined by the bishops as being the essence of "Catholic" health care.

ADAM J. MAIDA & NICHOLAS P. CAFARDI, CHURCH PROPERTY, CHURCH FINANCES, AND CHURCH-RELATED CORPORATIONS 57 (1984).

397. *Id.*

398. Jean deBlois & Kevin O'Rourke, *Introducing the Revised Directives: What Do They Mean for*

in turn could result in closure of the facility if it is owned either by the diocese or a religious order. If it is owned by an independent Board of Trustees, the hospital could continue its operations, but not as a Catholic facility.[399]

A code of medical ethics for hospitals in the United States was initially a project of the Catholic Hospital Association, the forerunner of today's Catholic Health Association (CHA).[400] Father Moulnier, the first president of the CHA believed that it was essential that Catholic hospitals meet American College of Surgeon's (ACS) standards.[401] Thus the code of ethics was first adopted by the CHA in 1921 at the height of the standardization movement in order to defuse a controversy over the role of the ACS in accrediting Catholic hospitals.[402] Some Catholic physicians believed that accreditation by ACS portended greater secular control over Catholic hospitals and threatened their religious mission.[403] In response to these concerns, Moulnier wanted to adopt a code of ethics in order to calm "fears that Catholic moral principles could be jeopardized by the secular accrediting agency."[404] Eventually, the 1921 Code was "accepted verbatim by many dioceses, and slightly modified by others."[405] The norms prohibited destruction of fetal life and sterilization.[406]

The 1921 code was replaced by a revised code entitled the *Code of Ethical and Religious Directives for Catholic Hospitals*, which was published in 1949 by the Catholic Hospital Association.[407] Since Catholic hospitals were collaborating more frequently with pubic agencies, it was deemed necessary "to articulate clear positions on issues such as birth control and contraceptive methods."[408] "The new code was also broader than its predecessor, addressing issues such as x-ray treatments, artificial insemination, and birth control information."[409] The 1949 *ERD* prohibited direct abortions even when necessary to save the life of the mother.[410] Direct sterilization was also forbidden.[411]

The 1949 *ERD* was not "an authorized version" and some contended that in practice they resulted in "geographical morality" particularly with respect to the moral permissibility of the performance of contraceptive sterilizations in Catholic hospitals.[412] Theologians at the time disagreed over the morality of sterilizations that were

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Catholic Healthcare?, HEALTH PROGRESS, April 1995, *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9504&ARTICLE=D.

399. *Id.*

400. KAUFFMAN, *supra* note 318, at 169.

401. *Id.* at 185.

402. *Id.*

403. *Id.*

404. *Id.*

405. Kevin D. O'Rourke, et al., *A Brief History*, HEALTH PROGRESS, Nov.-Dec. 2001, *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0111&ARTICLE=G.

406. *Id.*

407. CATHOLIC HOSP. ASS'N OF THE U.S. & CAN., ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HOSPITALS (1949).

408. KAUFFMAN, *supra* note 318, at 252.

409. Sharon Pentland, *What's Past is Prologue*, HEALTH PROGRESS, Jan.-Feb. 1995, *available at* http:www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9501& ARTICLE=O.

410. CATHOLIC HOSP. ASS'N, *supra* note 407, at 4.

411. KELLY, *supra* note 268, at 184.

412. deBlois & Rourke, *supra* note 398, at 19.

performed for clinical reasons to avoid pathologies that could result from future pregnancies.[413] In some dioceses, such sterilizations were deemed morally permissible if a future pregnancy could result in serious health problems in a woman, while others treated them as direct sterilizations and forbade them.[414] In the 1960s, due to the influence of revisionist theologians, bishops in some dioceses interpreted the *ERD* to permit direct sterilizations and the distribution of contraceptives in Catholic hospitals.[415] "Because of the problem of "geographical morality," the CHA asked the NCCB to compose one set of directives for the whole country.[416]

In 1971, the NCCB approved a revised version of the *ERD*.[417] The revision was primarily motivated by the need to address issues such as the provision of sterilization, contraception, and artificial insemination in Catholic hospitals in the aftermath of challenges to traditional teaching in these areas.[418] The revised directives were formulated and adopted during a time of vocal dissent from *Humana Vitae*, the Papal encyclical restating traditional church teaching on artificial birth control that was issued in 1968.[419] Many Catholic theologians were sharply critical of the 1971 *ERD*.[420] Upon publication of the 1971 *ERD*, noted ethicist Richard A. McCormick, S.J., attacked them as being too rigid because they prohibited the provision of sterilization, contraception, and artificial insemination in Catholic hospitals.[421] McCormick and others also criticized the 1971 *ERD* for its failure to take account of the pluralistic nature of contemporary society and the changing nature of Catholic hospitals.[422] Instead, they advocated relaxation of the traditional prohibition on material cooperation with evil so that Catholic hospitals could provide the reproductive health services prohibited by Catholic teaching.[423]

Despite the negative reaction of many well-known theologians, the NCCB overwhelmingly voted to approve the 1971 version of the *ERD*.[424] The subsequent widespread adoption of the 1971 version of the *ERD* by local bishops was further encouraged by the 1973 *Roe v. Wade* decision and the fact that, as noted by John Cardinal Krol, Archbishop of Philadelphia and President of the NCCB, Catholic hospitals might not be able to take advantage of recently adopted conscience clause legislation unless rules were in place that prohibited them from performing abortions.[425] Widespread adoption was also encouraged by the issuance in October of 1972 of an injunction by a U.S. District Court in Montana that enjoined a Catholic hospital from

413. *Id.*

414. *Id.*

415. O'Rourke, Kopfensteiner & Hamel, *supra* note 405.

416. *Id.*

417. KAUFFMAN, *supra* note 318, at 290.

418. *Id.*

419. *Id.* at 289.

420. O'Rourke, Kopfensteiner & Hamel, *supra* note 405 .

421. McCormick, *supra* note 319, *discussed in* KAUFFMAN, MINISTRY AND MEANING, *supra* note 318, at 290.

422. KAUFFMAN, *supra* note 318, at 291.

423. *Id.* at 290–91.

424. O'Rourke, Kopfensteiner & Hamel, *supra* note 405.

425. *Id.* at n.14 *citing to* Letter of John Cardinal Krol, President of NCCB, March 7,1973 (private papers of Rev. Kevin O'Rourke, OP).

prohibiting a physician from performing a tubal ligation on a patient.[426]

In a 1972 article in the *Linacre Quarterly*, Thomas J. O'Donnell, S.J., a consultant who was involved in preparation of the 1971 *ERD*, responded to the criticism of the *ERD*, noting: "The controversy is basically about the teaching of the Catholic Church on abortion and contraception."[427] Father O'Donnell further noted that the controversy over the 1971 *ERD* is not a controversy over the question of what the Church teaches on abortion and contraception, but rather a controversy over whether those teachings should be followed by Catholic institutions.[428]

As to abortion, the 1971 *ERD* reaffirmed the traditional prohibition of all direct abortions. Directive 12 of the 1971 *ERD* specifically prohibited "the directly intended destruction of a viable fetus."[429] Traditional prohibitions on contraception and sterilization were also reaffirmed by the 1971 *ERD*. Directive 18 of the 1971 *ERD* prohibited contraceptive sterilization "whether permanent or temporary."[430] Also prohibited is: "every action which, either in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an ends or as a means, to render procreation impossible."[431]

A revised and expanded text of the *ERD* was "developed by the Committee on Doctrine of the NCCB and approved as the national code by the full body of bishops at their November 1994 General Meeting."[432] The Preamble to the 1994 *ERD* notes the

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426. *Id.* at n.14 *citing to* Taylor v. St. Vincent's Hosp., No. c-1090 (D. Mont. Oct. 25, 1972). Subsequently, however, the court ruled that it did not have jurisdiction to hear the claim on the merits in light of changes in federal law in reaction to its earlier injunction. Taylor v. St. Vincent's Hosp., 369 F.Supp. 948 (Mont. 1973), aff'd., 523 F.2d 75 (9th Cir. 1975). In a footnote, the court quotes from the legislative history to P.L. 93-45; 87 Stat. 91, Section 401(b), the statute prohibits a court from finding that a hospital receiving Hill Burton money is acting under color of state law, as follows:

> The background for subsection (b) of section 401 of the bill is an injunction issued in November 1972 by the United States District Court for the district of Montana in Taylor v. St. Vincent's Hospital. The court enjoined St. Vincent's Hospital, located in Billings, Montana, from prohibiting Mrs. Taylor's physician from performing . . . a sterilization procedure on her during the delivery of her baby by Caesarean section.
>
> The suit to enjoin the hospital was brought under 42 U.S.C. § 1983 (which authorizes civil actions for redress of deprivation of civil rights by a person acting under color of law) and 28 U.S.C. § 1343 (which grants United States district courts jurisdiction of actions (authorized by another law) to redress deprivation, under color of any State law, of a Constitutional right). . . .
>
> Section (b) of 401 would prohibit a court or a public official, such as the Secretary of Health, Education, and Welfare, from using receipt of assistance under the three laws amended by the bill . . . as a basis for requiring an individual or institution to perform or assist in the performance of sterilization procedures or abortions, if such action would be contrary to religious beliefs or moral conviction.
>
> In recommending the enactment of this provision, the Committee expresses no opinion as to the validity of the *Taylor* decision.

Taylor v. St. Vincent's Hospital, 369 F. Supp. at 950, n. 1, *quoting from* H.R. No. 93-227; 1973 U.S. Code & Cong. & Admin. News 1553.

427. Thomas J. O'Donnell, S.J., *The Directives: A Crisis of Faith*, 39 LINACRE Q. 139 (Aug. 1972).

428. *Id.* at 146.

429. Nat'l Conference of Catholic Bishops, ETHICAL & RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES Directive 12 (1971) *reprinted in* O'DONNELL, MEDICINE AND CHRISTIAN MORALITY, *supra* note 315, at 314.

430. Nat'l Conference of Catholic Bishops, ETHICAL & RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES Directive 18 (1971) *reprinted in* O'DONNELL, MEDICINE AND CHRISTIAN MORALITY, *supra* note 315, at 315.

431. *Id.* at Directive 19.

432. Nat'l Conference of Catholic Bishops, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH

"extraordinary change" that has taken place in health care in the United States and in the Church.[433] Among the changes noted are "technological advances" as well as "significant changes in religious orders and congregations" as well as "the increased involvement of lay men and women."[434] As noted by commentators Sister Jean deBlois and Father Kevin O'Rourke, the drafters of the 1994 *ERD* as well as the bishops were well aware of the fact that by this time many of those "serving as trustees, administrators, or healthcare professionals in Catholic facilities are not Catholic."[435] Accordingly, they clearly intended that Catholics as well as non-Catholics with management roles in Catholic healthcare facilities should administer them in accordance with the *ERD*.[436]

The necessity of taking specific steps to preserve the religious identity of Catholic health care institutions was among the most important goals of the 1994 *ERD*. Its Introduction recognizes that laypersons and many non-Catholics are involved in Catholic health care.[437] There is also a realization that their participation is essential for the continuation of the Catholic health care mission.[438] Perhaps not coincidentally, the Introduction also recognized the unique responsibility of the local bishop in preserving the religious identity of Catholic health care in his diocese: "These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention."[439] Certainly, it was appropriate that the role of the bishop be emphasized in light of the continuing decline in the numbers of religious involved in the health care ministry. Indeed, greater involvement of the bishop in the supervision of the health care ministry could be viewed as an essential means of preserving Catholic identity in such an environment.

There was also a recognition that adherence to the directives is necessary for the purpose of maintaining Catholic identity. In order to reinforce the importance of the 1994 *ERD* in preserving religious identity, Directive 5 required Catholic institutions to adopt them as policy, to require adherence to them by employees and the medical staff, and to provide instruction on them for administrators and staff members.[440] There was a specific requirement that "[e]mployees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these directives."[441] Moreover, in an apparent response to critics who have argued that Catholic health care institutions in a pluralist society have the obligation to provide procedures that violate Catholic moral teaching, the introduction to the section on social responsibility specifically stated: "Catholic health care does not offend the rights of

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CARES SERVICES (1995) (taken from the inside cover of the pamphlet version published by the United States Catholic Conference).

433. *Id.* at 1 pmbl.

434. *Id.*

435. deBlois & O'Rourke, *supra* note 398, at 21.

436. *Id.*

437. Nat'l Conf. of Catholic Bishops, *supra* note 432, Introduction 1 at 4.

438. *Id.*

439. *Id.*

440. Nat'l Conf. of Catholic Bishops, *supra* note 432, at 7.

441. *Id.* at 8.

individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church."[442]

The 1994 *ERD* specifically addressed the care to be given to victims of sexual assault. The 1971 *ERD* had treated the use of curettage of the endometrium after rape as the equivalent of abortion, and thereby prohibited it.[443] But Directive 36 of the 1994 *ERD* recognized that the victim of a rape should be able to defend herself against conception and authorized treatment with medication to "prevent ovulation, sperm capacitation or fertilization."[444] The Directive further prohibited "treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."[445] In an accompanying footnote, there was a recommendation "that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures."[446] There was also a reference to guidelines issued by the Pennsylvania Catholic Conference for the treatment of victims of sexual assault.[447]

The treatment of abortion was unchanged from the 1971 *ERD*: direct abortions were never permitted.[448] As in the 1971 *ERD*, discussed *supra*, there was a specific admonition that Catholic hospitals are not to provide abortion service "even based upon the principle of material cooperation."[449] And in addition, in the 1994 *ERD*, there was a further admonition concerning the "need to be concerned about the danger of scandal in any association with abortion providers."[450] In addition, and perhaps in recognition of the widespread prevalence of abortion in the wake of *Roe v. Wade*, Catholic health care providers were encouraged to provide "compassionate physical, psychological, moral and spiritual care to those persons who have suffered from the trauma of abortion."[451]

Early induction of labor, post-viability, was permitted for "proportionate reasons."[452] This topic was not addressed in the 1971 *ERD*. Directive 52 of the 1994 *ERD* prohibited Catholic health care institutions from promoting or condoning contraceptive practices, and encouraged them to provide instruction on natural family planning.[453] This provision was more succinct than the treatment of the matter in the 1971 *ERD*.[454] The reference to the promotion of natural family planning in the context of the prohibition on promoting or condoning contraception may represent the

442. *Id.* at 7.

443. Directive 24, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES (1971), *reprinted in* O'Donnell, MEDICINE AND CHRISTIAN MORALITY, *supra* note 315, at 316–17.

444. Nat'l Conf. of Catholic Bishops, *supra* note 432, at 16.

445. *Id.*

446. *Id.* at 31 n. 19.

447. *Id. citing to* Pennsylvania Catholic Conference, *Guidelines for Catholic Hospitals Treating Victims of Sexual Assault*, 22 ORIGINS 810 (1993).

448. Nat'l Conf. of Catholic Bishops, *supra* note 432, at 19.

449. *Compare* Nat'l Conf. of Catholic Bishops, *supra* note 432, directive 45 at 19; *with* Directive 12, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES (1971), *reprinted in* O'Donnell, MEDICINE AND CHRISTIAN MORALITY, *supra* note 315, at 314.

450. Nat'l Conf. of Catholic Bishops, *supra* note 432, at 19.

451. *Id.*

452. *Id.*

453. *Id.* at 20.

454. *Cf.* Directive 19, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES (1971), *reprinted in* O'DONNELL, MEDICINE AND CHRISTIAN MORALITY, *supra* note 315, at 315.

recognition that by this time contraceptives were being routinely prescribed and dispensed in professional office buildings owned by Catholic hospitals.

The treatment of sterilization was similar to prior versions of the *ERD*. Directive 53 prohibited "direct sterilization, whether permanent or temporary" in Catholic health care institutions.[455] Procedures that induce sterility were, however, permitted where "their direct effect is cure or alleviation of a present and serious pathology and a simpler treatment is not available."[456] These provisions prohibited implicitly all direct sterilizations regardless of a possible justification based on the impact of future pregnancies on the woman's health. Another innovation in the 1994 *ERD* was the inclusion of a section dealing specifically with the formation of new partnerships among Catholic and non-Catholic health care institutions.[457] Concerns about the risk of scandal arising from such partnerships motivated the adoption of this section, at least in part.[458] Accordingly, Directive 67 required prior consultation with the local bishop before entering into partnerships that could contain "serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal."[459] Directive 68 required that partnerships that will affect the identity or religious mission of Catholic health care institutions "must respect Church teaching."[460] It further provided that "[d]iocesan bishops and other church authorities should be involved as such partnerships are developed, and the diocesan bishop should give the appropriate authorization before they are completed."[461] If the partnership was involved in activities that would violate Church norms, then the Catholic institution was required to limit its participation "in accord with the moral principles governing cooperation."[462] It was further emphasized that the possibility of scandal may, in some circumstances, preclude cooperation that would otherwise be morally appropriate.[463] Accompanying this new section on partnerships was an appendix setting out the principles governing cooperation.[464]

In the spring of 2001, the Congregation for the Doctrine of the Faith (CDF) asked the NCCB to revise Part Six of the 1994 *ERD*.[465] The request was motivated by specific concerns regarding the misapplication of the principle of cooperation in three arrangements entered into by Catholic health care institutions in the United States.[466] The CDF "sought a clarification of the distinction between material and formal cooperation so as to exclude any possibility of proportionalist interpretations of the principle."[467] At its June 2001 meeting, the Catholic bishops in the United States

455. Nat'l Conf. of Catholic Bishops, *supra* note 432, at 20.

456. *Id.*

457. *Id.* at 25–27.

458. *Id.* at 26.

459. *Id.*

460. *Id.*

461. Nat'l Conf. of Catholic Bishops, *supra* note 432, at 26.

462. *Id.* at 27.

463. *Id*

464. *Id.* at 29.

465. Ron Hamel, *Part Six of the Directives*, HEALTH PROGRESS, Nov.-Dec. 2002, *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0211&ARTICLE=I.

466. *Id.*

467. *Id.*

approved revisions of the 1994 *ERD*.[468] The revisions were not extensive, but, nonetheless, may hold a significant impact for collaborative arrangements between Catholic and non-Catholic institutions.[469] Indeed, the revisions were occasioned by the Vatican's concerns about the "culpable cooperation" of Catholic health care institutions in the immoral conduct of non-Catholic institutions.[470]

In recent years, a number of Catholic hospitals were accused of attempting to circumvent implementation of the *ERD* by cooperating with non-Catholic health care providers to provide reproductive services prohibited under the *ERD*. In 2001, the *ERD* was modified to make it more difficult for Catholic hospitals to utilize cooperative arrangements to continue to provide reproductive services such as sterilizations that hospitals would not be permitted to provide directly under the *ERD*. This revision was occasioned by the Brackenridge Hospital case in Austin, Texas, and other similar occurrences.

In 1995, the City of Austin entered into a thirty-year lease of Brackenridge Hospital to Seton Health Care, a Catholic health care system owned by the Daughters of Charity that later became part of Ascension Health.[471] At the time the lease was entered into, Seton agreed to continue to provide sterilizations, contraception (including emergency contraception) and abortion referrals at the facility.[472] Seton personnel did not provide the services; a separate company provided them under contract with the city within the leased hospital.[473]

Subsequently, in 2000 the local Bishop Coadjutor Gregory Aymond announced that the Vatican was dissatisfied with the arrangements at Brackenridge regarding reproductive health services and that Seton and the City of Austin were discussing modification of the lease provisions.[474] In June of 2001, Ascension Health notified the City that it would no longer provide sterilizations at Brackenridge.[475] This announcement came shortly before the United States Catholic Bishops tightened up the Directives to prohibit arrangements like the Brackenridge lease.[476]

Although the treatments of abortion,[477] contraception,[478] and sterilization[479] are

468. United States Conference of Catholic Bishops, *supra* note 21.

469. Peter J. Cataldo & John M. Haas, *Institutional Cooperation: The ERDs*, HEALTH PROGRESS (Nov.-Dec. 2002), *available at* http://www.chausa.org/PUBS/PUBSCONT.ASP?ISSUE=HP0211&ARTICLE=L.

470. *Id.*

471. Mary Ann Roser, *City-Seton Arrangement Likely to Survive Dispute; No One Else Seems Willing to Run Financially Risky Hospital,* AUSTIN-AMERICAN STATESMAN, Nov. 3, 2001, *available at* 2001 WL 4585626.

472. Kim Sue Lia Perkes, *Bishops to Weigh Hospital Services: Proposal to Enforce Limits on Reproductive Services Could Affect Brackenridge,* AUSTIN-AMERICAN STATESMAN, Oct. 26, 2000, *available at* 2000 WL 7342856.

473. *Id.*

474. Kim Sue Lia Perkes, *Hospital Issues Won't Be on Bishop's Agenda*, AUSTIN AMERICAN-STATESMAN, Nov. 10, 2000, *available at* 2000 WL 7343472.

475. *Texas Hospital Hit By Church Move*, MODERN HEALTHCARE, June 18, 2001, *available at* 2001 WL 9418842.

476. *Id.*

477. *Compare* Nat'l Conf. of Catholic Bishops, *supra* note 432, directives 45–49 at 19–20, *with* United States Conference of Catholic Bishops, *supra* note 21, directives 45–49 at 26–27.

478. *Compare* Nat'l Conf. of Catholic Bishops, *supra* note 432, directive 52 at 20, *with* United States Conference of Catholic Bishops, *supra* note 21, directive 52 at 28.

479. *Compare* Nat'l Conf. of Catholic Bishops, *supra* note 432, directive 53 at 20, *with* United States

unchanged from the 1994 *ERD*, the Appendix contained in the 1994 *ERD*, "The Principles Governing Cooperation", was removed from the 2001 *ERD* in an apparent response to the Brackenridge case and other similar occurrences. The 2001 edition notes that the Appendix was omitted because "the brief articulation of the principles of cooperation that was presented there did not sufficiently forestall certain possible misinterpretations and in practice gave rise to problems in concrete applications of the principles."[480] In addition, a new directive, Directive 70, was adopted that provides "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization."[481]

F. Catholic Identity

The concept of Catholic identity is related to the canonical status of Catholic health care ministries and the continuing sponsorship of those ministries by religious orders.[482] There is no specific reference in the 1983 Code of Canon Law to health care institutions.[483] And there are no guidelines in the Code for determining the Catholic identity of healthcare institutions.[484] In fact, Catholic identity is not a term of art under canon law.[485] On the other hand, "[t]he name or title 'Catholic' cannot be used without the consent of the competent church authority."[486] The diocesan Bishop determines whether a particular hospital is considered Catholic, and the determination of Catholic identity carries with it an element of "accountability to ecclesiastical authorities."[487] The religious orders that sponsor hospitals do so "as representatives of the Church itself under the authoritative directives of the canon law" and "[t]hus are not free to pick and chose among moral imperatives."[488] Moreover, "canon law positively prohibits officers

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Conference of Catholic Bishops, *supra* note 21, directive 53 at 28.

480. Nat'l Conf. of Catholic Bishops, *supra* note 21, at 36.

481. *Id.* at 36.

482. "Sponsorship" has been defined as:

> [A] reservation of canonical control by the juridic person/sponsor that founded and/or sustains an incorporated apostolate that remains canonically a part of the church entity. This retention of control need not be such as to create civil law liability on the part of the sponsor for corporate acts or omissions but should be enough for the canonical stewards of the sponsoring organization to meet their canonical obligations of faith and administration regarding the activities of the incorporated apostolate.

JORDAN HITE, A PRIMER ON PUBLIC AND PRIVATE JURIDIC PERSONS: APPLICATIONS TO THE CATHOLIC HEALTH CARE MINISTRY 37 (2000), *quoted in* Daniel C. Conlin, *Sponsorship at the Crossroads: Religious Institutes Must Consider the Direction in Which They Will Go*, HEALTH PROGRESS (July/Aug. 2001), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0107&ARTICLE=I.

483. Francis G. Morrisey, *Trustees and Canon Law*, HEALTH PROGRESS (Nov.-Dec. 2002), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0211&ARTICLE=G.

484. Francis G. Morrisey, *Catholic Identity in a Challenging Environment*, HEALTH PROGRESS (Nov.-Dec. 1999), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9911&ARTICLE=D.

485. HITE, *supra* note 482, at 13.

486. HITE, *supra* note 482, at 13 (citing to Canon 300, THE CODE OF CANON LAW: A TEXT AND COMMENTARY 245 (1985)).

487. Kenneth R. White & James W. Begun, *How Does Catholic Hospital Sponsorship Affect Services Provided*, 35 INQUIRY 398 (Winter 1998/1999), *available at* Proquest: http://gateway.proquest.com/openurl?ctx_ver+S39.88-2003res_id+xri:PDQ&rft_val_fmt+ori:fmt:kev:mtx:journnal&genre=article&rft_id=xri:PQD:DID=000000039310383.

488. Bassett, *supra* note 8, at 494.

and directors of church-affiliated hospitals from disguising their identity or allowing that identity to be eroded through contractual or personnel management decisions."[489] It is the diocesan bishop that determines whether a particular institution within his diocese has lost its Catholic identity.[490] Nonetheless, "aside from the use of the name 'Catholic,'" Catholic identity is more "a matter of public perception, rather than church law."[491]

Typically, in the United States, Catholic hospitals are owned by non-profit corporations that maintain a relationship of sponsorship with their founding religious institute. Naturally, the shift to lay management in these corporations, along with their affiliations with non-Catholic institutions, has inevitably raised questions as to what it means to be a Catholic hospital. Moreover, with the continuing decline in vocations, it has been said that the Church's "'control' over the health care apostolate is... fast giving way to an 'influence' approach."[492] As a result of these changes, when it comes to questions of Catholic identity, there has been an increased emphasis on the role of the local bishop in supervising health care institutions and on compliance with the *ERD*.[493]

Previously, bishops could rely "on religious congregations to operate and oversee their health care ministry" in accordance with Catholic ethical and moral standards.[494] When religious orders directly owned and operated their health care ministries, the bishop could exercise control through his "personal authority over particular congregation members."[495] With the changing relationship between the religious congregations and their health care enterprises, and the increasing role of the laity, this type of personal control is no longer feasible.[496] Instead, the preservation of Catholic identity in health care institutions must rely more on normative standards, i.e., the adherence of the institution to the norms set forth in the *ERD* as interpreted and applied by the local bishop.[497]

Ultimately, the preservation of Catholic identity requires continuing "commitment to the moral teachings and ethical norms of the church."[498] And this may be problematic because "[t]hese are at times, counter cultural stances, witnessing to respect for the integrity of human life in the face of abortion, sterilization, assisted suicide,

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489. *Id.* at 496.

490. Sharon Holland, *Sponsorship and the Vatican*, HEALTH PROGRESS (July-Aug. 2001), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0107&ARTICLE=K.

491. HITE, *supra* note 482, at 13.

492. MICHAEL DENNIS MCGOWAN, THE CANONICAL STATUS OF CATHOLIC HEALTH CARE FACILITIES IN THE PROVINCE OF NEW BRUNSWICK IN LIGHT OF RECENT PROVINCIAL GOVERNMENT LEGISLATION 95 (2000).

493. *Id.* at 175.

494. BEVERLY KATHRINE DUNN, S.P., SPONSORSHIP OF CATHOLIC INSTITUTIONS, PARTICULARLY HEALTH CARE INSTITUTIONS, BY THE SISTERS OF PROVIDENCE IN THE WESTERN UNITED STATES 183 (1995) (unpublished dissertation submitted to the Faculty of Canon Law, Saint Paul University, Ottawa, Canada, in partial fulfillment of the requirements for the degree of Doctor of Canon Law) (on file with the author).

495. *Id.*

496. *Id.* at 184.

497. *Id.* In a 1975 publication, Rev. Adam Maida, now Cardinal Archbishop of Detroit, recommended that the corporate bylaws of a Catholic health care facility "should specifically incorporate language which binds the facility and its personnel to following the medico-moral directives published from time to time by the National Conference of Catholic Bishops." A. J. MAIDA, OWNERSHIP, CONTROL AND SPONSORSHIP OF CATHOLIC INSTITUTIONS 62 (1975).

498. Holland, *supra* note 490.

euthanasia, and certain areas of research and experimentation."[499] Unfortunately, while all Catholic institutions "subscribe to the directives in theory, not all follow them in practice."[500] Nonetheless, the litmus test for the Catholic identity of hospitals in the United States should be whether the hospital follows and implements the *ERD* as interpreted and applied by the local Bishop in its day-to-day operations.

The sponsor, typically a religious order, has the responsibility of preserving the Catholic identity of its institutions and safeguarding the property used to further their mission.[501] In the 1980s, the focus shifted to the mission as the sponsoring orders attempted to clarify the fundamental values of Catholic health care and develop programs to inculcate those values in their lay employees.[502] "In many Catholic healthcare organizations, executive positions exist to promote and monitor the values of the sponsor."[503] Today, as the membership ranks of sponsoring orders continue to decline, there is increased attention directed toward the formation of laypersons as sponsor representatives.[504] In addition, since religious sponsors have delegated many of their powers to the governing boards of the health care institutions, the role of members of the corporate boards of trustees in ensuring faithfulness to the Catholic mission is receiving greater emphasis.[505] It is not, however, clear at this time that these attempts will be sufficient to preserve the identity and mission of Catholic health care institutions, particularly in light of the legal assault by liberal choice groups and the complexity of current health care systems.[506]

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499. *Id.*

500. Morrisey, *supra* note 484.

501. Holland, *supra* note 490; Maida and Cafardi note:

> To use an example from the health care field, when public juridic persons sponsor health care institutions, they are obliged to see that the institution is operated in conformity with the teachings of the Church. This is the case whether the health care facility is an unincorporated program of the religious sponsor, as are many old age or long term care homes, or whether it is separately incorporated, as most hospitals are. . . . The natural persons who oversee the affairs of the public juridic persons that sponsor health care institutions are obliged by the canon law to see that the teachings are followed in the activity of the sponsored institution (an affirmative responsibility) and that the sponsored institution does not *act* contrary to the teachings of the Church in its corporate activities.

MAIDA & CAFARDI, *supra* note 396, at 56.

502. Holland, *supra* note 490.

503. Jordan Hite, *Structures in Health Care Ministry in the Church*, HEALTH PROGRESS (Nov.–Dec. 1999), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9911&ARTICLE=E.

504. Mary Kathryn Grant & Margaret Mary Kopish, *Sponsor Leadership Formation: Qualifications for the Next Generation of Sponsors*, HEALTH PROGRESS (July–Aug. 2001), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0107&ARTICLE=T.

505. Morrisey, *supra* note 484. Morrisey states:

> From a canonical perspective, the primary duty of trustees is to ensure that the institutions under their supervision operate in accordance with the teaching, discipline, and laws of the Roman Catholic Church. This is to be done, however, taking into account the mission, vision, and values of the system they represent. These values are usually spelled out in the corporate documents or statutes governing the institution and its sponsors.

Id. (footnote omitted).

506. One commentator has noted:

> Health care systems of the size and scale constructed over the last five years make sponsorship influence difficult to achieve. In cosponsored ministries and in the new PJP [public juridic person] structures, leadership must be concerned about the evolution of Catholic culture and values. Sponsors at the local level still serve a powerful role in a practical and symbolic sense. In many ways they *are* the church in the local community. In many contexts, what is known of Catholicism

IV. CONCLUSION

Catholic hospitals are in a difficult situation: if they are to survive as distinctively Catholic institutions, then they must continue to emphasize their Catholic identity including their adherence to the *ERD*. As evidenced by mandatory contraceptive coverage and emergency contraception laws, however, there is recent trend toward the adoption of laws that may undermine the ability of Catholic hospitals to maintain their commitment to the *ERD*. As a legal and political matter, it is becoming increasingly difficult for Catholic hospitals to claim exemption from laws of general application that may require them to act in violation of Catholic teaching. Catholic hospitals could bolster their claim to statutory, if not constitutional protection, from such laws by becoming more pervasively Catholic. And it may be easier to argue for legislative exemption from such laws if Catholic institutions are generally perceived to be serious about their Catholic identity. But, on the other hand, emphasizing the distinctive mission of Catholic hospitals may strengthen claims in legislatures that public funding should be denied because of the sectarian nature of these hospitals.[507]

The religious orders that founded most Catholic hospitals are attempting to provide spiritual formation to their lay employees who ultimately will be responsible for maintaining the mission of the sponsoring order. They have foreseen the increasing importance of the laity and engaged in concerted planning to maintain their Catholic identity. In addition, the *ERD* provides a relatively clear set of norms that continue to apply in Catholic health care systems and provide standards for maintaining their Catholic identity. Indeed, Catholicity provides a distinctive brand in the health care marketplace that has developed an appeal to Catholics and non-Catholics. Health care institutions deal with life, death and suffering, and so the religious dimension of Catholic hospitals may even enhance their position in the marketplace. Physicians and nurses also view themselves as healers, and their interests readily align with the religious mission of Catholic institutions. Many health care providers appreciate the importance of the spiritual dimension of health care even if they are not Catholic.

This is not to say that there are no problems or difficulties in maintaining a Catholic

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> is known by virtue of the deep and abiding presence of the individual religious women. The danger exists of negating the roots of inspiration in individual religious in favor of only a programmatic approach to mission and ministry at the system level. Systematic approaches are required in our complex health systems, but some things can be learned from the living incarnations before us. For instance, we see that public trust is earned over decades; our employees still tend to go to the trusted sister advisor despite the fact that she may have no formal role, and if the sisters are not aligned with leadership, the leader will likely fail before the sisters do. The deeper issue is about forming and sustaining a culture without eradicating its foundation.

David J. Nygren, *Effective Governance in Complex Systems: With Sponsorship at a Crossroads, Navigating Change Becomes Vital*, HEALTH PROGRESS (July/Aug. 2001), *available at* http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0107&ARTICLE=U.

507. Even sectarian institutions that have conscientious objections to conventional medical care may receive Medicare and Medicaid funds for providing non-medical nursing services without violating the Establishment Clause. Kong v. Scully, 341 F.3d 1132, 1134 (9th Cir. 2003) (upholding the constitutionality of Medicare and Medicaid funding for provision of non-medical nursing services received at religious non-medical health care institutions against Establishment Clause challenge); Children's Healthcare Is a Legal Duty, Inc. v. Min De Parle, 212 F.3d 1084, 1088 (8th Cir. 2000) (upholding the constitutionality of Medicare and Medicaid funding for provision of non-medical nursing services received at religious, non-medical health care institutions against Establishment Clause challenge).

mission in health care institutions. At times, particularly with reference to the provision of contraception and sterilization, some Catholic health care institutions in particular circumstances have come dangerously close to abandoning a distinctively Catholic approach. By tolerating widespread dissent by theologians from *Humanae Vitae* the bishops in the United States may have unwittingly strengthened the hand of groups seeking legislation that would force Catholic hospitals to violate the *ERD*. And unfortunately, attempts by Catholic institutions to accommodate the prevailing culture by providing contraception and sterilization through creative arrangements that circumvent the *ERD* may further encourage attempts by those who seek legislation requiring Catholic hospitals to provide a full range of reproductive health services.

The Catholic Church is the only major western institution that continues to adhere to the belief that there is a universal moral law that provides specific absolute moral norms concerning human reproduction that are binding at all times on all persons. The sexual revolution has had a tremendous impact on the West, and the Catholic Church's position today is definitely counter-cultural. Elites in the West, including a majority of the Justices on the United States Supreme Court, have embraced an ethical relativism that views individual autonomy in sexual matters as a primary means of self-discovery and self-fulfillment.[508] In effect, this right of sexual self-fulfillment and a commitment to tolerance brings an antinomian orientation that trumps traditional moral principles that are viewed by these same elites as primitive and even malicious.[509] With this cultural shift among elites, it is not clear that the secular liberal western state will continue to permit the Catholic Church to continue to proclaim and effectuate its beliefs on the intrinsic immorality of direct abortion, direct sterilization and contraception even in its own institutions.[510]

If Catholic hospitals in the United States are not permitted to continue to follow the *ERD*, and particularly their restrictions on the provision of reproductive health services, the bishops will face a difficult dilemma. The continuing recognition of hospitals as Catholic institutions, even though they are providing reproductive health care services

508. *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 572 (2003), in which the Court refers to an "emerging awareness that liberty gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex." In the same opinion, Justice Kennedy also quotes the infamous mystery passage from Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992):

> These matters [referring to 'marriage, procreation, contraception, family relationships, child rearing, and education'] involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty 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 the compulsion of the State.

509. *Cf.* Romer v. Evans, 517 U.S. 620, 636 (1996) (Scalia, J., dissenting) ("This Court has no business imposing upon all Americans the resolution favored by the elite class from which the members of this court are selected, pronouncing that 'animosity' toward homosexuality . . . is evil.").

510. *Cf.* Stephen L. Carter, *Liberalism's Religion Problem*, FIRST THINGS 121 (March 2002), *available at* http://www.firstthings.com/ftissues/ft0203/articles/carter.html, noting:

> The liberal state is uncomfortable with deep religious devotion—and, for the most part, so is its product, liberal law. Religious belief is reduced to precise parity with all other forms of belief, an act of leveling that is already threatening to religion itself. In practice, liberalism often reduces religion to an even smaller role than other belief systems, seeking to limit or shut off its access to the public square and often deriding the efforts of the religious to live the lives they think the Lord requires when those efforts seem to conflict with other liberal goals.

in violation of the specific norms of the *ERD*, will undoubtedly create a risk of scandal among the faithful.[511] On the other hand, closure of these institutions or withdrawal of recognition of their Catholic nature and the severing of any links with the local bishop will substantially diminish the role of the Catholic Church in health care.

It is my hope that the Catholic hospitals in the United States will continue to adhere to the *ERD* and promote a "Culture of Life" even in the face of challenges from a post-Christian culture that embraces a "Culture of Death." It is also my hope that Catholic hospitals will remain free to develop their own value-based model of health care free from state and federal legislative mandates that may require them to violate the *ERD*. But if this is not the case, then the path of resistance to such mandates may become necessary. As the late Robert Cover noted, sometimes resistance to the state provides the defining moment for a religion.[512] It may be that in the future, Catholic health care in the United States will be called upon to resist the "Culture of Death" even in the face of state attempts to force Catholic hospitals to cooperate in providing immoral procedures. In his last novel, *The Thanatos Syndrome*, Walker Percy articulates an alternative vision for a marginalized Catholic health care ministry through the fictional character of Father Rinaldo, an alcoholic priest who some regard as insane. Father Smith's hospice was closed down for a time by medical authorities, but at its reopening he pleads:

> Listen to me, dear physicians, dear brothers, dear Qualitarians, abortionists, enthusiasts! Do you know why you are going to listen to me? Because every last one of you is a better man than I and you know it! And yet you like me. Every last one of you knows me and what I am, a failed priest, an old drunk, who is only fit to do one thing and to tell you one thing. You are good, kind, hardworking doctors, but you like me nevertheless and I know that you will allow me to tell you one thing—no, ask one thing—no, beg one thing of you. Please do this one favor for me, dear doctors. If you have a patient, young or old, suffering, dying, afflicted, useless, born or unborn, whom you for the best of reasons wish to put out of his misery—I beg only one thing of you, dear doctors! Please send him to us. Don't kill them! We'll take them-all of them! Please send them to us! I promise you, and I know that you believe me, that we will take care of him, her—we will even call on you to help us take care of them!—and you will not have to make such a decision. God will bless you for it and you will offend no one except the Great Prince Satan, who rules the world. That is all.[513]

511. Several provisions of the *ERD* (4th ed. 2001) refer to the risk of scandal. Directive 45 instructs Catholic health care institutions to "be concerned about the danger of scandal in any association with abortion providers." *Id.* at 26. Directive 67 states that decisions entailing a "high risk of scandal, should be made in consultation with the diocesan bishop or his health care liaison." *Id.* at 36. And Directive 71 states, "The possibility of scandal must be considered when applying the principles governing cooperation." *Id.* at 37 (footnote omitted).

512. Robert M. Cover, *Nomos and Narrative*, 97 HARV. L. REV. 4, 32, 46-53 (1993).

513. Speech by Father Smith, fictional character portrayed in WALKER PERCY, THE THANATOS SYNDROME 393 (Ivy Books 1987).