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Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers between Catholic and Non-Catholic Healthcare Systems

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THE MISPERCEPTION AND MISAPPLICATION OF THE FIRST
AMENDMENT IN THE AMERICAN PLURALISTIC SYSTEM:
MERGERS BETWEEN CATHOLIC AND NON-CATHOLIC
HEALTHCARE SYSTEMS

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I. INTRODUCTION

In 1999, the Republican presidential forerunner, Governor George W. Bush stated, “[I]n every instance where my administration sees a responsibility to help people we will look first to faith-based organizations, charities and community groups that have shown their ability to save and change lives.”¹ As President Bush took office in 2001, this proposal became a “top priority.”² “On January 29, 2001, President Bush fulfilled his promise to bring compassionate conservatism to Washington by signing an executive order creating a White House office aimed at linking religious organization with federal funding to run social service programs in their communities.”³ Though many have praised such efforts as consistent with the

¹Terry Neal, *Bush Outlines Charity-Based Social Policies*, WASH. POST, July 23, 1999, at A2.

²Associated Press, *Bush “Charitable Choice” Proposal Sparks Debate*, Freedom Forum Online, at <http://freedomforum.com/news/2001/01/11/bushnews>.

³United Press International, *Bush Creates White House Faith Office, Be Fearless*, available at http://befearless.oxygen.com/news/2001/01/29/up/0000-4734-.dstgovernment_02.html (“The White House Office of Faith-Based and Community Initiatives would allow religious organizations and secular groups to compete for federal funding to run social service programs such as welfare-to-work and drug treatments.”); For the full transcripts of President Bush’s announcement of the formation of the White House Office of Faith-based and Community Initiatives, see *Bush Pushes Faith-Based Plans, On Politics*, available at <http://www.washingtonpost.com/wp-srv/onpolitics/elections/bushtext012901.htm>.

American model of a pluralistic society, others have harshly criticized President Bush for eroding the constitutional firewall between church and state.⁴

The actions of President Bush have highlighted the tensions present when government attempts to support the actions of faith-based organizations in the realm of societal interests. However, a more immediate and less recognized battle has been waged in the realm of healthcare. Recently, mergers between Catholic and Non-Catholic healthcare services (hospitals and Health Maintenance Organizations (HMO's)) have raised concerns, some valid and some not.⁵ As part of these merger agreements, Catholic entities most often require that certain services no longer be provided.⁶ The services commonly removed are those that conflict with the moral stance of Catholic providers and generally include abortion, vasectomies, tubal ligations, use of the "morning after pill," and overall consultation regarding the use of contraceptives outside the bounds of marriage.⁷

This Note questions the wisdom of those who contend that Catholic health providers, to constitutionally qualify for government assistance or be permitted to merge with public entities, must be stripped of that which makes them most effective — their religious identity.⁸ The threat to sectarian healthcare has steadily been on the rise as can be seen in actions such as the American Public Health Association's recent approval of a policy statement recommending more government oversight to preclude the dropping of reproductive services when Catholic and Non-Catholic

⁴United Press International, *supra* note 3.

⁵Compare Amy Paulin, *Mergers with Catholic Hospitals Threaten Reproductive Rights*, Pro Choice On Line, at <http://www.wcla.org/95-summer/su95-06.html> ("Abortion continues to be a pivotal factor in healthcare reform. As economic survival drives hospitals to restructure their programs and services, the Roman Catholic Church is a key player." In 1994, there were "more than 100 mergers, affiliations, and joint ventures between Catholic and Non-Catholic hospitals, HMO's, and managed care networks. As part of each contract, parties must agree on how to handle medical procedures which [church guidelines prohibit].), with Nadya Labi, Dick Thompson & James Willwerth, *Holy Owned*, TIME, Nov. 15, 1999, at 85, 86 (stating number of mergers between Catholic hospitals and Non-Catholic hospitals: 1994, 14; 1995, 15; 1996, 28; 1997, 31; 1998, 32).

⁶Shari Roan, *When the Church and Medicine Clash: More Hospitals are Merging with Catholic Facilities to Survive*, L.A. TIMES, Feb. 2, 1995, at A1.

⁷*Id.*

⁸See e.g., *Conscience Violated*, Religious Coalition for Reproductive Choice, available at <http://www.incongress.com/issues/article.cfm?ArticleID=1008>; see also Patricia Lefevere, *Catholic Hospitals Face Myths*, NAT'L CATHOLIC REP., Nov. 20, 1998, at 21, 22. At a conference held at Seton Hall University's Law School, St. Joseph Sr. Jean de Blois, vice President of Mission Services for Catholic Health Association of the United States, noted that many mergers find opposition simply due to myths regarding Catholic healthcare. *Id.* Myths include: money goes to the Vatican from earnings in the Catholic facility, daily mass is required of all employees, all meetings must begin in prayer, the prohibition against doctor-assisted suicide means that a Catholic hospital will let no patient die, women are allowed to die in child-birth in order to save the baby, the local bishop's authority over the hospital means that he will run healthcare and will be involved in decision-making sessions between doctor and patient. *Id.*

hospitals merge.⁹ Section II explores why these mergers occur and why certain services are subsequently dropped. Section III applies a historical analysis to refute the argument that public and private are meant to remain separate. After establishing that pluralism has been and is presently the foundation of the American society and its healthcare, section IV evaluates whether the Establishment Clause or the Free Exercise Clause of the First Amendment is in danger of violation by mergers between Catholic and Non-Catholic hospitals. Finally, section V addresses the argument that Catholic healthcare mergers constructively deny women, most especially indigent women in rural areas, the right to reproductive services, namely abortion.

II. HOSPITAL MERGERS AND THE DIRECTIVES

In the late 1980s, a boom in hospital mergers began. Over forty percent of hospitals responding to a 1986 survey had merged or were considering a merger.¹⁰ The vast majority of mergers took place between hospitals similar in structure; however, some mergers occurred and still are occurring between Catholic hospitals and Non-Catholic hospitals.¹¹ Largely, this was due to the changing nature of healthcare as the fee for service structure began to be replaced by a managed care approach.¹² Though there is no standard definition of “managed care,” the basic idea is to coordinate all health care services an individual receives in order to maximize benefits and minimize cost.¹³ This has, to varying degrees, been accomplished through the use of HMOs.¹⁴

⁹See e.g., Deanna Bellandi, *Oversight on Catholic Deals Sought by Group*, MODERN HEALTHCARE, Nov. 20, 2000, at 4. “It is unfortunate that the resolution failed to recognize the significant past and current contribution of faith-based healthcare to the quality of healthcare in this country,” said the Rev. Michael Place, President and Chief Executive Officer of Catholic Health Association, which represents more than 2,000 Catholic healthcare providers, sponsors, and health plans. *Id.* The resolution did encourage hospitals to use creative solutions to preserve reproductive services, but apparently, to the 184-member governing council of the American Public Health Association, reproductive rights outweigh personal consciences. *Id.* But see Vida Foubister & Linda O. Prager, *AMA Votes For Patient Access to Sterilization*, American Medical Association, available at http://www.ama-assn.org/sci-pubs/amnews/pick_00/prl20703.htm. The AMA approved a *compromise* policy to ensure that all patients have access to pregnancy services. *Id.* AMA trustee John C. Nelson, M.D., stated “We are not going to be in the position of telling people or entities what they should or should not cover, or that they must or must not do something.”

¹⁰Anthony J. Celebrezze, Jr., *Hospital Mergers: Policy Implications for Consumers*, 62 J. ST. GOV'T 119 (1989).

¹¹Howard J. Anderson, *Catholic Hospitals Join Forces with Non-Catholic Competitors*, 64 HOSPITALS 44 (1990).

¹²Douglas S. Wood, *The Rise of the HMO*, CNN Interactive, at <http://cnn.com/SPECIALS/2000/democracy/doctors.under.the.knife/stories/hmo.history> (stating that in the early 1970's “medical costs were rising faster than the economy” and under the cost-based reimbursement system, doctors had little incentive to control costs).

¹³*Pennsylvania Guide to Understanding Healthcare: Medicare Program Overview*, available at <http://www.panpha.org/HMOGuide.htm>; for an overall understanding of managed care, see generally Heather Hutchinson, *The Managed Care Plan Accountability Act*, 32 IND.

The Nixon administration proposed in 1973, and Congress passed, the Health Maintenance Organization Assistance Act which created the term HMO and provided HMO's with federal funds to encourage development during their start up period.¹⁵ "An HMO is a group that contracts with medical facilities, physicians, employers and sometimes individual patients to provide medical care to a group of individuals;" nonetheless, patients generally do not have any significant "out-of-pocket" expenses because this care is usually paid for by an employer at a fixed price per patient.¹⁶ Although by the end of the 1970's only five percent of Americans enrolled in prepaid arrangements, the pace of enrollment increased rapidly in the 1980's and by 1990, seventy-four percent of employees were enrolled in employer-sponsored HMOs.¹⁷

The downside is most HMOs are usually for-profit corporations with responsibilities to stockholders that take precedence over responsibilities to patients; the HMO directly and indirectly controls the amount of health care that the doctor is allowed to provide.¹⁸ Currently, the majority of Americans with health insurance are enrolled in for-profit HMOs which represent seventy-five percent of all HMO plans.¹⁹ A 1999 study published in the *Journal of the American Medical Association* found that for-profit HMOs provide a lower quality of medical care in comparison to non-profit HMOs.²⁰ Dr. Sidney Wolfe, Director of Public Citizen's Health Research Group noted that the money in a for-profit HMO goes to bureaucracy and profits and that, generally, "the more profit, the less care."²¹

The consolidation of the health care industry as a whole has led to an extremely competitive market and Catholic healthcare has been forced to make economic decisions in regard to its hospitals as well as to innovatively seek alternatives to

L. REV. 1383 (1999); Anita S. Baker, *Diagnosis: Managed Care or Managed Cost*, 16 BUS. N.H., Issue 4, 12 (1999).

¹⁴Annemarie Franczyk, *Fourth HMO Could Be Joining Fray in Western New York*, 15 BUS. FIRST 6 (1999).

¹⁵Wood, *supra* note 12.

¹⁶*Physicians Who Care: How HMOs Work*, available at <http://hmopage.org/index.html>.

¹⁷Wood, *supra* note 12.

¹⁸*Physicians Who Care: How HMOs Work*, *supra* note 16.

¹⁹Wood, *supra* note 12.

²⁰*Public Citizen Healthcare Standards Lower in For-Profit HMO's*, available at <http://www.citizen.org/Press/pr-sid21.htm> ("The study examined 1996 quality of care data from 248 investor-owned and eighty-one not-for-profit HMO's that provided coverage to fifty-six percent of all Americans in HMO's. The study analyzed all fourteen quality indicators reported to the National Committee for Quality Assurance in 1997, ranging from routing care like pap smears to the treatment of seriously ill patients requiring life-saving heart drugs, and found that for every quality measure, for-profit HMO's scored lower than not-for-profit ones.").

²¹*Id.*; See also Franczyk, *supra* note 14 (Frank Colantuono, president of Independent Health, a Medicare HMO, stated "If you look at the plans dropping out, they are for-profit HMO's which have an obligation to shareholders. Happily, we do not have that problem. While we can not offer a product that will lose money, we do not have the obligation to provide a profit margin.").

secular HMO's.²² The vast majority of HMO plans only contract with a limited number of providers, and hospitals are thereby forced to aggressively seek out a managed care contract.²³ Those hospitals with the most services are logically at an advantage.

Health care restructuring, particularly by hospitals, has been dominated by a few major concerns. These concerns include financial distress characterized by high levels of uninsured, market changes in which neighborhoods deteriorate or grow, competitors that merge or affiliate, managed care that grows stronger and picks its partners, the ever expanding investor-owned companies that become the feared agitators, and infrastructures that age and require capital.²⁴ The goal of the modern hospital has been to achieve status as a "one-stop-shopping" facility.²⁵ This in turn attracts the managed care plan seeking to contract with the fewest providers offering the broadest array of services for the lowest cost.²⁶

To remain a competitive force, Catholic hospitals have merged with Non-Catholic hospitals.²⁷ For-profit and secular facilities are more likely than Catholic hospitals to close for financial reasons.²⁸ The most common situations that have arisen involve secular hospitals seeking a joint venture to pull their heads above the economic waters in conjunction with Catholic institutions seeking to combine services and improve their prospects of obtaining patients.²⁹ Hospital trustees and board members have spoken out in efforts to outline problems they continuously

²²See Rev. John J. Coughlin, *Catholic Healthcare and the Diocesan Bishop*, 40 CATH. LAW. 85, 88-89 (2000) ("As part of the effort to afford quality healthcare to the poor, the Catholic Bishops of New York State . . . recently established Fidelis Care, a not-for-profit HMO for Medicaid patient.").

²³Mark A. Hall, *Managed Competition and Integrated Healthcare Delivery Systems*, 29 WAKE FOREST L. REV. 1, 6 (1994).

²⁴Harry Nelson & Ann F. Monroe, *Converting and Merging Hospitals*, available at <http://www.milbank.org/reports-gvar.html>.

²⁵Mary Kathryn Grant & Margaret Mary Modde, *The Evolution of Catholic MultiInstitutional Systems*, 18 TOPICS IN HEALTHCARE FINANCING 24 (1989).

²⁶Lisa Scott, *Health Plans Fear Future of All-Inclusive Contracts*, MOD. HEALTHCARE, June 6, 1994, at 34.

²⁷Anderson, *supra* note 11, at 45-48.

²⁸Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1108 (1996).

²⁹Jane Hawksley, IN DEPTH: HEALTHCARE Q. *Cuts in Services Often Come as a Result of Hospital Mergers*, available at <http://www.bizjournals.com/albany/stories/1998/09/07/focus8.html>. Financial pressures are driving hospitals to affiliate and consolidate operations. A report in the Aug. 3 issue of the Business Review noted an overall drop in total operating profits in 1997 from the previous year among the region's eighteen hospital organizations. *Id.* It noted that hospitals need to specialize and consolidate in order for facilities to survive. *Id.* "In this day and age, when there is still some overcapacity in the acute-care sector, and the need to reconfigure and convert excess capacity to primary-care and continuing-care capacity, administrators need the flexibility to network and affiliate and merge overlapping services, and be able to save money and reinvest into building the services that are needed." *Id.*

face.³⁰ Sometimes their decisions were influenced strongly by for-profit or nonprofit systems that were simultaneously wooing and threatening to compete with them.³¹ The early and mid-1990's was a time of acute hysteria triggered by the enormous expansion of Columbia Health Care of America that, for many hospitals, presented a threat that demanded immediate decision making about their future.³² Catholic Hospital trustees have noted the swiftness of events as the number of sisters present in hospitals is reduced and for-profit chains approach.³³ Soon thereafter, the hospitals are sold.³⁴ For these reasons, specifically an intense pressure to cut costs and eliminate duplicative services to remain competitive, "religious hospitals, especially Catholic ones, are increasingly striking deals with non-sectarian hospitals . . . and establishing their own health maintenance organizations."³⁵

As early as 1987, analysts of medical healthcare reform were advising with fervor that healthcare services "look around . . . [j]oint ventures are the synergistic relationships between companies in which one plus one can and often does equal three."³⁶ The benefits of a joint venture were touted as: multiple services under one umbrella, diversification of program base and offerings, possibility of new program offerings, formation of HMOs to secure a client base, ability to hire and maintain high-level technical personnel, and elimination of duplicative services.³⁷ However one hospital board stated it simply: "We woke up and realized the big issue was survival."³⁸

Most indicative of a willingness on the part of Catholic healthcare to merge with secular institutions are the Ethical and Religious Directives for Catholic Health Care Services (Directives), which were revised in 1994 to include Part 6; it addresses "Forming New Partnerships with Health Care Organizations and Providers."³⁹ Church officials, though willing to join with Non-Catholic hospitals, were apprehensive about losing the distinctive Catholic identity so vital to their mission of healthcare.⁴⁰ The trustee of one Catholic hospital wondered whether his hospital system could continue its mission under a for-profit system: "Ours is a 24-hour hospital that is mission driven. Its problems have been maintaining the mission set

³⁰Nelson, *supra* note 24.

³¹*Id.*

³²*Id.*

³³*Id.*

³⁴*Id.*

³⁵Paul Clegg, *Healthcare Ties That Bind: Religious Control Often Ends Reproductive Services*, available at <http://www.calnurse.org/cna/news/sac71898.html>.

³⁶EDITA M. KAYE & DONALD SNOOK, *A GUIDE TO HEALTHCARE JOINT VENTURES* 16 (1987).

³⁷*Id.* at 156-57.

³⁸Nelson, *supra* note 24.

³⁹National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Healthcare Services* 25-27 (Nov. 1994) (hereinafter *Directives*).

⁴⁰Nelson, *supra* note 24.

by our church. When Columbia/HCA arrived, the question arose whether we were a nonprofit or for-profit organization.”⁴¹ To assist in such controversies that arise when merging with other entities, Catholic hospitals turn to a set of guiding principles.⁴² “Directives” are a guideline to Catholic behavior within the health industry published by the National Conference of Catholic Bishops (hereinafter “NCCB”).⁴³ The most recent amendment in 1994, is only the second amendment to the Directives which were first amended in 1975, four years after their initial publication.⁴⁴

The revisions include Directives 67 through 70.⁴⁵ Directive 67 states that when a decision may result in “serious consequences for the identity or reputation of Catholic health care services,” it should be made in consultation with a bishop of higher status.⁴⁶ Directive 68 states that when the identity of Catholic health care facilities will be affected by a partnership, that partnership “must respect church teaching and discipline.”⁴⁷ Directive 69 states that when a Catholic institution participates in a partnership, “which may be involved in activities judged morally wrong by the church, the Catholic institution should limit its involvement in accord with the moral principles governing cooperation.”⁴⁸ It is this directive that causes the most friction in pre and post mergers between Catholic and Non-Catholic hospitals. The final directive in Part 6, Directive 70, states that scandal, or the possibility of scandal, is an “important factor” to take into consideration when applying the principles of cooperation.⁴⁹

The Catholic doctrinal concept of cooperation is thoroughly discussed within the directives and essentially holds that Catholics must not participate in acts forbidden

⁴¹*Id.*

⁴²*Id.*

⁴³OFFICIAL CATHOLIC DIRECTORY lxxxv (1995).

⁴⁴U.S. Bishops’ Meeting, Ethical and Religious Directives for Catholic Healthcare Services, 24 ORIGINS NO. 27 at 459-60 (Dec. 15, 1994) (hereinafter “Bishops” Meeting); *but see* Bellandi, *supra* note 9 (stating that the National Conference of Catholic Bishops is mulling revisions to the church’s rules regarding deals between Catholic and Non-Catholic hospitals and the viability of so called creative solutions that were somewhat forcefully encouraged by the American Public Health Association); *see also* Coughlin, *supra* note 22, at 94-95, for an interesting and polite diatribe against those in the Catholic hierarchy who fail to pursue a uniform front. (“It may be detrimental to the common good when a bishop permits or tolerates a collaborative arrangement between a Catholic and Non-Catholic provider, which overlooks the possibility for collaboration between Catholic institutions. Likewise, it would seem to detract from the common good when one diocesan bishop permits what another bishop has taken care to prevent. A lack of uniform policy in the Church may give rise to confusion and scandal.”). Unfortunately, this Note does not afford the scope to better delve into the conflict existing within sectarian entities over mergers with non-sectarian institutions.

⁴⁵*Directives*, *supra* note 39, at 26-27.

⁴⁶*Id.* at 25.

⁴⁷*Id.* at 26.

⁴⁸*Id.*

⁴⁹*Id.* at 27.

by church teachings, either by assisting directly in that act while intending it to take place, or by providing assistance without intending the act to take place.⁵⁰ While applying the principles of cooperation, in conjunction with “activities judged morally wrong,” bishops and hospital boards have leeway in their decisions due to the notion that although the directives are to be followed, they are only guidelines.⁵¹ However, Directive 45 states that “abortion, that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus, is never permitted [and] Catholic health care institutions are not to provide abortion services, even based upon the principles of material cooperation.”⁵² This is not as uncompromising as it may at first appear: Catholic hospitals do not provide for elective abortions; however, medically necessary abortions are not eliminated.⁵³ The Directives further define church opposition to sterilization (including both vasectomies and tubal ligations), the “morning after pill,” the promotion of contraceptives for use by other than married couples, and termination of life-support.⁵⁴

Eliminated services vary among the Catholic mergers. Elective abortions are eliminated approximately forty-eight percent of the time Catholic hospitals merge with secular non-profit hospitals.⁵⁵ Other procedures most commonly eliminated include those unfavorably viewed within the Directives. Two of the negatives of healthcare mergers, warned of in the 1980’s, were incompatibility of organizational missions and patient resistance to joint venture.⁵⁶ These forewarnings have come to be thorns in the side of many mergers and even cause for dissolution between a few others.⁵⁷ On the other hand, many mergers between Catholic and Non-Catholic

⁵⁰*Directives, supra* note 39, at 29.

⁵¹Catholic Health Ass’n, *Ethical Issues*, PHYSICIAN-HOSPITAL JOINT VENTURES, at 21, 25 (1991).

⁵²*Directives, supra* note 39, at 19 (Directive 45).

⁵³Valeria Godines, *Catholic Hospital Giant’s Expansion Poses Dilemma; Some Say the Company May Limit Options in Reproductive Health*, PRESS ENTERPRISE, (Riverside, Calif.), August 13, 1998, at B3. (stating that the merger of Community Hospital of San Bernardino and Catholic Healthcare West put an end to abortions at the 90-year-old hospital unless the mother’s life is in danger); Ascension Healthcare Organization, *Ethics on Abortion*, available at <http://www.ascensionhealth.org/ethics/issues.htm#abortion> (“Indirect abortions are those procedures in which the termination of the pregnancy is not the immediate purpose of the procedure, but merely a foreseen and tolerated ‘side effect’ [i.e., a concomitant effect] of a medical intervention whose immediate purpose is the cure of a serious pathology of the pregnant woman.”).

⁵⁴*Directives, supra* note 39, at 16-23 (Directives 36, 52, 53, 60); Roan, *supra* note 6.

⁵⁵Robyn E. Blumner, *Hospitals at the Altar of Concession*, ST. PETERSBURG TIMES, Aug. 29, 1999, at C3.

⁵⁶KAYE, *supra* note 36, at 16.

⁵⁷Godines, *supra* note 53 (stating that Catholic Healthcare West, the largest nonprofit healthcare chain in California and the second largest Catholic-owned hospital chain, merged with Community Hospital of San Bernardino, putting an end to elective abortions; some doctors state that they fear this is a compromise that should not have been made); Philip Gailey, *Bayfront Fiasco Will Be On Our Minds During March City Elections*, ST. PETERSBURG

hospitals have resulted in successful, thriving healthcare facilities providing quality care to their communities.⁵⁸ This is the cost of a pluralistic society.⁵⁹

The current size and growth potential of Catholic health care indicates the prospective for increased conflict with anti-merger advocates. As of January 31, 2001, Catholic hospitals constituted the largest single group of the nation's not-for-profit hospitals, over 11% of the nation's total community hospitals, and 16.7% of all community hospital admissions.⁶⁰ In 1998, the staffs of Catholic ministry hospitals cared for more than 85 million inpatients and outpatients.⁶¹ Catholic health care systems, often covering multiple states and sponsoring regional health care networks, range in size from a few to more than one hundred facilities.⁶² Between 1990 and 1997, approximately eighty-four partnerships were formed between Catholic and Non-Catholic medical institutions.⁶³ Though mergers have occurred and will likely occur in the future, it is important to note that the trend of mergers in the whole realm of healthcare has slowed.⁶⁴ Even more relevant is that mergers between

TIMES, Oct. 29, 2000, at 3D (criticizing petty actions of city mayor who ended entanglement of local hospital, Bayfront Medical, with Baycare which had strong Catholic ties: "The [three-year] alliance has saved the financially struggling Bayfront, the primary provider of medical care for the poor more than \$10 million. The issue that ignited the controversy was Bayfront's decision to eliminate a handful of elective abortions to comport with Catholic religious and ethical directives.") Rather than negotiate, the city filed a lawsuit to force Bayfront out of the alliance. Legal fees amounted to nearly \$500,000. *Id.* See also George Gunset, *Two Area Hospitals Sever Ties*, CHI. TRIB., Aug. 14, 1998, at N1 (noting that in Chicago, Loyola University Medical Center and Oak Park's West Suburban Hospital Medical Center ended merger negotiations and a two-year affiliation after disagreeing over whether physicians would continue to provide contraceptive counseling and elective sterilizations to poor neighborhoods after the completion of the merger).

⁵⁸Evidenced by the fact that in comparison to the many mergers that have occurred between Catholic and Non-Catholic services within the past two decades, and in conjunction with the steady growth of Catholic healthcare, a relatively small percentage of mergers have resulted in negative media attention. See e-mail from Frank Ceasar, Public Relations Director, Catholic Health Association, to Jason M. Kellhofer Jan. 19, 2001 (on file with the author).

⁵⁹Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Healthcare Market*, 31 HOUS. L. REV. 1429, 1441-43 (1995) ("Legal pluralism seeks to describe law as it actually exists in society. In so doing, it observes societies as innumerable, semiautonomous, overlapping communities, each possessing its own code of behavior or rules. Accordingly, legal pluralists assert that society encompasses 'parallel legal regimes' in which official [state] and unofficial [non-state or private] law operate simultaneously. In accordance with this definition, the religious organizations that sponsor health ministries may be viewed as sovereignties competing with the state.").

⁶⁰See Catholic Health Associations, *Facts About The Catholic Health Association of the United States*, available at <http://cha/facts>.

⁶¹*Id.*

⁶²*Id.*

⁶³Karen Brandon, *Religion, Medicine Collide on Birth Care; Catholic Affiliations Cut Women's Options*, CHI. TRIB., July, 1998, at N1.

⁶⁴Heather H. Carlson, *Freedom at Risk: The Implications of City of Boerne v. Flores on the Merger of Catholic and Non-Catholic Hospitals*, 17 ST. LOUIS U. PUB. L. REV. 157, 181

secular and sectarian hospitals have slowed dramatically. In 1999, there were only twenty mergers or affiliations between Catholic and Non-Catholic hospitals.⁶⁵ This represents only 0.3 percent of all hospitals in the nation.⁶⁶

Where freedom of opinion is encouraged to flourish, there will be conflict. Innovative solutions are continuously being tested to resolve these problems as both secular and sectarian services have been forced to combine in order to survive the modern health care system.⁶⁷ Catholic health care has even established their own HMOs to avoid conflict and better meet market demands.⁶⁸ Nonetheless, many have condemned secular institutions for conceding to religious mandates that Catholic Hospitals have been unwilling to dismiss in merger situations.⁶⁹ The Catholic hospitals have received most criticism from pro-choice advocates complaining that abortion is legal, but women are effectively denied this right because hospitals with Catholic affiliations provide few or no reproductive services.⁷⁰ Additionally, Catholic HMOs have been criticized for denying services, to Medicaid patients.⁷¹

n.11 (1997) (“According to Modern Healthcare magazine, in 1997, 627 hospitals were merged with or acquired, an 18 percent drop from the 768 mergers and acquisitions in 1996.”).

⁶⁵E-mail from Frank Ceasar, *supra* note 58.

⁶⁶*Id.*

⁶⁷Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Healthcare Providers’ Beliefs and Patients’ Rights*, 51 STAN. L. REV. 1703 (1999) (“In practice, religious healthcare organizations have found different innovative strategies for accommodating patient demands while preserving the integrity of religious beliefs.”). Strategies are discussed as well as legislation allowing patients to refer themselves for sensitive services, bypassing their religious HMOs altogether). *See id.*

⁶⁸Arsenio Oloroso, *Catholic Group to Buy an HMO & Add a Hospital*, 20 CRAIN’S CHI. BUS. 4 (1997).

⁶⁹Paulin, *supra* note 5 (“Around the country the issue of abortion has brought many negotiations for future medical partnerships to a standstill . . . the Vassar Brothers Hospital agreed to stop performing abortions as part of an expanded collaboration with St. Francis Hospital, a Catholic-run medical facility.”).

⁷⁰*Id.*

⁷¹Sharon Lerner, *Fighting For Reproductive Choice For Medicaid Patients*, 43 VILLAGE VOICE 25 (1998). Article discusses plight of 27-year-old mother of two children who wished to obtain information about an abortion from her Medicaid healthcare provider, Fidelis. *Id.* The Fidelis salespeople did not mention, as a Catholic-backed HMO, they did not provide for abortions. *Id.* Because the situation involved allegations that no referral was offered either, Fidelis CEO and President Mark Lane stated that he would take corrective action if the allegations proved to be true. *Id.* The remainder of the article indicates that such situations will only increase in frequency. *Id.* *See also* Clarie Hughes, *Catholic Dioceses’ HMO Buys Buffalo Health Plan*, AM. CITY BUS. JOURNALS, Sept. 15, 1997, at 13, 14 (stating that Fidelis Care New York, a Medicaid-only health maintenance organization sponsored by the state’s Roman Catholic dioceses received the state’s blessing to purchase Better Health Plan, a Medicaid based HMO in Buffalo, and those who support access to reproductive services such as birth control, sterilization and abortion expressed concerns; Mark Lane, the plan’s president, said that while Fidelis does not offer those services, it provides information about them, including referral to other agencies); *Democracy Now: HMO and Catholic Mergers* (WPFW Pacifica Radio Broadcast, May 27, 1998) online broadcast available at http://www.pacifica.org/programs/democracy_now/may.html.

These attacks lack substance and dismiss the importance of religious healthcare recognized throughout American history.⁷²

III. AMERICAN PLURALISM: THE HISTORICAL BLURRING OF PUBLIC AND PRIVATE

“From its beginnings, medicine has been inextricably entwined with religion . . . [i]n short, with some faith commitment.”⁷³ Over the centuries, this faith has overwhelmingly been placed in that of the monotheistic religions of Christianity, Judaism, and Islam.⁷⁴ The modern era has witnessed the erosion of this faith for many individuals by a cultural move towards rationalism, agnosticisms, and atheism; nonetheless, “a persistent religious perspective on healing has survived despite these erosive tendencies.”⁷⁵ Academics, cynics and skeptics are continually surprised that religion has not faded away.⁷⁶ The Catholic Church is largely responsible for this by and through its efforts to remain faithful to its original calling despite criticism.⁷⁷ In recent years, that criticism has taken the form of attacks supposedly based on the First Amendment as well as claims that private institutions should remain separate from public institutions.⁷⁸ Such attacks ignore the American tradition of a pluralistic

⁷²See *infra* pp. 11-17.

⁷³EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *THE CHRISTIAN VIRTUES IN MEDICAL PRACTICE* (1996).

⁷⁴*Id.*

⁷⁵*Id.*

⁷⁶William Lee Miller, *The Moral Project of the American Founders*, in *ARTICLES OF FAITH, ARTICLES OF PEACE: THE RELIGIOUS LIBERTY CLAUSES AND THE AMERICAN PUBLIC PHILOSOPHY* 36 (Os Guinness ed., 1990).

⁷⁷Catholics for Free Choice, *CFFC Challenges Bishops' Closed-Door Policy on Healthcare; Criticizes Decision not to Discuss Vatican Call for New Policy on Sterilization Openly at NCCB Meeting*, available at <http://www.catholicsforchoice.org/new/pressrelease/111300NCCB%20meeting.htm>. Catholics for a Free Choice President Frances Kissling criticized the decision by the National Conference of Catholic Bishops [hereinafter “NCCB”] to remove a discussion about proposed changes to the Directives from the agenda of its annual meeting. *Id.* Under pressure from the Vatican, the NCCB has proposed a series of revisions to the Directives that would close an interpretation of church teaching that allows some Catholic-affiliated hospitals to provide tubal ligations, a procedure forbidden by the Catholic hierarchy. *Id.*

⁷⁸Press Release, The American Civil Liberties Union, *A Critical Moment for the Reproductive Rights Movement* (Aug. 16, 2000) (on file with ACLU) (stating that the landmark cases of the 1960s and ‘70s established reproductive freedom as a fundamental constitutional right grounded in the privacy protections of the First, Fourth, Fifth, Ninth, and Fourteenth Amendments of the United States Constitution); Press Release, American Civil Liberties Union, *Hospital Merger Threatens Reproductive Rights* (Aug. 16, 2000) (on file with ACLU) The ACLU of Florida along with three national advocacy organizations filed a federal lawsuit against the City of St. Petersburg and two local healthcare management systems alleging that the insertion of religious beliefs into the policy of a public hospital violates the separation between church and state. *Id.* “It is unconstitutional for a religious gatekeeper to determine the nature of healthcare services in a public hospital,” said ACLU of Florida cooperating attorney Marcia Cohen. *Id.*

system—a system that enables freedom within America to thrive.⁷⁹ To deny the importance of Catholic healthcare, one must deny the long record of Catholic established social services that continue until this day.

In the United States, healthcare originated in the early phase of development of the private or voluntary hospital.⁸⁰ Religiously motivated voluntary services gradually eclipsed the city poorhouse and caretaker facilities for the chronically and mentally ill as they tended to aged prostitutes, alcoholics, vagrants, and the homeless.⁸¹ “Catholics ministered to the physical, mental, emotional, and spiritual needs of people representing the entire spectrum of religious and secular traditions.”⁸² As early as 1823, physicians at the University of Maryland opened an infirmary in Baltimore staffed by five sisters.⁸³ The Baltimore Infirmary housed only fifty beds and is recognized as the first university hospital managed and staffed by a Catholic community in the United States.⁸⁴

With regard to social welfare, poor relief was primarily a self-induced responsibility of religious groups in many parts of the United States during the late eighteenth and early nineteenth centuries.⁸⁵ Virginia is but one of thousands of similar examples in which parishes regularly provided money and food to parishioners in need.⁸⁶ In addition, the Virginian parishes would collect additional tithes from the parishioners to reimburse members of the parish for support of the elderly, orphans, and the indigent, as well as for upkeep of housing facilities.⁸⁷ In others states, especially in the North, townships took responsibility for poor relief, but this was under the strong religious influence and with the active participation of local churches.⁸⁸ Either the institution or its lay members helped those who were willing to work but had simply fallen on hard times.⁸⁹

Philadelphia was noted as a pioneer in establishing a secular system of public poor relief (administered by city officials who assessed and collected a “poor tax”),

⁷⁹Rev. Michael D. Place, Healthcare: Essential Building Block for a Free Society, Address at Eighth Annual Joseph B. Brennan Lecture (April 20, 1999), available at <http://www.chausa.org/PRESPAGE/GEORGETOWNADDRESS.ASP> (centering on freedom within America and the Catholic tradition of speaking out against the challenges or threats to what are essential to the well-being of individuals and society).

⁸⁰CHRISTOPHER J. KAUFFMAN, *MINISTRY & MEANING: A RELIGIOUS HISTORY OF CATHOLIC HEALTHCARE IN THE UNITED STATES I* (1995).

⁸¹*Id.*

⁸²*Id.*

⁸³PELLEGRINO, *supra* note 73, at 9.

⁸⁴*Id.* at 33.

⁸⁵Harold J. Berman, *Religious Freedom and the Challenge of the Modern State*, in *ARTICLES OF FAITH, ARTICLES OF PEACE: THE RELIGIOUS LIBERTY CLAUSES AND THE AMERICAN PUBLIC PHILOSOPHY* 46 (Os Guinness & James D. Hunter eds., 1990).

⁸⁶*Id.*

⁸⁷*Id.*

⁸⁸*Cf.* LOUIS B. WRIGHT, *THE CULTURAL LIFE OF THE AMERICAN COLONIES* 23-27 (1957).

⁸⁹*Id.*

yet the need for private charity remained and thus the various religious denominations maintained parallel systems of relief for their own adherents.⁹⁰ “The public and the private systems worked together; while successfully combating epidemics of yellow fever in the late 1700’s and early 1800’s, Philadelphia physicians, ministers, and merchants cooperated in administering both public and private funds.”⁹¹ Furthermore, public and private relief of disease and of poverty was combined in an effort to help the poor “onto the path of industry and morality.”⁹² This early combination is but one example of how the public and private spheres can and should merge towards accomplishing a better health care system.

The Supreme Court has periodically declared in unequivocal language that **no** public tax dollars may go to support religion.⁹³ The oft-quoted ringing phrase “a wall of separation between church and state” is generally mentioned.⁹⁴ Nonetheless this “impregnable wall” does not stop a host of religiously based nonprofit organizations such as Catholic hospitals from receiving millions of public tax dollars. In 1993, sixty-five percent of Catholic Charities’ revenues came from government sources.⁹⁵ This is an apparent anomaly, unless one is privy to the fact that “[o]ne of the best-kept secrets in the United States is that when it comes to public money and religious nonprofit organizations, sacred and secular mix.”⁹⁶

Hospitals are managed in various ways and may be considered public (government-owned), community institutions (private non-profit with a community board), private for-profit (investor-owned), or private non-profit (private in structure yet not profit seeking).⁹⁷ Catholic hospitals are run as private non-profit institutions. The effect of such categorizing is that Catholic hospitals are tax exempt under section 501(c)(3) of the Internal Revenue Code.⁹⁸ Additionally, Catholic hospitals receive Medicaid and Medicare patients, meaning that they provide a significant amount of government-insured care to elderly, disabled, and low-income patients. This corresponds with Directive 3 in which the Catholic health ministry expresses a strong commitment to care for “the poor, the uninsured and the underinsured.”⁹⁹

⁹⁰JOHN ALEXANDER, *RENDER THEM SUBMISSIVE: RESPONSES TO POVERTY IN PHILADELPHIA 1760-1800* (1980).

⁹¹*Id.*

⁹²*Id.*

⁹³*See* *Everson v. Bd. of Educ.*, 330 U.S. 1, 16 (1947) (“No tax in any amount, large or small, can be levied to support any religious activities or institutions, whatever they may be called, or whatever form they may adopt to teach or practice religion.”).

⁹⁴*Id.*

⁹⁵Sean Mehegan, *The Federal Connection: Nonprofits are Looking More and More to Washington*, *NONPROFIT TIMES*, Nov. 8, 1994, at 43.

⁹⁶STEPHEN V. MONSMA, *WHEN SACRED AND SECULAR MIX* 13 (1996).

⁹⁷Lester M. Salmon, *Nonprofit Organizations: The Lost Opportunity*, in *THE REAGAN RECORD* 262 (John L. Palmer & Isabel V. Sawhill eds., 1984).

⁹⁸I.R.C. § 501(c)(3) (1996); *see also* OFFICIAL CATHOLIC DIRECTORY, *supra* note 43, at Part II, ix-xvi.

⁹⁹*Directives*, *supra* note 39, at 7.

This has been accomplished largely by means of public funding regardless of its status as a private non-profit.

The pattern of government achieving public policy objectives via funding to such organizations has become so common that various observers have coined the phrase “third-party government” to refer to the nonprofit sector.¹⁰⁰ This third party is distinguished by a mutual dependence between government and nonprofit organizations: “neither can get along without the other.”¹⁰¹ Without government funds, private nonprofit associations would be forced to collapse and without private nonprofit associations, government would have to expand dramatically to meet public needs in areas such as healthcare.¹⁰² Mutual dependence justifiably blurs the illusory line between what is public and what is private. As a result, where government has pervasively entered into an area of service, nonprofit activity blossoms:

“Government has tended to turn to nonprofit providers to help deliver publicly funded services — in health, education, and social services. As a consequence, the growth of government has helped to expand the nonprofit role, not limit it. As a result, nonprofit organizations retain a significant foothold in virtually every sphere of human services, and in many cases have been able to expand their activities as a direct by-product of government involvement.”¹⁰³

An understanding of the large role played by the nonprofit sector is incomplete without knowledge of the large role played by religiously based nonprofit organizations. “Following the Civil War, various religious groups, and especially Roman Catholics, founded a series of hospitals.”¹⁰⁴ In areas outside of medicine, religious nonprofits were also extremely prevalent.

“One of the primary meeting grounds of this nation is not city hall but the local congregation. . . . Actions on issues relating to soup kitchens, shelters for the homeless, care of battered women and children, counseling for families under siege, child care, international efforts to curb hunger and provide disaster relief were not initiated by government but to a large extent by people in congregations”¹⁰⁵

Regarding education, in 1994 there were nearly 9,000 Catholic schools, with an enrollment of over 2.5 million students, and more than 11,000 other religiously based

¹⁰⁰Salmon, *supra* note 97, at 100.

¹⁰¹MONSMA, *supra* note 96, at 5.

¹⁰²*Id.*

¹⁰³Salmon, *supra* note 97, at 105.

¹⁰⁴MONSMA, *supra* note 96, at 8.

¹⁰⁵VIRGINIA A. HODGKINSON, *The Future of Individual Giving and Volunteering: The Inseparable Link Between Religious Community and Individual Generosity*, in FAITH AND PHILANTHROPY IN AMERICA: EXPLORING THE ROLE OF RELIGION IN AMERICA’S VOLUNTARY SECTOR 285 (Robert Wuthnow & Virginia A. Hodgkinson eds., 1990).

schools with an enrollment of 1.5 million students.¹⁰⁶ Most of the earliest institutions to care for children in the U.S. were established by churches and religious orders.¹⁰⁷ In 1988, it was reported that one-third of all childcare providers were church-based.¹⁰⁸ In New York City, it was noted that private agencies under contract to the city provide most of the foster care for children and that most of those agencies were religiously based.¹⁰⁹ “Religion is a large and important part of the nonprofit sector and has given birth to many other nonprofit institutions. . . . Directly and indirectly, religion has been the major formative influence on America’s independent sector.”¹¹⁰ Typically, though secular and government agencies principally follow, religiously motivated persons have been the first to plunge into areas of societal need.

Many religious based organizations receive large amounts of government funds, just as their secular counterparts do. “For over a hundred years there has existed in the United States a partnership between local governments and sectarian welfare.”¹¹¹ In 1991, a nonprofit entity, Catholic Relief Services, received \$187 million in government contracts, grants, and other assistance.¹¹² In New York alone, the state Roman Catholic archdiocese received some \$1.75 billion (seventy-five percent of its annual budget) from government sources.¹¹³ Roughly one billion dollars is direct federal funding of Medicaid and Medicare payments to Catholic Hospitals and other health care agencies.¹¹⁴ “Government has sent tax dollars to a host of religious, private organizations in its efforts to accomplish its public policy goals, and religious private organizations have looked to government as a source of funds.”¹¹⁵ However, this co-dependency has resulted in a dangerous situation for nonprofit organizations most appropriately summarized by the adage “he who pays the piper calls the tune.”

The advantages of nonprofit religious organizations are numerous: Independence, flexibility, creativity, a mission of caring and compassion, idealism, and a strong sense of religious or ethnic solidarity.¹¹⁶ But, dependency on government funds has recently brought questions of whether religious nonprofits will be able to maintain their autonomy and the advantages presumed to flow from them.¹¹⁷ One purpose of

¹⁰⁶U.S. Bureau Of The Census, *Statistical Abstracts Of The United States* 172 (114th ed. 1994).

¹⁰⁷DIANA S. RICHMOND GARLAND, *CHURCH AGENCIES: CARING FOR CHILDREN AND FAMILIES IN CRISIS* 15 (1994).

¹⁰⁸Congressional Quarterly Weekly Report 46, at 1834 (July 2, 1988).

¹⁰⁹See DENNIS R. YOUNG & STEPHEN J. FINCH, *FOSTER CARE AND NONPROFIT AGENCIES* (1977).

¹¹⁰MICHAEL O’NEIL, *THE THIRD AMERICA: THE EMERGENCE OF THE NONPROFIT SECTOR IN THE UNITED STATES* 18 (1989).

¹¹¹BERNARD J. COUGHLIN, *CHURCH AND STATE IN SOCIAL WELFARE* 57 (1965).

¹¹²MONSMA, *supra* note 96, at 10.

¹¹³*Id.*

¹¹⁴*Id.*

¹¹⁵*Id.*

¹¹⁶*Id.*

¹¹⁷MONSMA, *supra* note 96, at 10.

this Note is to present the historically anomalous behavior in regard to the so-called separation of church and state where religious health care has been involved. This question has recently come to the forefront of constitutional law when dealing with the merger of secular and sectarian hospitals. Some have concluded that in most cases, "the fact remains . . . accepting government funds to support the work of Christian service organizations requires compromising the character of that work. . . ."¹¹⁸ This bleak outlook need not be the norm in a republic to which millions have pledged allegiance as one Nation under God.

The issue of blurring what is private and what is public, what is secular and what is sectarian, is the same whether in regard to social service providers or medical service providers. President George W. Bush recently established a White House office dedicated to encouraging religious organizations to seek billions in federal dollars for helping address alcoholism, drug addiction, homelessness, and other social ills.¹¹⁹ The President's arguments in support of such actions are also applicable to the present discussion. His statements make it apparent that no one religion is favored over another, and that such actions certainly accommodate religion, but for the benefit of secular and sectarian alike.¹²⁰ Furthermore, such action does not fund the religious activities of these organizations.¹²¹ Finally, it would be improper to discriminate against such organizations on nothing more than their religious nature.¹²²

Federal, state, and local governments reimburse hospitals only for services they provide.¹²³ Thus, there should be no concern that Catholic hospitals are somehow being paid or receiving funds for elective procedures that they are unable to provide based on conscience.¹²⁴ Some critics have charged that hospitals choosing not to provide abortions or sterilizations should be barred altogether from participation in Medicaid and Medicare, which together account for more than half of all hospital payments.¹²⁵ But, no hospital provides all possible services. Indeed, would participation in these programs be denied to a hospital if it had no birthing room? If so, that would be thirty-two percent of all hospitals within the U.S..¹²⁶ It is the patients who would be harmed by such a ludicrous policy because the hospital serving their communities would no longer be financially viable.

¹¹⁸THOMAS H. JEAVONS, *WHEN THE BOTTOM LINE IS FAITHFULNESS* 72 (1994).

¹¹⁹Steve Holland, *Bush Sets Up Faith-Based Office at White House*, available at <http://thriveonline.oxygen.com/news/2001jan29/39.html>.

¹²⁰United Press International, *supra* note 3; Chuck Babington, *Bush Pick for Faith Based Office Sparks Debate*, WASH. POST, Jan. 29, 2001, at A3. Bush emphatically stated: "[G]overnment will never be replaced by charities and community groups." *Id.*

¹²¹*Id.*

¹²²*Id.*

¹²³Cesar e-mail, *supra* note 58.

¹²⁴*Id.*

¹²⁵*Id.*

¹²⁶*Id.*

Since the inception of this country, religion has supplemented the work of the government. Public and private have co-existed — as they must. Much like the States are independent of the Union, they still achieve law and justice together. So it is with faith-based organizations in the achieving of health care. Such a pluralistic system leaves open the danger of religious favoritism on the part of the government as well as dangers of religious organizations losing their identity. Just as a one-religion mandate must fail as contrary to the human spirit of freedom, so must any policy seeking to utterly jettison personal beliefs existing within public spheres. Aware of this, yet desirous of such a model, the framers wisely constructed the First Amendment to allow for the American pluralistic society to exist.

IV. THE FIRST AMENDMENT

The twin religion clauses of the First Amendment are possibly the most misinterpreted, misapplied, and misunderstood phrases found within all twenty-seven amendments to the Constitution.¹²⁷ “The Supreme Court has struggled for fifty years now with the basic idea that government should be neutral towards religion.”¹²⁸ Those in opposition to secular and sectarian mergers in any form whatsoever invariably turn to the First Amendment as basis for claims that these mergers effectively deny them of their constitutional right to the free exercise of religion.¹²⁹ This is an illustration of how the Free Exercise Clause of the First Amendment is often inappropriately combined with the Establishment Clause of the First Amendment.

A. *The Free Exercise Clause*

1. The Federal Perspective

“The purpose of the Establishment Clause is not to safeguard individual religious rights. That is the role of the Free Exercise Clause, indeed its singular role.”¹³⁰ Unlike the Establishment Clause, the Free Exercise Clause protects against personal

¹²⁷Douglas Laycock, *The Supreme Court and Religious Liberty*, 40 CATH. LAW. 25, 42 (2000). Academics as well as the Justices grapple with the extent to which religious practices as well as beliefs are protected by the Free Exercise Clause. Compare; Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 HARV. L. REV. 1410 (1990) (concluding that constitutionally compelled exemptions from generally applicable laws are consistent with the Clause’s origins in religious pluralism), with Marshall, *The Case Against the Constitutionally Compelled Free Exercise Exemption*, 40 CASE W. RES. L. REV. 357 (1989-90) (arguing that such exemptions establish an invalid preference for religious beliefs over non-belief).

¹²⁸*Id.*; *Walz v. Tax Comm’n of N.Y.*, 397 U.S. 668, 678 (1970) (“The Court has struggled to find a neutral course between the two Religion Clauses, both of which are cast in absolute terms, and either of which, if expanded to a logical extreme, would tend to clash with the other.”).

¹²⁹Carlson, *supra* note 64, at 168; *Faith-Based or Faith-Biased?*, CHRISTIAN SCI. MONITOR, July 31, 2000, at A1; *see also* Clegg, *supra* note 35.

¹³⁰Carl H. Esbeck, *Differentiating the Free Exercise and Establishment Clauses*, J. OF CHURCH & ST., at 311 (2000).

religious harm and thus safeguards individual religious rights.¹³¹ This is well-illustrated by various Supreme Court decisions in which the redressing of harm to an individual's religious belief or practice is determined as the only function of the Free Exercise Clause.¹³² The Free Exercise Clause is violated when government enforces a restriction that intentionally discriminates against religion, religious practice, or against an individual because of his or her religion.¹³³ In fact, where there is a lack of such religious compulsion, a party is to be denied standing.¹³⁴ In sum, a free exercise claim is about the free exercise of religion rather than the exercise of non-belief. "Rejecting religion is an exercise of freedom, but it is not an exercise of religion (amputation is not a way of exercising my foot)."¹³⁵ This is perfectly rational when realizing that to suffer a personal religious harm, an individual must first profess a religion.¹³⁶ Therefore, claims which are merely personal preference, do not rise to the demands of the Free Exercise Clause.¹³⁷ For these reasons, the Free Exercise Clause is not a valid basis upon which to claim that women are harmed by sectarian and secular hospital mergers; however, it is precisely the foundation upon which these hospitals are free to manage their business as they find morally appropriate.

Nonetheless, "[i]t is by now familiar history that *Employment Division v. Smith* sharply cut back on free exercise protections."¹³⁸ Under *Smith*, a burden on religious exercise does not require justification if it is imposed by "generally applicable law."¹³⁹ Though no such law has yet been enacted to force religious providers to perform procedures in conflict with their religious beliefs, it has been noted that the present Constitutional legal principles do not mesh with current practices and therefore religiously based nonprofit organizations have been placed in a vulnerable position.¹⁴⁰ Often, it is determined that a right of access to healthcare trumps

¹³¹*Id.*

¹³²*Abington Sch. Dist. v. Schempp*, 374 U.S. 203 (1963) (holding that in a free exercise claim it is necessary to show governmental coercion on the practice of religions); *Engel v. Vitale*, 370 U.S. 421 (1962) (stating that the Establishment Clause goes much further than to relieve coercive pressure on religious belief and practice).

¹³³*Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520 (1993).

¹³⁴*Harris v. McRae*, 448 U.S. 297 (1980); *Tilton v. Richardson*, 403 U.S. 672 (1971) (rejecting free exercise claim because there was no evidence of impact on claimants' religious belief or practice); *McGowen v. Maryland*, 366 U.S. 420 (1961) (denying standing to plead free exercise claim when alleged damages were economic rather than religious).

¹³⁵John H. Garvey, *An Anti-Liberal Argument for Religious Freedom*, J. OF CONTEMP. LEGAL ISSUES, at 275 (1996).

¹³⁶*Frazee v. Illinois Dept. of Empl. Sec.*, 489 U.S. 829 (1989) (observing that only beliefs rooted in religion are protected by the Free Exercise Clause — secular views will not suffice).

¹³⁷*Wisconsin v. Yoder*, 406 U.S. 205 (1972).

¹³⁸*Laycock*, *supra* note 127 (citing *Employment Div. V. Smith*, 494 U.S. 872 (1990)).

¹³⁹*Id.*

¹⁴⁰MONSMA, *supra* note 96, at 14.

religious rights of hospitals and physicians to refuse to perform certain medical procedures.¹⁴¹

Writing for the majority in *Smith*, Justice Antonin Scalia took exception to claims that those acting out of strongly held religious beliefs could refuse compliance with neutral laws founded upon the state's regulatory power.¹⁴² *Smith* dealt with the use of peyote, a drug used at religious ceremonies conducted at Native American churches.¹⁴³ Rehabilitation counselors, discharged for having taken the drug, had been denied unemployment compensation benefits because of the misconduct charges based on their use of the drug.¹⁴⁴ Before *Smith*, the general test applied was the *Sherbert* test which weighed the assertion of religious beliefs against compelling government interests.¹⁴⁵ However, the *Sherbert* test was all but abandoned as Justice Scalia admonished critics by stating that any other course would encourage an unacceptable departure from civic responsibilities.¹⁴⁶ He went on to note that conditions akin to anarchy might result.¹⁴⁷ If an accommodation of religion was the objective, Justice Scalia counseled, its achievement would best be served by recourse to the political process.¹⁴⁸

Justice Sandra Day O'Connor's evaluation, though a concurring opinion on the surface, was critical of the excessive majoritarianism championed by Scalia.¹⁴⁹ She deplored the departures from previously established free exercise jurisprudence.¹⁵⁰ Unlike Justice Scalia's call for almost unerring respect for "neutral" laws, often with criminal penalties attaching, Justice O'Connor reminded the Court of the nation's historic dedication to religious liberty accompanied by a vigorous compelling interest test to justify any infractions.¹⁵¹ O'Connor would likely have agreed with Harold J. Berman who wrote that in seeking the meaning of the religious liberty clauses, one should first understand the role that religion played in the social life of

¹⁴¹Carlson, *supra* note 64.

¹⁴²*Smith*, 494 U.S. at 879.

¹⁴³*Id.*

¹⁴⁴*Id.*

¹⁴⁵*Id.* at 882-83 (citing *Sherbert v. Verner*, 374 U.S. 398, 402-03 (1963)).

¹⁴⁶*Id.* at 883-84.

¹⁴⁷*Smith*, 494 U.S. at 888 (noting that "any society adopting such a system would be courting anarchy").

¹⁴⁸*Id.* at 890.

¹⁴⁹*Id.* at 902 (O'Connor, J., concurring) (explaining her belief that the First Amendment was enacted to protect the religious practices of the minority).

¹⁵⁰*Id.* at 892 (O'Connor, J., concurring) (stating that the majority's holding strains the First Amendment and disregards Free Exercise doctrine).

¹⁵¹*Id.* at 895, 902-03 (O'Connor, J., concurring) (expressing her view that religious liberty occupies a "preferred position" in American jurisprudence). *See also* Michael W. McConnell, *Free Exercise Revisionism and the Smith Decision*, 57 U. CHI. L. REV. 1109, 1130-53 (1990) (discerning critique of *Smith*, an appraisal of its negative effects on religious liberty, and its virtual abandonment of free exercise as a preferred freedom).

those who wrote the Constitution.¹⁵² To hold to such a premise “is to be faithful to Madison’s conception that religion comprises not only ‘the duty which we owe to our Creator’ but also ‘the manner of discharging’ that duty.”¹⁵³

Congress sought a return to the *Sherbert* standard and a general disavowal of *Smith* in the Religious Freedom Restoration Act of 1993 (RFRA).¹⁵⁴ The RFRA stated that the government shall not substantially burden one’s exercise of religion even if the burden results from a rule of general applicability.¹⁵⁵ However, the Act was subsequently struck down in 1997.¹⁵⁶ Yet, the Clinton administration held to the position that RFRA remains valid as applied to federal law:

Not every United States Attorney has gotten the word, but if the federal government or a private litigant challenges RFRA as applied to federal law, the Justice Department will intervene to defend the statute. It takes a narrow view of what RFRA means, but it is quite convinced that RFRA is constitutional.¹⁵⁷

“Federal free exercise has not risen to the level of a preferred liberty despite a succession of efforts to maintain accommodation,” thus institutions such as non-profit religious hospitals are very much at risk.¹⁵⁸

2. The State Perspective and Conscience Clauses

The striking down of the RFRA is part of a general invigoration and extension of doctrines to limit federal power. *Printz v. United States* struck down a requirement that local law enforcement officials help screen gun-buyers for criminal records.¹⁵⁹ *Printz* announced the new federalism doctrine that Congress cannot require the states to help enforce federal law.¹⁶⁰ For the first time since 1936, the Court is striking down statutes as beyond the reach of the commerce power. The Court struck down the Gun Free Schools Act in *United States v. Lopez*,¹⁶¹ and the Violence Against Women Act in *United States v. Morrison*,¹⁶² and narrowly construed the federal arson act in *Jones v. United States*.¹⁶³ Furthermore, state sovereign immunity

¹⁵²Berman, *supra* note 85.

¹⁵³*Id.*

¹⁵⁴Religious Freedom Restoration Act, Pub. L. No. 103-41, 107 Stat. 1488 (1993).

¹⁵⁵*See generally* City of Boerne v. Flores, 521 U.S. 507 (1997).

¹⁵⁶*Id.* (finding that as broad as the powers of Congress may be, the RFRA “contradicts vital principles necessary to maintain separation of powers”).

¹⁵⁷Laycock, *supra* note 127, at 40.

¹⁵⁸Stanley H. Friedelbaum, *Free Exercise in the States: Belief, Conduct, and Judicial Benchmarks*, 63 ALB. L. REV. 1059, 1066 (2000).

¹⁵⁹521 U.S. 898 (1997).

¹⁶⁰*Id.*

¹⁶¹514 U.S. 549 (1995).

¹⁶²529 U.S. 598 (2000).

¹⁶³529 U.S. 848 (2000).

doctrines have especially been reinvigorated. In *Seminole Tribe v. Florida*, the Court eliminated congressional power to override Eleventh Amendment immunity, except in statutes to enforce the Fourteenth Amendment.¹⁶⁴ The overall effect of such holdings is that state law is assuming a much greater importance, particularly in the area of free exercise of religion.¹⁶⁵

“State constitutions and state statutes matter; it is malpractice not to plead, brief, and fully develop your state constitutional free exercise claim.”¹⁶⁶ Six states have now expressly rejected *Smith* as a matter of constitutional law,¹⁶⁷ others have decisions inconsistent with it,¹⁶⁸ and one has held the issue open in the face of conflicting precedents.¹⁶⁹ Eleven other states have enacted state Religious Freedom Restoration Acts.¹⁷⁰ The bottom line is that “in at least twenty-three states, state law is plausibly read to require government to justify substantial burdens on religious exercise, without regard to whether the law is generally applicable.”¹⁷¹ In America this is but one more example of how a pluralistic society functions. Just as the courtroom is constructed to entertain the adversarial system, so are our state and federal legislatures.¹⁷² Through this conflict, we arrive at truth, justice, and liberty.

In *Taylor v. St. Vincent's Hospital*, the District Court for the District of Montana enjoined a Catholic hospital from refusing to allow a sterilization procedure to occur in its facility.¹⁷³ *Taylor* involved a civil rights action resulting from St. Vincent's religious based refusal to allow the performance of a tubal ligation.¹⁷⁴ A few months earlier, St. Vincent's had merged its maternity department with that of Billings

¹⁶⁴517 U.S. 44 (1996) This rule was later extended to state courts. See *Alden v. Maine*, 527 U.S. 706 (1999).

¹⁶⁵Friedelbaum, *supra* note 158, at 1066 (“Since federal free exercise does not seem likely to regain the judicially conferred distinction that marked its pre-*Smith* status, it is to the state courts and the state constitutions, whose provisions they have become increasingly prone to construe with dramatic effect, that attention reasonably should be directed.”).

¹⁶⁶Laycock, *supra* note 127, at 43.

¹⁶⁷See *Attorney Gen. v. Desilets*, 636 N.E.2d 233 (Mass. 1994) (rejecting *Smith*); *State v. Hershberger*, 462 N.W.2d 393 (Minn. 1990) (same); *Humphrey v. Lane*, 728 N.E.2d 1039 (Ohio 2000) (same); *Muns v. Martin*, 930 P.2d 318 (Wash. 1997) (same); *State v. Miller*, 549 N.W.2d 235 (Wis. 1996) (same).

¹⁶⁸See *State v. Evans*, 796 P.2d 178 (Kan. App. 1990) (ignoring *Employment Division v. Smith* and adhering to pre-*Smith* law); see also *Rupert v. City of Portland*, 605 A.2d 63 (Me. 1992) (applying pre-*Smith* law but reserving issue of whether to change in light of *Smith*).

¹⁶⁹*Smith v. Fair Employment & Hous. Comm'n*, 913 P.2d 929 (Cal. 1996).

¹⁷⁰Laycock, *supra* note 127, at 44.

¹⁷¹*Id.* at 45.

¹⁷²See generally, STEPHEN LANDSMAN, READINGS ON ADVERSARIAL JUSTICE: THE AMERICAN APPROACH TO ADJUDICATION (1988).

¹⁷³369 F. Supp. 948 (D. Mont. 1973), *aff'd on other grounds*, 523 F.2d 75 (9th Cir. 1976), *cert. denied*, 424 U.S. 948 (1976).

¹⁷⁴*Id.* at 949.

Deaconess Hospital.¹⁷⁵ The merge had included an agreement whereby a woman desiring sterilization following childbirth would be admitted to St. Vincent's to deliver her baby and then transferred to Deaconess the sterilization would be performed.¹⁷⁶ Mrs. Taylor was expecting to deliver her second child *via* Caesarean section and demanded a tubal ligation immediately after delivery at St. Vincent's.¹⁷⁷ St. Vincent's refused, a suit was instituted, and St. Vincent's was forced to perform the surgery despite its moral objections.¹⁷⁸

In 1973, Congress reacted to *Taylor* by enacting and passing the Church Amendment, popularly known as the "Conscience Clauses."¹⁷⁹ Initially, the Conscience Clauses protected those who received federal funds from any requirements forcing such recipients to participate in abortion or sterilization procedures in conflict with the provider's religious or moral beliefs.¹⁸⁰ One year later, likely in response to the anti-abortion protests resulting from *Roe v. Wade*,¹⁸¹ the Conscience Clauses were expanded to allow providers of health care to refuse to perform any service or research that conflicted with their personal beliefs.¹⁸² These laws have afforded doctors, hospitals, and other health care providers some protection from being forced to provide health services with which they morally or religiously disagree; nonetheless, their effectiveness is questionable. The Supreme Court has upheld the validity of these provisions,¹⁸³ but many states have adopted conscience clauses that are far more limited than their federal counterparts.¹⁸⁴ Additionally, many state constitutions protect reproductive rights of patients more broadly than the U.S. Constitution.¹⁸⁵

¹⁷⁵*Taylor*, 523 F.2d at 78.

¹⁷⁶*Id.*

¹⁷⁷*Taylor*, 369 F. Supp. at 949.

¹⁷⁸*Taylor*, 523 F.2d at 76.

¹⁷⁹42 U.S.C. § 300(a)-7 (1988) (Senator Church introduced his amendment as a direct result of the *Taylor* decision); *see also* The Church Amendment, H.R. 227, 93rd Cong., 1 Sess., at 11 (1973) (enacted), *reprinted in* 1973 U.S.C.C.A.N. 1464, 1473.

¹⁸⁰42 U.S.C. § 300(a)-7(b); 119 Cong. Rec. 9595 (1973) (Senator Church: "I can well understand the deep concern being expressed by hospital administrators, clergyman, and physicians whose religious beliefs prohibit abortions and/or sterilization in most cases It is simply contrary to the Catholic faith, regardless of what the civil law may say.").

¹⁸¹410 U.S. 113 (1973).

¹⁸²42 U.S.C. § 300(a)-7(d).

¹⁸³*See Doe v. Bolton*, 410 U.S. 179, 197 (1973).

¹⁸⁴*See* Lynn D. Wardle, *Protecting the Rights of Conscience of Healthcare Providers*, 14 J. LEGAL MED. 177 (1993) (comparing and contrasting the range of conscience clauses among the forty-four states that have them); Planned Parenthood of New York City, *What Are Conscience Clauses?*, available at <http://www.ppnyc.org/facts/facts/conscienceclauses.html> ("As of May 1999, there were only four states without conscience laws for abortion, but there were only thirteen states with conscience clauses which allow individuals or facilities to refuse to provide for contraceptive services and/or information.").

¹⁸⁵*See, e.g., Valley Hosp. Ass'n v. Mat-Su Coalition For Choice*, 948 P.2d 963 (Alaska 1997).

In *Valley Hospital Ass'n v. Mat-Su*, the Supreme Court of Alaska held that Valley Hospital Association (VHA), could not refuse to perform abortions.¹⁸⁶ The court determined that VHA, though a non-profit corporation, was for purposes of the Alaska Constitution a quasi-public institution, and therefore subject to the constitution's inclusion of a right to privacy which was held to include reproductive rights.¹⁸⁷ VHA argued that, regardless of religious affiliation or lack thereof, under Alaska Statute 18.16.010(b), the legislature had already determined that a "hospital may decline to offer abortions for reasons of moral conscience."¹⁸⁸ The court determined that the statute was invalid to the extent that it applied to VHA and that it could only be applied towards sectarian facilities.¹⁸⁹ At best, this was a bitter-sweet victory for sectarian institutions who, for the moment, appeared protected, and at worst, it was an omen of the increasing ability of the judiciary to narrowly construe what appeared to be an adequate conscience provision. In fact, courts have generally held that state law requirements, that a hospital provide certain services, are unaffected by federal or state conscience clauses.¹⁹⁰

Apprehension is appropriate after considering the less than sympathetic nature often applied by the courts towards a physician's conscience. Over and over, "courts have shown their willingness to downplay a physician's professional conscience."¹⁹¹ Moreover, "little generosity is shown to laws designed to protect consciences," and courts often apply strict interpretation as the ordinary rule when conscience clauses

¹⁸⁶*Id.*

¹⁸⁷*Id.* at 973 (holding that factors used to determine such status included the relationship with the state, and the amount and quality of funds received by the hospital for construction and operation. ("The elements that led us to conclude that the hospital in *Storrs* was quasi-public show that the hospital in this case is quasi-public; thus the conduct of VHA qualifies as 'state action,' meaning that it 'may be fairly treated as [the action] of the State itself.'). *Id.* However under such a test as this, indeed no hospital could fail, secular or sectarian.

¹⁸⁸*Id.* at 969.

¹⁸⁹*Id.* at 972.

¹⁹⁰Carlson, *supra* note 64, at 165-66 (The inadequacy of conscience clauses are seen in cases such as *Doe v. Bridgeton Hosp. Ass'n* in which the New Jersey Supreme Court held that private non-sectarian hospitals must provide first trimester elective abortion procedures, and *St. Agnes Hosp. v. Riddick*, 748 F. Supp. 319 (D. Md. 1990), in which the United States District Court for the District of Maryland held that Maryland's conscience clause statute did not exempt St. Agnes from providing residential training in elective abortions, sterilizations, and artificial contraception regardless of the hospital's adherence to the Ethical and Religious Directives of the Catholic Church).

¹⁹¹Judith F. Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J.L. & MED. 221, 229 (1995); *see also* Ronald B. Flowers, *Government Accommodation of Religious-Based Conscientious Objection*, 24 SETON HALL L. REV. 695, 734-35 (1993) (operating under the assumption that the Religious Freedom Restoration Act had effectively circumvented the *Smith* case, the author stated: "With the exception of the bad days when Americans lived under the *Smith* opinion, the country has a long tradition of accommodating conscience. Indeed, religious freedom, which has been the basis of accommodations, has been a major contributor to making this the unique country that it is.").

are at issue.¹⁹² This is exemplified in cases such as *Brownfield v. Daniel Freeman Marina Hospital* in which the court construed the statute narrowly by holding that estrogen pregnancy prophylaxis was not identical to abortion, which therefore precluded the conscience provision from offering the hospital any protection.¹⁹³ Other cases have held that such clauses only protect those directly involved with the abortion and not those peripherally affected.¹⁹⁴ Though a physician's professional conscience plays a vital role in the way a doctor interacts with his or her patients, "[t]he notion that a physician brings to the bedside his or her own professional conscience is one that has received only bare recognition from courts and policy makers."¹⁹⁵ Such disregard is counter-intuitive; only a fool would desire surgery at the hands of an unwilling surgeon.

Additionally, conscience provisions may be held to only apply to individuals, thereby ironically providing no shelter to the aggregate moral principles held by institutions.¹⁹⁶ Moreover, where the protections afforded by conscience clauses are restricted to only private sectarian hospitals, healthcare workers are forced to forego opportunities to work at public and secular institutions in order to protect their rights of conscience.¹⁹⁷ Integrity of conscience and professional judgment are moral rights of physicians. Society and patients have an obligation to respect them.¹⁹⁸ Any solution will require compromise; however, individuals and institutions should not

¹⁹²Michael J. Frank, *Safeguarding the Consciences of Hospitals and Healthcare Personnel: How the Graduate Medical Education Guidelines Demonstrate a Continued Need for Protective Jurisprudence and Legislation*, 41 ST. LOUIS U. L.J. 311, 349 (1996); Malcolm Teresa, *Washington Mayor to Veto Contraception Bill*, NAT'L CATHOLIC REP., Aug. 11, 2000, at 13,14. Washington Mayor Anthony Williams vetoed a bill that would have forced religious institutions in the District of Columbia to include contraception in employee health coverage. *Id.* The importance of such a veto lay in the fact that though D.C. has a conscience clause, it defines religious employer so narrowly that most religious institutions, including Catholic social service agencies, would be excluded from the definition. *See also* Richard S. Myers, *California Mandates Contraceptive Coverage; Religious Liberty Jeopardized*, CHRISTUS MEDICUS NEWSL., Jan. 4, 2000, at 1 (stating that, on Jan. 1, 2000, California became the tenth state to require that health insurance plans provide coverage for contraceptives. This is a fundamental assault on religious liberty which must be changed in order for many religious individuals and entities to be able to faithfully discharge their religious obligations. Though there is an exemption, "the exemption is only available to nonprofits. The clear message is that anyone else, e.g., the devout Catholic who runs her own business, forfeits her right to religious freedom in this part of her life. Religion is only acceptable when it doesn't matter, or at least doesn't matter very much. Religion, in this understanding, is treated as a hobby, as a Yale professor once noted.").

¹⁹³Frank, *supra* note 192, (citing *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App.3d 405 (1989)).

¹⁹⁴*Id.* at 350.

¹⁹⁵*Id.*

¹⁹⁶*Id.*

¹⁹⁷*Id.*

¹⁹⁸Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 68 (1993).

be forced to compromise their conscience in order to satisfy what amounts to the moral decisions of the judiciary.

Therefore, a more expansive protection must be afforded, and not only to employees of religious hospitals (who clearly are at risk when sectarian and secular hospitals merge). “Protection must exist for those employed in all spheres of treatment. To adequately ensure this comprehensive protection of healthcare workers and institutions, specifically-tailored conscience statutes must be enacted.”¹⁹⁹ These statutes “must delineate, in as much detail as possible, the scope and extent of protection, lest the force of the law be lost in judicial interpretation.”²⁰⁰ When such actions are taken, society will have effectively safeguarded the moral integrity of its members.²⁰¹

Since it appears unlikely that federal free exercise will regain the judicially conferred distinction that distinguished its pre-*Smith* status, it is to the state courts and constitutions that attention reasonably should be directed.²⁰² Some pessimists claim “it is doubtful that a resort to independent state grounds will result in a major turnabout in free exercise jurisprudence.”²⁰³ Nonetheless, one must appreciate the fact that the very constitution they refer to is the greatest example of this Nation’s ability to overcome what is “doubtful.”

B. *The Establishment Clause*

As explained above and in relation to hospital mergers, though the First Amendment right to free exercise of religion has been diminished, it does not

¹⁹⁹*Id.*

²⁰⁰*Id.* (“Until such times as these specific provisions are enacted, and until such time as judges will fairly and consistently interpret them, the moral rights of those who serve society’s healthcare needs will remain in peril.”); see Boozang, *supra* note 59, at 1493, 1502, 1509, 1514 (indicating that the approach of Professor Wardle, who advocates the enactment of model conscience clause legislation that would preclude any payer from refusing to contract with institutions that refuse services on religious grounds, is an approach which “perpetuates a fundamental flaw in our healthcare delivery system — a lack of patient access to desired healthcare services.” Nonetheless “although legislative protections may in many instances prove wholly inadequate, I believe the legislature is best suited to develop policies designed to achieve the dual goals of securing hospitals’ religious freedom and ensuring patient access to healthcare.” Finally Professor Boozang concludes that “creative state regulators can achieve comprehensive access without impinging upon a sectarian hospital’s religious beliefs.”).

²⁰¹An example of successful legislation is the Managed Care Bill of Rights which passed the Pennsylvania Legislature on June 9, 1998. See Pennsylvania Catholic Conference, *HMO ‘Bill of Rights’ Includes Conscience Protection*, at <http://www.pacatholic.org/NEWS%20RELEASES/NRA61098.htm> (“Without conscience protection, Catholic health care providers could have been marginalized, and due to patient population loss, could have been forced to curtail or discontinue services according to Sister Clare Christi Schiefer, OSF, president of the PCHA. Robert O’Hara, Jr., executive director of the Pennsylvania Catholic Conference, stated, ‘This conscience protection language is vital to Catholic healthcare facilities.’”).

²⁰²Friedelbaum, *supra* note 158 (discussing several recent state cases which appear to make incremental steps towards a more enlightened understanding of the Free Exercise Clause).

²⁰³*Id.*

support the mantra-like oft-quoted language of “separation of church and state.” To claim that mergers violate the principle of separation of church and state simply because the merged hospital upholds its religious convictions to the extent of denying certain services to the public is simply unsupportable under Establishment Clause jurisprudence.

The task to be accomplished by the Establishment Clause is independent of the Free Exercise Clause’s protection of individual rights. Arguments have been made, however, that grammatically there is but one First Amendment Clause with two prepositional phrases in relation to religion.²⁰⁴ Therefore, there is but one purpose, the protection of individual religious freedom.²⁰⁵ This argument is without merit because, historically, each prepositional phrase carried its own operative meaning. This is apparent by the fact that both the Senate and House in the first congress debated and amended the text of the first clause of the First Amendment as having two independent phrases.²⁰⁶

Further insinuation that the religion clauses inherently overlap is the common reference to a “tension” between free exercise and no establishment.²⁰⁷ However this “clause-in-conflict” argument makes no sense. A casebook widely used in law schools supplies an all too common example of the “tension” argument:

The two clauses... protect overlapping values, but they often exert conflicting pressures. Consider the common practice of exempting church property from taxation. Does the benefit conveyed by government to religion via that exemption constitute an ‘establishment’? Would the ‘free exercise’ of religion be unduly burdened if church property were not exempted from taxation? Articulating satisfactory criteria to accommodate the sometimes conflicting emanation of the two religion clauses is a recurrent challenge in this chapter.²⁰⁸

At its core, this premise is flawed because the religious rights of individuals and the ordering of relations between government and religion are “altogether different enterprises.”²⁰⁹ When the claimed “freedom from religion”²¹⁰ is detached from the religion clauses as a constitutionally protected right, the believed “tension” fades away.²¹¹ This does not leave such a claim without protection, but it does mean that such protection is only a by-product of the First Amendment.²¹²

²⁰⁴Richard John Neuhaus, *Establishment Is Not The Issue*, RELIGION & SOC’Y REP., June 1987, at 4.

²⁰⁵*Id.*

²⁰⁶WALTER BERNS, *Religion and the Founding Principle*, in THE MORAL FOUNDATIONS OF THE AMERICAN REPUBLIC 204 (1986).

²⁰⁷*See, e.g.,* Suzanne Sherry, *Lee v. Weisman: Paradox Redux*, SUPREME CT. REV. 123 (1992).

²⁰⁸KATHLEEN M. SULLIVAN & GERALD GUNTHER, *FIRST AMENDMENT LAW* (1999).

²⁰⁹Esbeck, *supra* note 130, at 324.

²¹⁰*See* McConnell, *supra* note 151, at 1136.

²¹¹*Id.* at 1136 n.42.

²¹²*Id.*

In the hands of the Supreme Court, the Establishment Clause has not been regarded as a personal right; rather it has been applied to keep two centers of authority — government and religion — in their proper relationship.²¹³ The Establishment Clause is a limitation (“make no law respecting an establishment of religion”) — a boundary keeper.²¹⁴ “In setting out to locate that boundary, it is a useful reminder that the keeper’s task is to restrain government, not the private individual, not the church, and not religion.”²¹⁵ In regard to the Establishment Clause and situations in which religious hospitals merge with public hospitals, the only behavior to question is that of the government. The only conflict is whether government, if involved, has overstepped the boundary. Moreover, “[t]he boundary has been disputed for over 2000 years, so it would be naïve to suppose that there is an easy formula for determining what is Caesar’s and what is God’s.”²¹⁶ This is especially true in a pluralistic society — the key however is understanding the seeming contradiction whereby though “Caesar” must take a *lassaiz faire* stance toward what is “God’s,” the inverse does not hold true.

To hold that the phrase “separation of Church and State” inclusively sets the boundary is a misperception.²¹⁷ “‘Church and State’ is a profoundly misleading rubric.”²¹⁸ The implied suggestion is that there is a single church, but there are a myriad of ways in which religious belief is organized in America.²¹⁹ The phrase suggests that there is a single state, but in America there is an overlapping hierarchy organized into a federal government, fifty state governments, a variety of municipalities, and a division of power among executive, legislative, and judicial entities.²²⁰ “Worst of all, ‘Church and State’ suggests that there are two distinct bodies set apart from each other in contrast if not in conflict.”²²¹ The fact is that churches and states are comprised of people, some believers and others nonbelievers; some citizens and others officials; thus religion and government not only coexist, they overlap.²²² Much of the time, individuals are simultaneously believers and wielders of power.²²³

²¹³McCullum v. Board of Educ., 333 U.S. 203 (1948) (“[T]he First Amendment rests on the premise that both religion and government can best work to achieve their lofty aims if each is left free from the other within its respective sphere.”).

²¹⁴Esbeck, *supra* note 130, at 324.

²¹⁵*Id.*

²¹⁶*Id.* at 326; *see also* GAILLARD HUNT, THE WRITING OF JAMES MADISON 33 (1910) (“I must admit moreover that it may not be easy, in every possible case, to trace the line of separation between the rights of religion and the Civil authority with such distinctness as to avoid collision & doubts on unessential points.”).

²¹⁷Esbeck, *supra* note 130, at 326.

²¹⁸JOHN T. NOONAN, JR., THE BELIEVERS AND THE POWER THAT ARE xvi (1987).

²¹⁹*Id.*

²²⁰*Id.*

²²¹*Id.*

²²²*Id.*

²²³NOONAN, *supra* note 218.

Religion cannot be regulated to a solely private belief, because private beliefs propel individual decisions which in turn affect public actions. "Freedom should include not only the freedom to exercise inner belief but also the freedom to exercise social commitments intrinsically involved in such belief."²²⁴ The Supreme Court has reconciled such conflict by generally finding that the government does not exceed the restraints of the Establishment Clause unless it is acting on topics that are inherently religious such as prayer,²²⁵ devotional Bible reading,²²⁶ veneration of the Ten Commandments,²²⁷ classes in confessional religion,²²⁸ and the biblical story of creation taught as a science.²²⁹ These topics are exclusively religious, hence by virtue of the Establishment Clause, off limits as objects of legislation or any other purposeful action by civil officials.

However, strong argument has been made that some topics of legislation can be described as "arguably non-religious" for no-establishment purposes and thereby not prohibited.²³⁰ This contention is supported by cases finding certain situations as not inherently religious merely because a social program reflects the moral judgment shared by some religions about conduct thought harmful or beneficial to society. Sunday-closing laws,²³¹ teenage sexual abstinence counseling,²³² and the availability of abortion²³³ are instances deemed not inherently religious.

A wall that separates church and state is fine; one that separates morality from law isn't. When, in the name of separation, a school protects a child from government-sponsored religious exercises, it is defending the [wall] . . . [but when] a school teaches condom use instead of abstinence, it's violating principles of that same moral universe.²³⁴

Justice William Brennan wrote that the common thread in the Court's analysis of whether legislation transgresses the Establishment Clause restraint "is whether the statutes involve government in the 'essentially religious activities of religious institutions.'"²³⁵ Thus, it does not matter that the secular hospital and the Catholic

²²⁴Berman, *supra* note 85, at 51.

²²⁵Lee v. Weisman, 505 U.S. 577 (1992); Wallace v. Jaffree, 472 U.S. 38 (1985).

²²⁶See *Abington*, 374 U.S. 203.

²²⁷Stone v. Graham, 449 U.S. 39 (1980).

²²⁸See *McCullum*, 333 U.S. 203.

²²⁹Edwards v. Aguillard, 482 U.S. 578 (1987).

²³⁰LAWRENCE TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1ST ED., § 14-6, at 828-33 (1978).

²³¹McGowen v. Maryland, 366 U.S. 420 (1961) (upholding Sunday-closing legislation as a mere labor law).

²³²Bowen v. Kendrick, 487 U.S. 589 (1988) (upholding a federal funding program for centers counseling teenagers concerning sexuality, including faith-based centers).

²³³Harris v. McRae, 448 U.S. 297 (1980) (upholding a federal restriction on the funding of elective abortions).

²³⁴Clifford R. Goldstein, *Getting Reality Right*, *LIBERTY* 92, May/June 1997, at 30-31.

²³⁵Lemon v. Kurtzman, 403 U.S. 602 (1971) (Brennan, J., concurring).

hospital get the very same Medicare and Medicaid reimbursement, because it does not matter that one is religious and one is secular.²³⁶ The essential, frequently disregarded point is that both are delivering medical care to people.²³⁷

Under such rationale, faith-based social service providers are increasingly finding that they are eligible to apply for and receive grants or contracts from government sources.²³⁸ Fears are increasing though as these providers are unsure as to what strings may be attached to such financial support.²³⁹ The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 contained a “charitable choice” provision entitled “Nondiscrimination and Institutional Safeguards for Religious Providers.”²⁴⁰ This permits states to involve faith-based providers in the delivery of welfare services funded by the federal government through block grants to the states, which can then be distributed to faith-based entities through contracts, or indirectly through vouchers.²⁴¹ In the same year, George W. Bush became the first governor to issue an executive order prohibiting state agencies from snubbing or secularizing religious charities.²⁴² In 1997, Bush went on to pass legislation promoting prison ministries, deregulating religious drug-treatment programs and allowing child-care centers (mostly church-based) to seek private accreditation.²⁴³ Such acts only violate constitutional principles if one holds to the notion that religious organizations are unable to maintain religious convictions when receiving public funds. Indeed, charities on the public dole tend to look just like their government counterparts — therapeutic, judgment-free, and secular.²⁴⁴ However, incorrect actions taken in the past should not preclude positive future advancements. Some have concluded that the transforming nature of religion will have to remain outside the realm of government funding, even if it is an effective route out of chronic poverty, crime, and addiction.²⁴⁵ Such a defeatist mindset can only harm society. Governor Bush recently made the transition to President Bush and has repeatedly rebutted fears of government steamrolling over the principles of faith-based organizations. “As long as there are secular alternatives, faith-based charities should be able to compete for

²³⁶Laycock, *supra* note 127, at 49.

²³⁷*Id.*

²³⁸See Abigail Lawlis Kuzma, *Faith Based Providers Partnering with Government: Opportunity and Temptation*, J. OF CHURCH & ST., Winter 2000, at 37.

²³⁹*Id.*

²⁴⁰Federal Personal Responsibilities and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, § 104, 110 Stat. 2105 42 USC 604a (1996).

²⁴¹*Id.*

²⁴²Joe Loconte, *Leap of Faith*, NAT’L REV., July 12, 1999, at 5.

²⁴³*Id.*

²⁴⁴*Id.*

²⁴⁵See Michael Kress, *A Question of Faith*, Salon News, available at <http://www.salon.com/news/feature/1999/08/30/faith/>.

funding on an equal basis, and in a manner that does not cause them to sacrifice their mission.”²⁴⁶

A proliferation of private sector public service providers, many of which have an affiliation with sectarian institutions, have been stepping in to close the gap left in the wake of diminishing government programs.²⁴⁷ The overall acceptance of this option is largely due to the fact that faith-based providers are the most effective and cost efficient providers due to their accessible neighborhood locations and their use of committed volunteers who are willing to do more than hand out service at arms length.²⁴⁸ Religiously motivated volunteers may be willing to walk the extra mile, spend more time and effort building trust and friendship with their clients.²⁴⁹ John Dilulio, political science professor at Princeton University, recognized that “most volunteers in this country are people of faith . . . [and t]he biggest asset of the Christian community is Christianity.”²⁵⁰ For this very reason, stripping religious providers of their religious nature before allowing them to participate in either social or medical services is simply counter-intuitive.

In the realm of healthcare, sectarian hospitals merging with secular hospitals are fearful that “[a] spoonful of government aid may be just enough to spoil the mission.”²⁵¹ It is worth noting that the Supreme Court’s treatment of faith-based organizations that provide healthcare has been different from that of parochial schools,²⁵² which have generally been regarded as involving “excessive government entanglement” in violation of the Establishment Clause.²⁵³ Healthcare as a religious mission has rarely been discussed in the context of the Establishment Clause.²⁵⁴ Religion has been part and parcel of many of this nation’s most prominent hospitals,

²⁴⁶President George W. Bush, Remarks by the President in Announcement of the Faith-Based Initiative, *available at*, <http://www.whitehouse.gov/news/releases/2001129-5.html>.

²⁴⁷*See* Kuzma, *supra* note 239, at 37, 38.

²⁴⁸MAYOR STEPHEN GOLDSMITH, *THE TWENTY-FIRST CENTURY CITY* 188 (1997) (stating that, “Church-based groups are infinitely better suited than government to help vulnerable individuals. Government is typically unable to discriminate between the truly needy and those simply seeking a handout . . . when church congregations help needy individuals, they do more than merely pass out checks to case numbers — they help their neighbors, thereby strengthening the bonds of the community.”); *see* Bellandi, *supra* note 9 (A top official from the Vatican visited Pittsburgh Mercy Health Systems to see how Roman Catholic healthcare works in America. *Id.* He was pleased to note that the hospital ran a program jointly with a women’s shelter in which the hospital screens for victims of domestic violence, outreach programs bringing medical care to the homeless, donations to help the needy, and that often people and their families received medical care though they had no money or insurance coverage. *Id.*

²⁴⁹*See generally* AMY SHERMAN, *RESTORERS OF HOPE* 137-70 (1997).

²⁵⁰Tim Staffore, *The Criminologist Who Discovered Churches*, *CHRISTIANITY TODAY*, June 14, 1999, at 38.

²⁵¹John Loconte, *Seducing the Samaritan*, *WORLD*, Aug. 15, 1998, at 15.

²⁵²Kuzma, *supra* note 239, at 42.

²⁵³*See Lemon*, 403 U.S. 602.

²⁵⁴*Id.*

which were originally established as part of a religious mission.²⁵⁵ “Nevertheless, such hospitals have long partnered with government in the provision of health care.”²⁵⁶ The likely reason for hospitals previously remaining apart from the “problem areas” of the Establishment Clause is that there is minimal regulation of the religious aspects of hospitals.

In contrast to the many Supreme Court decisions in the area of schools, the Court has only reviewed one case involving the Establishment Clause implications of government funding of health care. In *Bradfield v. Roberts*, there was an Establishment Clause challenge to a direct federal congressional appropriation for a capital improvement that would be turned over to Providence Hospital when completed.²⁵⁷ The Court held that the Catholic membership of the board of directors and the ownership of the property of the hospital “vested in the Sister of Charity of Emmitsburg,” did not alone render the congressional appropriation in violation of the Establishment Clause, given that the hospital was separately incorporated with a charter indicating a secular purpose involving the care of the injured and the infirm.²⁵⁸ Today, religious hospitals are largely permitted to receive funding without hassle because they provide a secular service that comports with Establishment Clause jurisprudence.²⁵⁹

In the past, the First Amendment has been interpreted as beneficial towards religious healthcare. Likely this is due to the necessity of faith-based organizations in that government is simply inadequate to meet the social and medical needs of the entire country. Nonetheless, free exercise has been constrained in recent years, and situations deemed as establishing religion have increased. Moreover, the present safeguards, namely conscience clauses, at both the state and federal level, are inadequate to effectively protect Catholic hospitals who merge with non-Catholic institutions. Presently, the law favors permitting mergers and permitting hospitals and individual physicians the choice to not participate in objectionable medical procedures; however, present trends place these hospitals and individuals in grave danger of losing their right of freedom of conscience.

V. MERGERS HAVE NOT RESULTED IN THE CONSTRUCTIVE DENIAL OF THE RIGHT TO ABORTION

In an interview with Morley Safer of *60 Minutes*, Frances Kissling, President of Catholics for a Free Choice, stated “[I]t’s not like the old days. Doctors are no longer gods. Now we have bishops who are gods.”²⁶⁰ Such language is not difficult to find within works by many organizations and institutions politically at odds with the moral convictions of the Catholic Church in the areas of abortion and birth control methods outside of marriage. Kissling claims to be an exception in that she

²⁵⁵*Id.*

²⁵⁶*Id.*

²⁵⁷*See Bradfield v. Roberts*, 175 U.S. 291 (1899).

²⁵⁸*Id.*

²⁵⁹*Lemon*, 403 U.S. 602.

²⁶⁰*60 Minutes: Do Beliefs Influence the Care Granted* (CBS television broadcast, Dec. 12, 2000) [hereinafter *60 Minutes*].

is a proclaimed Catholic speaking on behalf of Catholics.²⁶¹ Others disagree.²⁶² Regardless, the claim that women are being denied a lawful right to reproductive services is without merit as a matter of fact.

Catholic hospitals have chosen to not provide certain procedures based on moral grounds. Logically, the decision to not provide a service results in some person not receiving that service. This, however, is no basis upon which to brand the non-provider as per se culpable, or even blameworthy. For example, pornography is perfectly legal, however many businesses choose to not provide it based purely on moral objections. This non-service is not wrong; in fact many, if not most, view it as right. Providing healthcare and providing pornography are obviously dissimilar actions; however the point remains: non-service is not the type of denial of a right that is cause for branding the non-provider at fault. The denial of the service should at least provide some form of substantial harm to justify questioning the religious decisions of Catholic hospitals. Pro-abortion and family planning advocates have used the mergers between secular and sectarian hospitals as a platform to present their views while alleging civil rights infringements resulting from religious moralities.²⁶³ The publicized troubles however are much less pervasive and much less of a "harm" than the doom and gloom scenarios recently presented make them out to be. This is not to say that power and authority within Catholic hospitals have never been abused. Influence within any institution is likely to be abused and it is that instance which requires addressing, not the entire system. Indiscriminately throwing the baby out with the bathwater is what opponents of these mergers have hastily proposed.

The most common opposition to the merger of sectarian and secular hospitals is the fact that when these hospitals merge, certain reproductive services are no longer provided as a stipulation made by the Catholic entity.²⁶⁴ Abortion is most often the

²⁶¹*Id.*

²⁶²*Id.* (describing letter written by lay Catholic to TV Station, which stated: "Ms. Kissling does not represent the views of the Catholic majority.")

²⁶³*See also 60 Minutes, supra* note 260 (stating, on a subsequent follow up segment, aired Jan. 10, 2001, that they had received over 100 letters which appeared to be handwritten by individuals who believed that Catholic mergers with Non-Catholic hospitals were unethical and deprived women of their constitutional rights; it was found out that the letters were copies all sent by a pro-abortion facility.). Westchester Coalition for Legal Abortion, Inc., *Activists Defeat Mid-Hudson Catholic-Secular Hospital Merger*, at <http://www.wcla.org/98-autumn/au98-18.htm>. A coalition of three grassroots groups, assisted by FPA'S MergerWatch project and Planned Parenthood of Mid-Hudson, besieged the hospitals with petitions, letters to the editor, newspaper advertisements, bumper stickers ("No religious hospital merger"), lawn signs ("People of all faiths use our hospitals"), demonstrations, rallies and even roadside billboards proclaiming "The hospital merger is taking us in the wrong direction. With the guidance of the National Women's Law Center and MergerWatch, the community coalition submitted to the FTC information demonstrating the likely harmful effects on consumers." *Id.*

²⁶⁴Press Release, Catholics for Choice, *Catholic Healthcare Expansion Denies Emergency Services to Women Who Have Been Raped* (May 6, 1999) (on file with Catholics for Choice), available at <http://www.catholicsforchoice.org/new/pressrelease/chealth.htm> (Catholic hospitals are bound to follow a set of rules on health practices, known as the Directives, which ban many basic reproductive health services, including: contraceptive sterilization, contraceptive education and supplies, in vitro fertilization and artificial insemination, AIDS

center of attention but ironically, only seven percent of abortions take place at hospitals.²⁶⁵ Abortion is generally a procedure no longer provided when hospitals merge. However, more likely than not, abortions were never performed in the first place. One is left to assume that the uproar must be over the portion of that seven percent that happens to take place at a non-Catholic hospital that has merged with a Catholic hospital. Some point out that though there may not be a large number of hospitals, percentage-wise, dropping abortion services, these are the abortions most in need of a hospital setting because of medical necessity or complications.²⁶⁶ However, research failed to locate even one Catholic hospital which discontinued medically necessary abortion services. Only those abortions that are elective and fall under the rubric of Directive 45 are dropped.²⁶⁷

Concerning possible complications during an abortion, anti-merger proponents claim that there are medical conditions, such as high blood pressure, which may require a hospital setting for an abortion.²⁶⁸ This is precisely the reason that abortion

prevention education and condom distribution and abortions. Since 1990, thirty-four states experienced a Catholic/Non-Catholic merger or affiliation. In fifty percent of those mergers, the consolidation eliminated all or some reproductive health services.). *But see, e.g.,* Ron Shinkman, *Survival vs. Directives: One Catholic Hospital Opts to Permit Tubal Ligations to Stay Viable*, MODERN HEALTHCARE, Nov. 11, 2000, at 19, 20 (Catholic hospital loosened restraints on performing tubal ligations. Even so, not a full dropping of limitations: the tubal ligation still had to be considered medically necessary. But what was necessary was extended to include a situation in which a future pregnancy could endanger the mother's health. Additionally, any requests for tubal ligations had to be submitted at least a week in advance, and the procedure must be done in conjunction with a Caesarean section or an analogous abdominal surgery performed under anesthesia.). *See also* Vince Galloro, *No "Pastoral Exceptions": Catholic Church Clamps Down on Tubal Ligations, Vasectomies at North Dakota Clinic*, MODERN HEALTHCARE, Dec. 11, 2000, at 16, 17 ("The ends does not justify the means. It does not legitimize doing something intrinsically evil. You are mutilating a healthy organ.").

²⁶⁵American Civil Liberties Union, *Hospital Mergers: The Threat to Reproductive Health Services*, available at <http://www.aclu.org/library/hospital.html>. Alan Guttmacher Institute, ("Only seven percent of all abortions in the United States are performed in hospitals."); *Induced Abortion, Incidence of Abortion*, available at http://www.agi.usa.org/pubs/fb_induced_abortion.html ("93% of U.S. abortions are performed in clinics or doctors' offices").

²⁶⁶*See e.g.,* Jane Hochberg, Comment, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 OR. L. REV. 945, 954 (1996).

²⁶⁷Godines, *supra* note 53 (stating the merger of Community Hospital of San Bernardino and Catholic Healthcare West will put an end to elective abortions at the ninety-year-old hospital); *Ethics on Abortion, supra* note 53 (stating this prohibition against abortion applies to any and all direct abortions, that is, any procedure in which the immediate purpose, either as an end in itself or as a means to some other good, is to terminate the pregnancy by destroying the developing human fetus at any stage after conception or to expel it before it is viable).

²⁶⁸American Civil Liberties Union, *Hospital Mergers: The Threat to Reproductive Health Services, supra* note 265 ("[t]hey are often the most serious and complicated abortions, including those performed because a woman's life or health is in danger or in later stages of pregnancy, when severe fetal anomalies are first detected.").

clinics must meet stringent demands under federal and state regulations.²⁶⁹ In general, clinics are better equipped to handle any complications arising from an abortion.²⁷⁰ Doctors and staff specialize in the procedure and perform it daily. As a second point, the type of abortion relevant to this discussion is an elective abortion. This is an elective procedure, and no surgical procedure is risk-free as patients are well aware.²⁷¹ Those who elect to have plastic surgery, liposuction, breast implants, eyesight correction, and abortions are all aware that they have voluntarily elected to have a non-medically necessary surgery which inherently involves risk, whether it be minimal or not.²⁷² Women whose breast implants have leaked have no claim against a non-related hospital simply because that hospital chose to not provide a service which may have turned out differently had it been performed there. Why the hospital chose to not provide that specific service, whether for religious or economic

²⁶⁹Center for Public Health Law and Abortion Law, *Health and Safety Regulations Upheld for Abortion Clinics*, available at http://plague.law.umkc.edu/cphl/cases/reproduction/greenville_womens_clinic_brief.htm

“Greenville Women’s Clinic v. Bryant deals with the constitutionality of health and safety regulations on abortion clinics. As amplified herein, we reverse this decision and uphold the constitutionality of Regulation 61-12 because (1) the Regulation serves a valid state interest and is little more than a codification of national medical- and abortion-association recommendations designed to ensure the health and appropriate care of women seeking abortions; (2) the Regulation does not “strike at the [abortion] right itself,” *Planned Parenthood v. Casey*, 505 U.S. 833, 874 (1992) (joint opinion of O’Connor, Kennedy, and Souter, JJ.); (3) the increased costs of abortions caused by implementation of the Regulation, while speculative, are even yet modest and have not been shown to burden the ability of a woman to make the decision to have an abortion; and (4) abortion clinics may rationally be regulated as a class while other clinics or medical practices are not.”); *The Delivery of Abortion Services: Setting the Record Straight*, National Coalition of Abortion Providers, at <http://www.ncap.com/Delivery.html> (“Virtually all abortion providers are already operating under strict, medical-care standards. Many of these are self-initiated. Also, we’ve adopted other standards to comply with malpractice insurance carriers and state and federal authorities.”)

²⁷⁰*Id.*; National Women’s Health Organization of Raleigh, North Carolina, at <http://gynpages.com/rwho/> (“Raleigh Women’s Health Organization is a State-licensed ambulatory surgery Center which specializes in reproductive healthcare including emotionally supportive abortion care. Our physicians performing abortions are licensed medical doctors with specialized expertise in abortion medicine.”).

²⁷¹See e.g., Plastic Surgery Center, *Plastic Surgeons Advise Liposuction Patients to Obtain Full Information Before Surgery*, at <http://www.plasticsurgery.org/mediactr/lipopress.htm> (“It is important to remember that liposuction is a surgical procedure.”).

²⁷²*What are the Health Risks Involved with Breast Implants*, Let’s Get Physical, Ask Pat, at <http://www.colostate.edu/Depts/HHS/physical.htm#3> (“Because there is usually not a medical reason for this surgery, breast enlargement is considered a cosmetic procedure and is not covered by medical insurance. For this reason bankruptcy can be a risk, in addition to any physical risk.”); *Plastic Surgery for Breast Implants Alternatives and Considerations*, at <http://www.all-naturalbreasts.net/breastimpberc.htm> (“The top three plastic surgery procedures in the world are breast implants, liposuction, and face lifts. All three are major surgical procedures; however, neither the cost, the risk, nor the discomfort involved with any of these surgical procedures has discouraged large numbers of women from having one or all three.”).

reasons, is irrelevant. Catholic hospitals may choose to not provide abortions; however, by no means does this cause them to be liable for any resulting harms to those who have the procedure performed elsewhere. This is especially true when the likelihood is that they will receive better care elsewhere.

A second argument raised is that circumstances caused by these mergers, in which abortion is no longer provided for by the hospital, leads to abortion-providing clinics being singled out for protests, harassment, and violence.²⁷³ To the legal mind, this is an obvious stretch because of the well-recognized difference between proximate cause and actual cause.²⁷⁴ But for a mother giving birth to a future criminal the crime would not have occurred, and but for the abandoning of certain services by Catholic hospitals, protestors would not focus their actions elsewhere. To blame either the mother or the hospitals in these examples is ridiculous. Of course, as the locations at which a protested service is provided decrease, the likelihood that the remaining locations will become the focus of attention for protestors will increase. Many individuals have a moral objection to pornography, which is a perfectly valid and legally protected right.²⁷⁵ Regardless of the general sentiment of any particular community, businesses are free, based on purely religious motives, to not provide pornographic materials to their patrons. Moreover, if violence or harassment increases at another store providing such material, to charge anyone other than those violent individuals is simply absurd. Additionally, if harassment (even to the point of violence) is a dilemma that plagues abortion providers, do hospitals not have the right to avoid this by dropping such services and creating a safer environment for all of their patients?²⁷⁶

It has been stated that many people do not view abortion clinics as “normal medical facilities” and that women are made to feel “even more guilty” when forced to visit such establishments.²⁷⁷ As mentioned, only seven percent of abortions are performed at hospitals.²⁷⁸ If anyone is going to be made to feel “more guilty,” it

²⁷³See e.g., Hochberg, *supra* note 266, at 947.

²⁷⁴See D.E. Buckner, *Foreseeability as an Element of Negligence and Proximate Cause*, 100 A.L.R.2D 942 (2000).

²⁷⁵American Center for Law and Justice, Jay Sekulow, *Removing Pornography from Your Community*, at <http://www.aclj.org/publications/kyr/pubplace.asp#remove> (“Communities have the right to regulate pornography according to local standards. That means they can restrict what is sold, where it is sold, and who is able to buy it. They can even prohibit pornography altogether.”).

²⁷⁶David A. Grimes, M.D., *Clinicians Who Provide Abortions*, OBSTETRICS & GYNECOLOGY, Oct. 1992, at 4, 5 (Harassment and intimidation may dissuade skilled clinicians from entering this field or convince them to quit. Harassment of providers takes many forms, ranging from picketing of homes and offices to obscene telephone calls to death threats. Abortion Clinics have been the targets of an epidemic of arsons and bombings; during 1984, 1 percent of all clinics in the United States were attacked.); see also *Abortion Services at Hospitals*, at http://www.reproactivist.org/AAP/publica_resources/fact_sheets/abortion_servicesathospitals.htm (Between 1978 and 1988, 600 hospitals in the U.S. stopped providing abortions. Between 1988 and 1992, the number decreased by another 18 percent. Anti-abortion threats have played a major role in the decline of hospital-based abortion services.).

²⁷⁷See e.g., Hochberg, *supra* note 266, at 946.

²⁷⁸See *supra* note 265 and accompanying text.

must be women within that seven percent. However, as noted above, these abortions are generally medically necessary procedures that are needed when hospitals merge. Therefore, the only women whose guilt could be increased are the small percentage of the seven percent who believe that clinics are less than adequate. Even if mergers did increase feelings of guilt, where the choice to receive an abortion is one causing pangs of guilt then the opportunity to carefully think through that decision is a good thing — a hasty choice could bring not moments, but years, of guilt.²⁷⁹ In any case, public perception of abortion providers is not within the purview of a hospital's responsibility and should not be a factor overcoming their economic or moral resolutions to drop services. Additionally, if guilt is an issue, surely a much worse case involves the guilt of individuals forced to act contrary to their conscience.²⁸⁰ Just as few Americans would agree that individual physicians should be forced to provide abortions in violation of their conscience, few Americans would agree that an organization such as a Catholic hospital should be forced to do the same.²⁸¹

Often, the argument is raised that merger situations deprive women not only of services, but also of their own personal doctors because the patients are forced to go elsewhere.²⁸² This is a well-recognized and increasingly common phenomenon to present day healthcare as a whole.²⁸³ Most surgeries and medical procedures result

²⁷⁹Rachel's Vineyard, *Life Stories: The Journey From Abortion to Healing, Jennifer's Story*, at <http://www.rachelsvineyard.org/stories.htm> ("I am a post abortive mother. I suffer from the internal wounds that pierced my heart that day sixteen years ago when I chose to abort my baby. . . . The guilt, shame, sorrow and regret created a great 'black hole' inside myself. I tried to fill it with numerous things: marriage, children, a career and volunteer work. For the next sixteen years I felt isolated, depressed and anxious."); *Roe vs. Roe, Norma McCorvey, Life Stories*, at <http://sites.netscape.net/corganization/stories.html#Story1> ("Norma McCorvey, the plaintiff in the Roe v. Wade case that legalized abortion, who is now a pro-life Christian, tells her own story: 'It might have been victory for Weddington, Kaufman and all the other pro-aborts, but it was shame for me. The definition for abortion hit me in the face. I could see little babies being pulled out of their mamas, but they were alive. That's what I lived with for the better part of 14 years.'").

²⁸⁰Catholic Health Association of the United States, *AMA Resolution 218: Access to Comprehensive Reproductive Healthcare*, at <http://www.chausa.org/NEWSREL/218FACTS.ASP> ("The resolution seeks to force all hospitals providing prenatal services to offer a full range of reproductive services, including those few elective procedures that cannot be provided by Catholic hospitals based on conscience [*e.g.* direct abortions and voluntary sterilizations]. While the title of the resolution sounds admirable, the intent and effect is to force Catholic hospitals to act contrary to their religious and ethical beliefs.").

²⁸¹Ceasar e-mail, *supra* note 58.

²⁸²See *e.g.*, *Democracy Now*, *supra* note 71.

²⁸³M. SARA ROSENTHAL, *WHEN SHOULD YOU FIRST SEE THE DOCTOR?* 12 (1999) ("Whatever your medical history, you should also contact the specialist who usually manages your condition and see him or her a few times during your pregnancy. For example, if you're diabetic or are taking thyroid hormone, it's crucial that your endocrinologist sees you when you're pregnant to balance your medication appropriately. If you've had breast cancer, it's important that your breast surgeon and medical oncologist see you during the pregnancy to make sure that all is well."); C. NORMAN COLEMAN, *UNDERSTANDING CANCER: A PATIENT'S GUIDE TO DIAGNOSIS, PROGNOSIS AND TREATMENT* 3 (1998) (Because there are many types of cancer and many complicated treatments, your family doctor or internist probably does not have all the specialized knowledge needed to treat your illness. However, your family doctor

in a patient seeing a person other than his or her regular or family doctor.²⁸⁴ The largest percentage of women receiving abortions is between the ages of twenty and twenty-four years.²⁸⁵ Women, especially within this age group, prefer to see a doctor other than their own for an abortion, as it often involves an emotional decision they prefer not to remember each and every time they come in for a check-up.²⁸⁶

The fact that women often wish to see individuals other than their own doctors for abortion procedures rebuts another point claimed by anti-merger advocates. Though her ideas are much more neutral than its citers have let on, Kathleen Boozang brought attention to the situation that mergers cause for indigent women in rural communities.²⁸⁷ According to Francis Kissling, “[t]hese mergers have an effect on poor women, who disproportionately seek reproductive health care in hospitals.”²⁸⁸ Others have asserted that subsequent to a merger it is more likely that the services no longer provided may be either less available or totally unavailable elsewhere in a rural setting.²⁸⁹ Though the cost of traveling two to three hours to receive an abortion seems awfully inexpensive when the alternative is raising a child for eighteen years, anti-merger activists point to this as an overwhelming negative effect resulting from the influx of Catholic healthcare.²⁹⁰ Regardless of financial

will be able to help you arrange a consultation with an oncologist--a physician who specializes in the treatment of cancer. Your family doctor may or may not transfer the primary responsibility for your care to the oncologist, but in either case he or she will probably remain involved and may help you select your treatment. While the necessary staging studies are being performed, you are likely to see several different oncologists. Your family doctor may refer you to a large cancer center where you can get several expert opinions, for example, or you may go to such a center to receive treatments that require the expertise of several different specialists.).

²⁸⁴*Id.*

²⁸⁵Margaret Sykes, *15 Abortion Facts*, About-Pro-Choice, at <http://prochoice.about.com/newsissues/prochoice/library/blfifteenfacts.htm> (based on the latest abortion statistics from the Centers for Disease Control: “Women aged 20 to 24 years have one in three abortions (32 percent) . . . [and] abortion rates are highest for women in their early 20s.”).

²⁸⁶National Coalition for Abortion Providers, *Time for a National Conversation About Abortion*, at <http://www.ncap.com/NEWCONVE.htm> (“Women will travel hundreds of miles to avoid being seen walking into their local clinic.”).

²⁸⁷Boozang, *supra* note 59 at 1439, 1515 (The article is much more objective than the typical text cited — “We believe that Catholic Hospitals should not abdicate their mission” — and states in conclusion: “Architects of a healthcare delivery system that will meet the needs of the next century must pursue the dual goals of comprehensive healthcare for all citizens and religious autonomy from sectarian healthcare institutions.”).

²⁸⁸Hospitals and Health Systems — Catholic Hospitals: Mergers Limit Reproductive Services (Amer. Pol. Network, Inc., Radio Broadcast, Apr. 7, 1998).

²⁸⁹Godines, *supra* note 53 (Dr. Muhtaseb is concerned that the changes on abortion will be a first step in a curtailment of family planning services. “Yes, we’re worried and not only about abortion,” he said. “Will a woman eventually have to drive 80 miles out of town for services? At the rate of Catholic acquisitions, she may have to drive out of state.”).

²⁹⁰*Id.*, *AMA Resolution 218: Access to Comprehensive Reproductive Healthcare*, *supra* note 280 (“Showing a lack of evidence problem, other options for abortions and sterilizations are almost always available in the same community – either in hospitals or other healthcare

status, many women prefer to not publicize the fact that they are receiving an abortion and, therefore, would not go to a regular doctor. The desire to keep their decision private is heightened in rural communities where “everyone knows everyone” and they are, therefore, more likely to travel elsewhere for the procedure.²⁹¹ Indeed, Charles M. Cutler, M.D., chief medical officer for the American Association of Health Plans has stated that most managed care enrollees live in urban areas, where choices in treatment facilities exist.²⁹² He went on to note that he had not heard of patients having trouble accessing reproductive services and, if they were, health plans would find alternative sources within the community.²⁹³

In 1998, the *Boston Globe* reported that a Catholic New Hampshire hospital refused to perform an emergency abortion on a woman when her water broke at only fourteen weeks of pregnancy.²⁹⁴ Immediately, anti-merger advocates utilized this circumstance as an opportunity to produce a poster case. In response a hospital spokeswoman stated that the doctor had not given the hospital staff a chance to review whether the case met its new abortion guidelines.²⁹⁵ In fact, the patient successfully received an abortion at a hospital located approximately eighty miles away.²⁹⁶ Those who have decided to criticize Catholic health care have apparently strained to use these already rare instances to place hospital mergers in a negative light.²⁹⁷ Frank Ceasar, public relations director for Catholic Health Association, notes that even after finding a possible exception, it is simply asinine to jump to the conclusion that women have “no access” to elective procedures.²⁹⁸ Other options are nearly always available within the community. The spectrum narrows even further because other options are certainly available in nearby communities. Situations in which the Catholic hospital is the sole provider with no nearby facility are less than one percent.²⁹⁹ A case highlighted in a broadcast by *60 Minutes*, portrayed St. Louise Regional Health Center in Gilroy, California, which had become the only medical provider in town.³⁰⁰ Though St. Louise was a Catholic hospital that did not perform tubal ligations, it should be noted that St. Louise was the only provider because another competing, investor-owned hospital made a business decision to leave.³⁰¹

settings – and they are certainly available in other settings or nearby communities in those extremely small number of cases where the Catholic hospital is the sole facility.”).

²⁹¹*Id.*

²⁹²Bellandi, *supra* note 9, at 5.

²⁹³*Id.*

²⁹⁴Reuters News Service, *Hospital Turns Away Women Seeking Emergency Abortion*, BOSTON GLOBE, May 23, 1998, at 5.

²⁹⁵*Id.*

²⁹⁶*Id.*

²⁹⁷This is the only instance of a woman denied what **may have been** a medically necessary abortion at a Catholic Hospital that was found during the author’s research.

²⁹⁸Ceasar e-mail, *supra* note 58.

²⁹⁹*Id.*

³⁰⁰*60 Minutes*, *supra* note 261.

³⁰¹Ceasar e-mail, *supra* note 58.

The Catholic hospital decided to continue what had been its mission for over 100 years and it stayed.³⁰² Concerning the entering of a Catholic facility and the subsequent dropping of a few services, Susan Whitten, Vice President of Strategy and Marketing for Catholic Healthcare West, declared, “I really believe the question needs to be turned around. What happens when a Catholic organization is not willing to come in and help provide resources?”³⁰³ Asking the wrong questions has overshadowed the work consistently performed by Catholic healthcare.

In the case of the poor, generally those receiving Medicaid, the situation is similar to receiving legal assistance. The Sixth Amendment provides that all citizens are entitled to the assistance of counsel.³⁰⁴ However there is no Constitutional right declaring who is to be appointed counsel. Nonetheless, the Supreme Court has held that a person accused of a crime has the right to have counsel appointed if retained counsel cannot be obtained.³⁰⁵ Similarly, the federal government has provided a means for the indigent to receive medical aid via Medicaid. The legal right to receive assistance of counsel nowhere declares that the best of counsel is to be appointed.³⁰⁶ This would be administratively infeasible, therefore it has been determined that the right to counsel is satisfied if counsel’s services are “reasonably effective.”³⁰⁷ Additionally, a defendant who has the misfortune to return to the court system may request a certain attorney; however, she has no “constitutional right” to that attorney’s services. Likewise, Medicaid patients are provided a service they did not purchase and though keeping the doctor/patient relationship is desirous, aid recipients have no enforceable “right” to such accommodation.³⁰⁸ And, because women desire to speedily receive an abortion, many forego their regular doctor and have the procedure done by the earliest available physician.

³⁰²*Id.*

³⁰³Godines, *supra* note 53.

³⁰⁴*See* U.S. CONST. amend. VI.

³⁰⁵Johnson v. Zerbst, 304 U.S. 458 (1932).

³⁰⁶Madden v. Township of Delran, 601 A.2d 211, 215 (N.J. 1992) (stating that Sixth Amendment provides only for the “right to counsel” and certainly “not to the best of counsel”).

³⁰⁷Strickland v. Washington, 466 U.S. 668, 687 (1984).

³⁰⁸*Medicaid Funding for Abortions*, at http://www.ppcna.org/pubaff/medicaid_funding_for_abortions.htm.

Medicaid recipients have no enforceable right to receive an elective abortion.³⁰⁹ Recent media coverage has provided Annie Keating, program director of the New York chapter of the National Abortion Rights Action League, the opportunity to speak out not only against Catholic hospitals but against Catholic HMO's regarding women's reproductive services.³¹⁰ In contrast to the majority of her speech and to the newsletter her organization provides, she stated that "abortion is the least of our concerns" during a 1998 interview on the radio program *Democracy Now*.³¹¹ Nonetheless, she went on to bombast Fidelis, a strictly Medicaid Catholic HMO, for its refusal to provide services conflicting with the Directives.³¹² The broadcast however was not entirely one-sided, as John Carey, executive director of the New York State Catholic Conference, was available to rebut the remarks of Ms. Keating.³¹³ He qualified her attacks by noting that Fidelis may not provide for certain services; however, it refers patients seeking those service to other establishments.³¹⁴ More importantly though, he made the poignant remark that struck at what should be the actual concern: "The issue is really a cultural question with legal, economic, and moral ramifications."³¹⁵ Squeezing Catholic healthcare out of the medical mission which they have faithfully committed themselves to for over 100 years is anything but productive.

VI. CONCLUSION

Traditionally, courts and legislators have tended to protect the religious character of the religiously affiliated hospital.³¹⁶ This tendency is threatened by misapplication of the phrase "separation of church and state" and misperceptions over the relationship between public and private in conjunction with recent media coverage centering on the antics of pro-choice, family planning, and feminist advocates. In a pluralistic society such as the United States, religion has historically played a key role in healthcare. Religious health providers have remained a vital, dynamic force

³⁰⁹*Id.* ("Every year since 1977, Congress has added one or another version of the so-called "Hyde Amendment" to the annual funding measure for the Department of Health and Human Services [hereinafter DHHS], restricting, to varying degrees, the use of federal funds for abortions for poor women. Since 1981, federal funds have been available for abortions for Medicaid recipients only if the life of the woman would be endangered if the pregnancy were carried to term. Despite the cutoff of federal funds, fifteen states and the District of Columbia continue to use their own funds to provide abortions for their residents. Some of these states provide such funding voluntarily and others do so as a result of litigation. In September 1993, an attempt to repeal the Hyde Amendment failed. However, in maintaining the restriction on Medicaid funding for abortion, Congress rewrote the amendment to allow funding under two additional conditions — when a pregnancy is the result of rape or incest.").

³¹⁰*Democracy Now*, *supra* note 71.

³¹¹*Id.*

³¹²*Id.*

³¹³*Id.*

³¹⁴*Id.*

³¹⁵*Democracy Now*, *supra* note 71.

³¹⁶Kuzma, *supra* note 238.

motivating better medical assistance in a variety of physical and emotional manners. Mergers have taken place as a matter of economy and have proven to the vast majority of communities in which they have occurred. The arguments against these mergers seek out exceptions to the norm and lack substance. There are costs to individuals when freedom is the overriding premise upon which a society is based; however, the benefits are far greater. Though one community may lose certain elective medical procedures when a Catholic hospital merges with a non-Catholic hospital, the cost to that community had the religious entity been denied the option to merge, would have been far worse. The amount of services lost when a hospital is forced to close its doors is greater by one hundredfold. Additionally, the individual forced to act against his conscience is much more deserving of protection than the individual who now will not receive what may have been the perceived benefit of that act. Present First Amendment law must begin to take into account the necessity of a pluralistic society, as well as recognize that it is not a new concept. The judiciary should give the freedom of conscience the deference that it deserves. By enacting tailor-made conscience clauses, legislative bodies at the state and federal level must prevent the current trend which, if allowed to continue, will ultimately result in Catholic healthcare being forced to abdicate its mission. Directly and indirectly, such a result would harm hundreds of thousands of religious and non-religious Americans. The successful American pluralistic system belies the existence of a strict separation between the many churches and many states that make up a united American nation. Those who thoughtlessly accept placing an impregnable wall between what is private and what is public, what is secular and what is sectarian, must deny not only the past, but the present. Compromise must be reached through creative solutions that protect above all, the freedom of conscience.

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