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ACLU Reproductive Freedom Project

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A critically ill pregnant woman refuses a blood transfusion because her religion teaches that it would rob her of any hope of eternal life, but the hospital seeks a court order to require her to undergo the transfusion to save both her and her fetus. A religiously affiliated community health center serving an inner-city neighborhood refuses to distribute or advise patients to use condoms to prevent the spread of AIDS. A church seeks an exemption from a bill that would require it, and all other employers, to include coverage for prescription contraception in their otherwise comprehensive health insurance plans for employees. An obstetrician, fearing that her patient will choose to have an abortion, refuses to inform her that prenatal tests have revealed a severe anomaly in the fetus she is carrying. A woman who wants to prevent pregnancy following unprotected sex with her husband goes to her local pharmacy to obtain emergency contraception, but the pharmacist refuses to fill her prescription because he believes that the drug may destroy a fertilized egg.

It is a mistake to view these situations as a straightforward contest between religion and reproductive rights. Patients of all faiths and no faith need reproductive health care. Health professionals of all faiths and no faith must make decisions about how to balance their personal convictions with their professional obligations to their patients. Institutional religions stand on both sides of the debate about reproductive choice.

Proceeding from a long-held position of profound respect for both reproductive rights and religious liberty, the ACLU Reproductive Freedom Project has developed and offers in this report a framework for reconciling the competing interests involved when religious belief affects decision-making about reproductive health care. We seek two ends: avoiding impositions on people who do not share the beliefs that motivate the refusal, and protecting the religious practices of insular, sectarian institutions while insisting on compliance with general rules in the public, secular world. Our framework is both informed by and informs our work in diverse settings – from the public arena to the legislatures to the courts – as we take positions on religious refusals in the reproductive health context. We hope it will be a useful guide to others struggling with these same questions.

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REFUSAL CLAUSES: THE FACTORS THAT FUEL THE DEBATE

We set out here a brief history of refusal clauses in the reproductive health context. Refusal clauses are laws that permit entities and/or individuals to refuse to provide or cover health services they object to on religious or moral grounds. We review the introduction of such clauses into federal and state law in the mid-1970s. We then discuss the current wave of refusal clauses and the major causes of their resurgence, including fast growth in the religiously affiliated health care system, the explosion of managed care, the development of new reproductive technologies, and the increased intensity of advocacy efforts on both sides of the debate.[1]

Refusal clauses pertaining to certain reproductive health services swept the nation in the years following the Supreme Court's 1973 decision legalizing abortion in *Roe v. Wade*.[2] Congress started the trend that same year when it passed the Church Amendment (named for its sponsor, Senator Frank Church) in reaction to a 1972 court order that had required a Catholic hospital to allow a sterilization procedure to be performed on its premises.[3] Among other things, the Church Amendment established that the receipt of federal funds under various public health programs would not require individuals or entities to perform or assist in sterilization or abortion procedures to which they had moral or religious objections.[4] The states soon followed suit. According to the Alan Guttmacher Institute, by the end of 1978, more than forty states had enacted refusal clauses pertaining to abortion, and several had enacted clauses related to sterilization and/or contraception.[5]

For twenty years after this initial spate of legislation, the issue remained dormant, except for isolated cases in which patients were denied critical services because a hospital refused to provide them.[6] By the mid-1990s, however, we began to see a second wave of refusal clauses. The Clinton administration's early foray into health care reform stirred the waters that produced this wave. The promise of a basic set of health services to which every American would be entitled brought with it a mounting cry from the representatives of religiously affiliated health systems demanding that they be allowed to refuse to provide some of the services proposed for inclusion in the basic package.

Even after hopes of universal health coverage had evaporated, conditions leading to an intensified debate about refusal clauses remained. First, the sectarian health system emerged as one of the fastest growing sectors in the U.S. health care market. A recent study by MergerWatch, which monitors this sector, shows that, in 1999, eighteen percent of hospital beds were in religiously affiliated institutions.[7] Extensive research by Catholics for a Free Choice documents the expansion of the Catholic health system. Between January 1990 and September 1999, there were 139 mergers and affiliations between Catholic and non-Catholic hospitals, approximately half of which resulted in the elimination of all or some reproductive health services.[8] Moreover, significant consolidation within the Catholic system has given it dominance in certain geographic areas. For instance, by 1999, Catholic Healthcare West was the largest operator of hospitals in California, running forty-six hospitals, eighteen of which were formerly secular.[9] And, in more and more communities, Catholic hospitals are the only ones in town. By 1998, ninety-one Catholic hospitals in twenty-seven states were operating as the only hospitals in their counties.[10] (See inset.) This growth in the sectarian health system has given it more bargaining power to insist upon laws that permit religiously affiliated institutions to refuse to provide or cover health services – often reproductive health services – they believe to be sinful.

Women living in areas where the only nearby hospital is Catholic have faced significant health risks as a result. Thirty-four-year-old Zina Campos, for example, was denied a sterilization procedure immediately following the birth of her ninth child. Although her doctor counseled against a tenth pregnancy and was willing to tie her tubes after delivery, when the sterilization procedure is safest and easiest, the sole hospital in rural Gilroy, California – a Catholic facility – would not permit the procedure.[11]

Second, the managed care revolution erupted, bringing with it new demands for laws protecting patients' rights on the one hand and new calls for exemptions from such laws on the other. Managed care ushered out a health care market in which patients had shopped around for providers. In a free market, a provider's refusal to offer certain services posed less of a problem because patients were at least theoretically able to seek out alternative doctors, hospitals, and other facilities whose practices matched their needs. Not so under managed care, in which patients find themselves locked into networks with radically reduced alternatives and therefore increasingly at the mercy of the practices and policies of the few providers to whom they have access. Moreover, managed care has brought new players into the fray: following in the footsteps of health facilities and professionals who objected to providing certain services, religiously affiliated health insurance companies began to object to covering certain services in their managed care plans. As managed care has restricted patients' choices of health providers and placed patients under more direct control by health insurance companies, patients and their advocates have become increasingly concerned about ensuring comprehensive and medically sound services within networks and not letting the religious beliefs of sectarian health plans or facilities stand in the way. Yet virtually every law or bill aimed at protecting patients' rights in this health care environment has met with demands for loopholes. (See inset.)

The rules surrounding family planning services in the Medicaid program (a government-funded health insurance program for low-income people) reveal some of the tensions created by managed care. Medicaid patients are entitled by law to coverage for family planning services.[12] **When Congress incorporated managed care into the Medicaid program, however, it did not require managed care organizations serving Medicaid patients to provide family planning services, and it left Medicaid patients free to obtain such services outside of their managed care networks from alternative Medicaid providers of their choice.**[13] **This system had the benefit of preserving patients' access to a wide range of family planning providers, but it also created the risk that family planning services would fall through the cracks because patients would not know how or where to get them outside the confines of their regular managed care networks.**

Congress later required the states to inform patients about how to obtain covered services, including family planning services, that their managed care organizations did not provide.[14] **Congress explicitly declined, however, to require the managed care organizations themselves to provide or cover any counseling or referral service to which they had religious or moral objections.**[15] **As a result of this confused system, Medicaid patients who are enrolled in ▸**

religiously affiliated managed care organizations are sometimes misled or told nothing when they turn to their primary source of medical information and referrals for help in obtaining family planning services.[16]

Third, new reproductive technologies have fueled the debate. For example, when emergency contraception – a high dose of oral contraceptives used to prevent pregnancy following unprotected intercourse (not to be confused with the early abortion pill the FDA approved in 2000) – was finally marketed in this country in 1998, it created an outcry among pharmacists who objected to filling prescriptions for this drug.[17] The state legislatures were soon proposing and passing laws that permitted pharmacists to refuse to fill prescriptions for drugs they considered objectionable.[18] On the pro-choice side, women began to demand that emergency contraception be more readily available so that they could actually obtain the drug within seventy-two hours after unprotected sex, the period during which the contraceptive is most effective. In particular, pro-choice advocates proposed legislation to require hospitals to offer the drug to all sexual assault victims who sought treatment in a medical facility within seventy-two hours of the rape. Bills intended to ensure immediate access for rape survivors have met with resistance, primarily from representatives of Catholic health systems which object not only to providing emergency contraception but also to making referrals for this drug.[19]

Finally, advocates on both sides of the divide have sought changes in the law that sharpen the controversy over refusal clauses. Reproductive rights advocates have focused increasing attention in recent years on the passage of laws that would give more women more certain access to basic reproductive health services, especially contraception. Such proposals include contraceptive equity laws, which require employment-based health insurance plans to cover prescription contraceptives on the same terms as other prescription drugs and devices.[20] Other proposals would mandate comprehensive sexuality education in the schools or extend Medicaid coverage for family planning services to women living just above the poverty line.[21] In response, those religiously affiliated groups that oppose the reproductive health services at issue have stepped up their advocacy efforts. They often aim to block such legislation altogether, but, failing that, they seek to secure exemptions based on religious objections. Their efforts to persuade the legislatures to write exemptions into the laws have intensified as Supreme Court decisions have eroded the foundations of federal constitutional claims for religious exemptions.[22] The religious groups now urgently seek to obtain through legislative advocacy exemptions they can no longer win through constitutional litigation.

These and many other factors have contributed to the renewed controversy over refusal clauses. Calls for patients' rights and reproductive freedom increasingly collide with claims of religious liberty. The task now is to find a way to reconcile these competing demands. In "Refusal Clauses: A Framework for Analysis," we attempt this task.

Notes

1 For more comprehensive background on refusal clauses, *see* Angela Bonavoglia, *Co-opting Conscience: The Dangerous Evolution of Conscience Clauses in American Health Policy,* ProChoice Matters (ProChoice Resource Center, Port Chester, N.Y.), Jan. 1999.

2 410 U.S. 113 (1973).

3 *See Taylor v. St. Vincent's Hosp.,* 523 F.2d 75, 76 (9th Cir. 1975).

4 42 U.S.C. § 300a-7.

5 Rachel Benson Gold, *Conscience Makes a Comeback in the Age of Managed Care,* The Guttmacher Report on Public Policy (Alan Guttmacher Institute, New York, N.Y.), Feb. 1998, at 1; Rachel Benson Gold, *Provider 'Conscience' Questions Re-emerge in Wake of Managed Care's Explosion,* State Reproductive Health Monitor, June 1997, at 3, 6.

6 *See, e.g., Brownfield v. Daniel Freeman Marina Hosp.,* 256 Cal. Rptr. 240 (Ct. App. 1989) (stating that a rape victim could bring a damages action against a Catholic hospital that denied her information about emergency contraception); *see also* ACLU Reprod. Freedom Project, Conflicts Between Religious Refusals and Women's Health: How the Courts Respond (2002).

7 Lois Uttley & Ronnie Pawelko, MergerWatch Project, Educ. Fund of Family Planning Advocates of N.Y.S., No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States 9-11 (2002) (this study surveyed more than 4000 non-federal acute-care hospitals, thus excluding Veterans Administration hospitals as well as facilities dedicated to rehabilitation, long-term care, or other non-acute services).

8 Catholics for a Free Choice (hereinafter CFFC), Catholic Health Restrictions Updated 4 (1999); CFFC, Caution: Catholic Health Restrictions May Be Hazardous to Your Health 5 (1999).

9 CFFC, Catholic Health Restrictions Updated, *supra* note 8, at 4.

10 CFFC, Caution, *supra* note 8, at 6.

11 Leslie Laurence, *The Hidden Health Threat That Puts Every Woman at Risk,* Redbook, July 2000, at 112, 114.

12 42 U.S.C. § 1396d(a)(4)(C).

13 *Id.* § 1396n(b)(4); *id.* § 1396a(a)(23)(B).

14 *Id.* § 1396u-2(a)(5)(D).

15 *Id.* § 1396u-2(b)(3).

16 *See, e.g.,* Miriam Hess & Robert Jaffe, NARAL/NY Found., When Religion Compromises Women's Health Care: A Case Study of a Catholic Managed Care Organization 24-26 (2001).

17 Susan A. Cohen, *Objections, Confusion Among Pharmacists Threaten Access to Emergency Contraception,* The Guttmacher Report on Public Policy (Alan Guttmacher Institute, New York, N.Y.), June 1999, at 1-2; Marie McCullough, *Abortion Debate Spreads to Pharmacy Counter,* Phila. Inquirer, Mar. 28, 1999, at Front Page.

18 *See, e.g.,* S.D. Codified Laws § 36-11-70 (statute immunizing pharmacists' refusal to dispense drugs that might be used to cause abortion, "[d]estroy an unborn child," or cause death); S.B. 26, 2001 Gen. Assem., 135th Reg. Sess. (Ky. 2001) (bill to immunize pharmacists' refusal to dispense drugs, including abortifacients, that they object to on "moral, religious, or professional grounds").

19 Christi Parsons & Ryan Keith, *State Debates Contraception for Rape Victims,* Chi. Trib., Mar. 29, 2000, § 2, at 1.

20 For periodically updated lists of state contraceptive equity laws, see Nat'l Health Law Program, Contraceptive Equity Statutes As of July 9, 2001, http://www.nhelp.org/pubs/20010709.contraceptive.equity.pdf; Alan Guttmacher Inst., State Policies in Brief: Insurance Coverage of Contraceptives), http://www.guttmacher.org/pubs/spib_ICC.pdf.

21 For a periodically updated list of states requiring comprehensive sexuality education, see Alan Guttmacher Inst., State Policies in Brief: State Sexuality Education Policy, http://www.guttmacher.org/pubs/spib_SSEP.pdf. For a periodically updated list of states that extend Medicaid coverage for family planning services to women living above the federal poverty line, see Alan Guttmacher Inst., State Policies in Brief: Medicaid Family Planning Waivers, http://www.guttmacher.org/pubs/spib_MFPW.pdf.

22 *See, e.g., Employment Div. v. Smith,* 494 U.S. 872 (1990).

REFUSAL CLAUSES: A FRAMEWORK FOR ANALYSIS

The ACLU Reproductive Freedom Project here proposes a framework for assessing whether or not an entity or individual should be allowed to refuse to provide or cover a health service based on a religious objection. We begin by defining the term "refusal clause" in the health care context. We then review the relevant constitutional principles and conclude that the United States Constitution neither requires nor forbids most refusal clauses. In the absence of clear constitutional commands, policymakers are left to decide whether to honor a religiously driven refusal to treat or insure a patient. We end by suggesting a framework for grappling with this problem. The framework centers on two factors. First, policymakers should consider whether a particular refusal would place burdens on people who do not share the beliefs that motivate the refusal. The more the burdens fall on such people, the less acceptable any claimed right to refuse. Second, policymakers should consider whether a refusal would protect the religious practices of a sectarian institution or would instead protect an entity operating in a public, secular setting. The more public and secular the setting, the less acceptable an institution's claimed right to refuse.

A Definition

A refusal clause (sometimes also called a religious exemption or "conscience clause") is a law that allows entities and/or individuals to refuse to provide or cover certain health services based on religious or moral objections. Such a law may stand alone, or it may be part of a more comprehensive piece of legislation. Whatever form it takes, a refusal clause serves no function unless there would otherwise be some *duty* to provide health services or coverage. Such a duty may arise from a state constitution, a statute or regulation, a series of court decisions, an employment relationship, a contract, a professional ethical obligation, or any other source. A refusal clause operates in the health care context to relieve an entity or individual from what would otherwise be a duty to counsel, refer, treat, or insure a patient.

The Constitutional Landscape

The United States Constitution does not dictate the precise contours or even the existence of refusal clauses. While both proponents and opponents of such clauses have genuine claims that interests of constitutional dimension are at stake, federal constitutional law will only rarely resolve a policy debate over whether a refusal clause is warranted and what it should look like. Neither the Fourteenth Amendment's protection of reproductive freedom nor the First Amendment's guarantees of religious liberty determine the outcome of most such debates.

Although the U.S. Constitution protects reproductive rights, it does not ensure access to comprehensive reproductive health services or coverage. In first declaring and then repeatedly reaffirming constitutional protection for reproductive choice over the last quarter-century, the Supreme Court has recognized that women cannot achieve freedom or equality unless they have the right to decide whether and when to bear children.[1] The Court has held, however, that the federal Constitution does *not* require public hospitals to provide abortions or any other reproductive health service; nor are government health insurance programs constitutionally obligated to cover abortions or other services.[2] And the Constitution imposes no

requirements at all on nongovernmental institutions such as religiously affiliated hospitals and health plans. While other laws, including several of the state constitutions, require the provision or coverage of certain reproductive health services, the U.S. Constitution is not the source of any such mandate. Under current Supreme Court precedent, a woman has no federal constitutional right to receive the health care or insurance she needs from any given institution.

Moreover, if a duty to treat or insure a patient exists under a statute, regulation, state constitution, or contract, the U.S. Constitution offers little guidance about how to respond to a religious objection to fulfilling this duty. The First Amendment contains two provisions aimed at protecting religious freedom, the Free Exercise Clause and the Establishment Clause. The Free Exercise Clause protects "the right to believe and profess whatever religious doctrine one desires."[3] It prevents the government from burdening religious beliefs or targeting religious practices for special restriction. As currently interpreted by the Supreme Court, however, it "does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability" on the ground that the law conflicts with the individual's religious beliefs.[4] The Court has stated that the Free Exercise Clause does not make "each conscience . . . a law unto itself."[5] A religious observer or institution therefore has no federal constitutional right to refuse to abide by a general law requiring the provision of health services or coverage.

The Establishment Clause prevents the government from favoring one religion over another and, in general, from privileging religion over nonreligion. Some have argued that refusal clauses violate the Establishment Clause by giving religious institutions a special right to refuse to fulfill a legal obligation while others remain bound to comply. The Supreme Court has indicated, however, that the Establishment Clause tolerates broad religious exemptions from otherwise generally applicable laws. For example, rejecting an Establishment Clause challenge, the Supreme Court upheld a federal law that exempts religiously affiliated organizations from the general rule that otherwise prohibits religious discrimination in employment. A religiously affiliated organization is therefore free under federal law to discriminate on the basis of religion against employees engaged in a broad range of activities, including activities (such as maintaining a public, nonprofit gymnasium) that may seem secular but that an organization defines as part of its religious mission.[6] Moreover, the Court has held that an exemption may run exclusively to religiously affiliated institutions and need not "come[] packaged with benefits to secular entities."[7]

A survey of the constitutional landscape reveals few boundaries.

A survey of the constitutional landscape thus reveals few boundaries. The federal Constitution does not mandate the provision of reproductive or other health services or coverage, but if a legal obligation arises from another source, the Constitution in most instances neither requires nor forbids an exemption relieving religious believers of that obligation. Politics and policy will therefore usually drive legislative decisions about whether to create and how to craft exemptions from legal duties to provide reproductive health care or coverage. Because constitutional challenges are of limited utility to fix or invalidate refusal clauses that have been enacted, legislative advocacy is of paramount importance in this area. (See inset.)

The Limits of Constitutional Claims: A Case Study

An important pending case illustrates the limits of constitutional challenges. In *Catholic Charities v. Superior Court*,[8] a Catholic social service agency sued the state claiming a constitutional right to be exempted from the California Women's Contraception Equity Act. This statute requires health insurance policies that include prescription drug benefits also to include coverage for prescription contraceptives.[9]

The law contains a refusal clause permitting "religious employers" to opt out of covering contraceptives in their employee health benefit plans. "Religious employers" are narrowly defined as those for which:

- **The entity's purpose is to inculcate religious values;**
- **The entity employs primarily persons who share its religious tenets;**
- **The entity serves primarily persons who share its religious tenets; and**
- **The entity is a nonprofit organization under provisions of the federal tax code that grant tax exemptions to churches and certain affiliated entities.[10]**

Catholic Charities conceded that it meets none of these criteria. It does not proselytize; seventy-four percent of its employees are not Catholic; and it serves the public. Nonetheless, Catholic Charities argued that its sincere and deeply held religious beliefs forbid it to "facilitate financially the sin of contraception by employees who use the prescription drug benefit to obtain contraception."[11]

The California Court of Appeal rejected Catholic Charities' constitutional claims. The court found that the contraceptive equity law served the dual, overriding governmental interests of "preserving public health and well-being . . . [and] eliminating gender discrimination."[12] The law contributed to the public health by increasing access to the most reliable forms of contraception, allowing families to space their children and fostering healthier pregnancies. The law redressed gender discrimination by ensuring that women would not continue to spend over sixty percent more out-of-pocket for health care than men, a long-term discrepancy that is attributable at least in part to the exclusion of prescription contraceptives from many health insurance plans.[13]

The court held that "[a] religious exemption from this neutral and generally applied civic obligation is not required by the Free Exercise Clause" of the United States or California Constitutions, neither of which demanded that the law include any refusal clause at all.[14] The legislature was free, however, to accommodate religion by enacting the refusal clause it did "without violating the Establishment Clause's prohibition against government endorsement of religion."[15] Thus, although the Constitution did not compel an exemption for Catholic Charities or any other organization, the refusal clause the legislature had crafted was constitutionally sound.

Catholic Charities has appealed the Court of Appeal's decision to the California Supreme Court, which has agreed to hear the case.

A Framework for Analysis

While constitutional rules neither require nor forbid most refusal clauses, legal principles are useful in constructing a framework for analyzing when an exemption is called for and what it should look like. Based in part on our study of the case law, we have identified two measures for evaluating refusal clauses. We consider first whether granting an exemption would impose burdens on people who do not share and should not bear the brunt of the objector's religious beliefs. Exemptions that impose little or no burden on others are more acceptable; exemptions that impose substantial burdens are less so. We consider next whether the exemption protects the religious practices of pervasively sectarian institutions or instead protects institutions operating in the public sphere. Exemptions that insulate core religious functions are more acceptable than those that spill over into the secular world.

These measures are not part of any currently accepted legal test. They reflect concerns, however, that have been an undercurrent in many relevant cases without necessarily determining the outcome of those cases. Although each measure has independent importance, there is some overlap between the two: the imposition of particular religious beliefs on those who don't share them is less likely within a pervasively sectarian institution performing religious functions than in a more secular setting.

Avoiding Imposition on Others

In the reproductive health context, the risk of imposition on those who do not share the objector's beliefs is especially great when an employer, hospital, health plan, pharmacy, or other corporate entity seeks an exemption. The refusal of such institutions to abide by reproductive health mandates directly affects employees, patients, enrollees, and customers of diverse backgrounds and faiths. The law should not permit an institution's religious strictures to interfere with the public's access to reproductive health care.

The courts have repeatedly shown themselves wary of the imposition of an institution's religious beliefs on others. In the *Catholic Charities* case, for example, the court explained at length why the state was justified in adopting a narrow refusal clause that permitted only pervasively sectarian organizations – such as churches, religious orders, and some parochial schools – to refuse to include contraceptive coverage in health plans for their employees. A broader exemption, granting a right to refuse to Catholic Charities and other church-affiliated organizations that employ diverse workforces, would have meant "imposing the employers' religious beliefs on employees who did not share those beliefs." An expansion of the refusal clause would also have "undermin[ed] the anti-discrimination and public welfare goals of the prescription contraceptive coverage statutes."[16]

Another court expressed similar concerns in *St. Agnes Hospital v. Riddick*.[17] There, a board that oversees graduate medical education had withdrawn accreditation from a Catholic hospital's ob/gyn residency program because of several deficiencies, including the hospital's refusal to provide or otherwise allow its medical residents to obtain clinical training in contraception, sterilization, or abortion procedures. The hospital claimed that the withdrawal of its accreditation amounted to religious discrimination. The court rejected this claim, concluding that the state had

more than sufficient reason to insist on comprehensive medical education despite the hospital's religious objection. These reasons included the public's "overwhelmingly compelling interest in . . . competently trained physicians" and the importance of preventing the hospital from "impos[ing] its Catholic philosophy on its residents, many of whom are not Catholic."[18]

The threat of imposition on others is significantly reduced when the law protects individual – as opposed to institutional – decisions about whether to provide certain health services.

The threat of imposition on others is significantly reduced when the law protects individual – as opposed to institutional – decisions about whether to provide certain health services. A federal law called the Church Amendment (named for Senator Frank Church) contains provisions that shield the conscientious decisions of doctors, nurses, and other practitioners. These provisions serve as a useful model in that they protect both those who refuse to participate in and those who provide certain reproductive health services. The Church Amendment prohibits federally funded institutions from discriminating in employment or training against any health care professional either because the professional refuses to perform or assist in an abortion or sterilization procedure or because the professional does perform or assist in abortion or sterilization procedures in a separate setting.[19]

Such laws offer important protections for health care professionals but may endanger patients unless adequate additional safeguards are included. There should be limits even to an individual health care provider's right to refuse. For example, whatever their religious or moral scruples, doctors and other health professionals should give complete and accurate information and make appropriate referrals. Both legal and ethical principles of informed consent require doctors to tell patients about all treatment options, "including those [the doctor] does not provide or favor, so long as they are supported by respectable medical opinion." Doctors who refuse to treat should also "refer the patient to a physician who does offer or favor the alternative treatment."[20] Nor can religious or moral convictions ever justify endangering a patient's safety. In line with this view, courts have been appropriately intolerant of lapses in medical professionalism, even when they are religiously motivated. For example, a federal court of appeals held that a New Jersey hospital was not liable for religious discrimination in firing a labor and delivery nurse who twice refused on religious grounds to scrub for emergency obstetrical procedures. She refused because she believed that the procedures risked the lives of the fetuses, although in both cases the pregnant women's lives were threatened, and the hospital claimed that the nurse's refusal in the second case caused dangerous delay in treating a hemorrhaging patient.[21]

Insulating the Religious Functions of Pervasively Sectarian Institutions

The second measure we use to evaluate refusal clauses focuses on the nature of the institution and activity exempted. Churches, temples, mosques, seminaries, and other pervasively sectarian institutions engaged in religious practices ought generally to be free of the requirements of laws repugnant to their beliefs. Among health care institutions, Christian Science sanatoria may exemplify those that should qualify for a religious exemption. These sanatoria are staffed by Christian Science healers, and they attend only to those seeking to be healed exclusively through prayer.[22] Such institutions generally conform to the definition set out in the "religious employer" exemption to California's contraceptive equity law, described above.

When, however, religiously affiliated organizations move into secular pursuits – such as providing medical care or social services to the public or running a business – they should no longer be insulated from secular laws. In the public world, they should play by public rules. The vast majority of health care institutions – including those with religious affiliations – serve the general public. They employ a diverse workforce. And they depend on government funds. A recent study found that Medicare and Medicaid accounted for 46% of total revenues to religiously affiliated hospitals in California in 1998, while unrestricted contributions, including charitable donations from church members, accounted for only .0015% (or $15 in every $10,000) of total revenues.[23] These institutions ought to abide by the same standards of care and reproductive health mandates as apply to other health care institutions.

When religiously affiliated organizations move into secular pursuits, they should no longer be insulated from secular laws. In the public world, they should play by public rules.

Again, the courts have recognized the importance of distinguishing the religious from the secular context. In refusing to allow employment discrimination claims by ministers and other clerics against their churches, for example, the courts have concluded that the state should not intrude into matters of church governance and administration because a church's autonomy in these areas is central to its religious mission.[24] The courts have also noted that the employees of churches and comparable religious institutions may be assumed, "based on the religious nature of the employment, [to] agree with or willingly defer their personal choices to the religious tenets espoused by their employer."[25] On the other hand, the courts have acknowledged the appropriateness of preventing entities engaged in secular endeavors from foisting their religious principles on members of the general public.[26]

Conclusion

Our proposed framework balances protection for the public health in general, reproductive health in particular, patient autonomy, and gender equality with protection for individual religious belief and institutional religious worship. We reject the imposition of religious doctrines on those who do not share them, especially at the expense of the public health. At the same time, we seek the maximum possible accommodation of an individual's religious or conscientious objections, so long as no patient is misled or endangered as a result. We also seek to insulate pervasively sectarian institutions from having to comply with laws that interfere with their religious practices.

To strike the proper balance, policymakers and advocates must consider each proposed refusal clause carefully, tailoring it to its context. Concrete examples may be clearer than general principles: every rape survivor ought to be offered emergency contraception to protect herself from getting pregnant as a result of the assault, no matter where she is treated; an administrative assistant working at a Catholic university should not have to pay out-of-pocket for birth control pills because her employer believes contraception is a sin; but a church should not have to purchase contraceptive coverage for its ministers and other clerics; and a doctor, nurse, or pharmacist who cannot in good conscience participate in abortions or contraceptive services should be allowed to opt out, so long as the patient is ensured safe, timely, and financially feasible alternative access to treatment. The factors we have identified for evaluating refusal clauses should lead to these kinds of fair results.

Notes

1 *See, e.g., Roe v. Wade,* 410 U.S. 113 (1973); *Planned Parenthood v. Casey,* 505 U.S. 833 (1992).

2 *Poelker v. Doe,* 432 U.S. 519 (1977); *Harris v. McRae,* 448 U.S. 297 (1980); *Webster v. Reprod. Health Servs.,* 492 U.S. 490 (1989).

3 *Employment Div. v. Smith,* 494 U.S. 872, 877 (1990).

4 *Id.* at 879 (internal quotations omitted) (holding that Oregon could include the sacramental use of peyote within its general criminal drug prohibitions and thus deny unemployment benefits to employees fired for using peyote in religious rituals). In contrast to the federal Constitution, some state constitutions require a religious exemption where compliance with a law would substantially burden religion and an exemption would not undermine compelling state interests. *See, e.g., Minnesota v. Hershberger,* 462 N.W.2d 393 (Minn. 1990).

5 *Smith,* 494 U.S. at 890.

6 *Corp. of the Presiding Bishop v. Amos,* 483 U.S. 327 (1987) (upholding an exemption from Title VII of the Civil Rights Act that permits a wide array of religious organizations to discriminate on the basis of religion in employment decisions as to all employees, including the plaintiff in this case who lost his suit against the Mormon Church, which fired him from his job as a building engineer in a church-run, public, nonprofit gymnasium because he was not in good standing as a Mormon).

7 *Id.* at 338.

8 109 Cal. Rptr. 2d 176 (Ct. App.), *petition for review granted,* 31 P.3d 1271 (Cal. 2001).

9 Cal. Health & Safety Code § 1367.25; Cal. Ins. Code § 10123.196.

10 Cal. Health & Safety Code § 1367.25(b)(1); Cal. Ins. Code § 10123.196(b)(1).

11 109 Cal. Rptr. 2d at 184.

12 *Id.* at 187.

13 *Id.* at 182.

14 *Id.* at 189, 199.

15 *Id.* at 189.

16 *Id.* at 183.

17 748 F. Supp. 319 (D. Md. 1990).

18 *Id.* at 330. The Accreditation Council for Graduate Medical Education (ACGME) has since made clear that ob/gyn residency programs must offer clinical training in contraception and sterilization. In addition, the standards require clinical training in abortion, unless a residency program has a "religious, moral, or legal restriction," in which case the program must nevertheless (1) ensure that residents receive training in how to manage abortion complications; (2) permit residents to receive abortion training elsewhere; and (3) publicize the restriction to all residency applicants. Program Requirements for Residency Education in Obstetrics & Gynecology § V.A.2.d., e. (ACGME, effective Sept. 1999), http://www.acgme.org/req/220pr999.asp. A federal law requires, however, that residency programs be treated as accredited – for licensing, funding, and other governmental purposes – notwithstanding any refusal to offer, refer for, or arrange for abortion training. 42 U.S.C. § 238n.

19 42 U.S.C. § 300a-7(c), (d), (e).

20 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship 76 (1982); *see also* Principles of Medical Ethics of the American Medical Association, Policy E-8.08 Informed Consent (issued 1981), *available at* http:// www.ama-assn.org (using policy finder); American College of Obstetricians & Gynecologists Committee Opinion No. 108, Ethical Dimensions of Informed Consent 7-8 (1992).

21 *Shelton v. Univ. of Med. & Dentistry,* 223 F.3d 220 (3d Cir. 2000); *see also* ACLU Reprod. Freedom Project, Conflicts Between Religious Refusals and Women's Health: How the Courts Respond (2002); *infra* p. 16.

22 One court, however, has held that Christian Science sanatoria are not pervasively sectarian and can receive public funds. *See Children's Healthcare Is a Legal Duty v. Min De Parle,* 212 F.3d 1084 (8th Cir. 2000), *cert. denied,* 121 S. Ct. 1483 (2001).

23 Lois Uttley & Ronnie Pawelko, MergerWatch Project, Educ. Fund of Family Planning Advocates of N.Y.S., No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States 15 (2002).

24 *See, e.g., Gellington v. Christian Methodist Episcopal Church,* 203 F.3d 1299 (11th Cir. 2000).

25 *Catholic Charities,* 109 Cal. Rptr. 2d at 189.

26 *Riddick,* 748 F. Supp. at 330; *Catholic Charities,* 109 Cal. Rptr. 2d at 189.

HEALTH CARE DENIED: THE WOMEN WHO ARE HARMED BY RELIGIOUS REFUSALS

While legislators, advocates, and lawyers debate the policy and constitutional merits of refusal clauses, real women are being denied essential health care. As more hospitals are managed by religious entities and more states adopt broad refusal clauses allowing health care providers to deny treatment on the basis of religious or moral objections, more women are harmed and more physicians find themselves thwarted in their efforts to care for their patients. For example:

- In the emergency rooms of many religiously affiliated hospitals throughout the country, rape victims are neither given nor told about emergency contraception. They are thereby deprived of a drug that could protect them from becoming pregnant as a result of the rape.[1]

- In many religiously affiliated hospitals, women who are scheduled to give birth by cesarean section are told that they can't have their tubes tied at the time of delivery because the procedure violates the hospital's religious principles. Instead, they must risk their health and incur significant extra expenses by having a separate surgery at another hospital after they recover from the cesarean.[2]

- Some religiously affiliated HIV/AIDS prevention programs are forced to stop handing out condoms because the distribution of condoms for any purpose goes against the religious beliefs of their sponsors.[3]

- Some women seeking contraception find that their employers or insurers refuse, based on religious objections, to cover FDA-approved contraceptives in their prescription drug plans, even though the same plans cover other prescription drugs.[4]

- Other women seeking to fill prescriptions for birth control pills and emergency contraception are turned away from their local pharmacies because the pharmacist on duty opposes the use of such pills, and the pharmacy does not require its employees to refer the patient to another pharmacist or pharmacy.[5]

- Low-income women on Medicaid who are enrolled in religiously affiliated managed care organizations are sometimes misled or told nothing about family planning services when they turn to their primary source of medical information and referrals.[6]

- Obstetrics and gynecology residents in some religiously affiliated hospitals are denied clinical training in abortions, sterilization, and contraceptive services because these common medical treatments go against the institutions' religious tenets. These residents go on to practice obstetrics and gynecology even though they lack skills critical to providing comprehesive care to their patients.[7]

Below we describe in detail three situations in which real women, facing serious and even life-threatening medical emergencies, had difficulty receiving the medical care they needed because their health care providers or local hospitals refused treatment based on religious or moral objections. These are just a few examples of the impact that a refusal to treat can have on women's lives.

✦

In the spring of 1994, a nineteen-year-old woman in Nebraska, Sophie Smith,[8] was admitted to the emergency room of a religiously affiliated hospital with a blood clot in her lung. Tests revealed that Smith was approximately ten weeks pregnant, and the clotting problem resulted from a rare and life-threatening condition exacerbated by the pregnancy. The hospital immediately put her on intravenous blood-thinners to eliminate the existing blood clot and to help prevent the formation of more clots that could kill Smith instantly if they lodged in her lungs, heart, or brain.

Smith's doctors told her that she had two alternatives. She could stay in the hospital on intravenous blood-thinners for the remaining six-and-a-half months of the pregnancy. She would also need a procedure in which a doctor would insert into one of her primary veins an umbrella-like device designed to catch blood clots before they reached a vital organ. Or she could have a first-trimester abortion, switch to oral blood-thinners, and be released from the hospital.

Smith decided to have an abortion. She wanted to go home to her two-year-old child. Because she was poor, Medicaid was covering her medical expenses but would pay for an abortion only upon proof that it was necessary to save her life. Four doctors at the hospital certified that Smith needed a lifesaving abortion, and Medicaid agreed to cover it.

On the morning Smith was scheduled to have surgery, however, the hospital's lawyer appeared in the operating room. He announced that the hospital would not permit an abortion – lifesaving or otherwise – to take place on its premises. The procedure was canceled, and Smith was wheeled back to her room.

On the morning Smith was scheduled to have surgery, the hospital's lawyer appeared in the operating room. He announced that the hospital would not permit an abortion – lifesaving or otherwise – to take place on its premises.

Ten days of dangerous delay followed. Smith wanted to be transferred to a facility that would perform the abortion, but moving her increased the risk that she would throw a life-threatening blood clot. Moreover, because the blood-thinners she was taking made her prone to excessive bleeding during surgery, Smith's doctors felt that it was in her best interest to be treated in a hospital. The hospital, however, stood by its decision not to let the abortion take place in its facilities. Notwithstanding the risks, Smith was ultimately transferred by ambulance to her doctor's office. He performed the abortion and sent Smith back to the hospital, which provided follow-up care.

On the morning the hospital's lawyer stopped the abortion, he was armed with a state law that included the following refusal clause: "No hospital, clinic, institution, or other facility in this state shall be . . . required to allow the performance of an abortion therein."[9] Smith's doctor, troubled by the hospital's policy and the grave threat it had posed to his patient's health and life, called the ACLU Reproductive Freedom Project to find out if the hospital was really entitled to rely

on this law in denying his patient lifesaving care. Because Smith ultimately decided not to sue the hospital, no court ever ruled on this question.

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In November of 1995, a woman arrived at a university hospital in New Jersey. Susan Johnson[10] was eighteen weeks pregnant and standing in a pool of blood. An ultrasound revealed that she suffered from a complete placenta previa, a condition that could become fatal to both Johnson and her fetus. In the last forty-eight hours, Johnson had suffered three episodes of heavy vaginal bleeding. Even if the hospital could stabilize Johnson at the time of her visit, her doctors believed that she faced a high risk of suffering another severe and possibly fatal bleeding episode. The attending physician called for an emergency cesarean section.[11]

The labor and delivery nurse on duty, Yvonne Shelton, was asked to "scrub in" so that she could aid in the procedure. Shelton refused, citing her faith, which, in her words, prevented her from "participating 'directly or indirectly in ending a life.'"[12] The hospital scrambled to find another nurse to cover Shelton's shift. According to the hospital, staffing cutbacks had left a limited number of nurses available to step in and relieve Shelton of her duties. The hospital claimed that Shelton's refusal delayed the surgery for a dangerous thirty minutes, jeopardizing Johnson's health and life.

This was not the first time Shelton had refused to assist in an emergency obstetrical procedure. In October of 1994, a pregnant woman, Trisha Williams,[13] had arrived at the hospital with a ruptured membrane, a condition the hospital considered life-threatening. In an effort to save Williams and her fetus, the attending physician decided to induce labor. Fearing that the fetus would not survive the delivery, Shelton asserted a religious objection and refused to carry out her duties as a nurse. At the time of this incident, there were enough nurses assigned to Shelton's shift to allow the hospital to accommodate Shelton's refusal. By the time of the incident involving Susan Johnson, however, the hospital contended that it did not have this option. Instead, it had to find a more permanent solution to address Shelton's refusal to perform some aspects of her job.[14]

The hospital claimed that Shelton's refusal delayed the surgery for a dangerous thirty minutes, jeopardizing Johnson's health and life.

In an attempt to accommodate Shelton's religious beliefs without risking its patients' health and lives, the hospital offered to transfer her to a staff-nurse position in the newborn intensive care unit or to help her identify other available nursing positions in the hospital. When Shelton declined these offers, the hospital fired her.

Shelton later sued the hospital, claiming that she was the victim of religious discrimination. The court ruled against her, holding that the hospital had made reasonable efforts to accommodate her religious beliefs while still fulfilling its duty to "provide treatment in time of emergency."[15]

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When Catholic Medical Center and non-sectarian Elliot Hospital of Manchester, New Hampshire, announced that they were merging in 1994, many critical reproductive health services were suddenly eliminated in this city of more than 100,000. In one instance, the recently merged Elliot refused to allow a physi-

cian to perform an abortion for a teenager who early in her pregnancy discovered that she was carrying a severely deformed fetus. And there were reports that rape survivors being treated at the hospital were neither offered emergency contraception nor referred to other facilities to obtain the drug so that they could protect themselves from becoming pregnant as a result of the assault.[16]

As egregious as these examples are, it was not until May of 1998, when one woman and her doctor went public with their story, that the community really began to fight to restore comprehensive reproductive health services in the region. The woman, Kathleen Hutchins, was working at the drive-thru window at the local Dunkin' Donuts. She was fourteen weeks pregnant when her water broke. Her ob/gyn, Dr. Wayne Goldner, told her that her chances of carrying the pregnancy to term were remote. Even if she stayed in bed for the remaining six months of her pregnancy, the fetus would have only a two percent chance of surviving. Moreover, Hutchins risked getting an infection that could render her infertile or even threaten her life. Goldner and his associates discussed the options with Hutchins; she decided to have an abortion.

Goldner scheduled Hutchins for an emergency abortion at Elliot. The hospital, however, refused to allow the procedure to take place in its facilities.

Goldner scheduled Hutchins for an emergency abortion at Elliot. The hospital, however, refused to allow the procedure to take place in its facilities because doing so would violate the religious tenets of Catholic Medical Center and thereby breach the terms of the merger. As part of the merger, Elliot had adopted a policy that banned all abortions not consistent with Catholic moral doctrine.[17]

Despite Goldner's attempts to get the hospital administration to change its decision, and despite the public outcry that erupted as a result of this case, the administration would not allow the abortion to take place in its facilities.

Hutchins had no choice but to seek the care she needed elsewhere. But the nearest alternative hospital was eighty miles away, and she did not have the means to get there. Goldner's practice ended up paying a taxi $400 to drive Hutchins to the nearest available facility to have the procedure. The solution was far from optimum from the doctor's and the patient's point of view; both wanted her to be treated near home, in familiar surroundings, and by a doctor she knew and trusted.

This incident caused a public-relations nightmare for the merger, one from which it never recovered. A year later, after much public and private wrangling, hospital officials called off the merger. They were unable to resolve the abortion issue, and an investigation by the state attorney general had found that the merger violated the charitable missions of both hospitals. By not addressing from the outset the incompatibility between Elliot's and Catholic Medical Center's reproductive health care policies, the merger had breached the community's trust, the attorney general concluded.[18]

✦

The women in these cases were lucky in the end. All of them survived the risks they faced when hospitals or health professionals refused to treat them. But the risks themselves were unacceptable. Women must have immediate access to emergency health care; religious objections should not be allowed to stand in the way.

Notes

1 *See, e.g,* United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services (hereinafter Catholic Directives), Directive 36 (4th ed. 2001), http://www.nccbuscc.org/bishops/directives.htm; Catholics for a Free Choice, Caution: Catholic Health Restrictions May be Hazardous to Your Health 7-10 (1999); NARAL/NY Found., Preventing Pregnancy After Rape: Does Your Hospital Provide Emergency Contraception to Rape Survivors? (1999); Steven S. Smugar, M.D., Bernadette J. Spina, B.A., & Jon F. Merz, J.D., Ph.D., *Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims,* 90 Am. J. of Pub. Health 1372 (2000); *Caring for Victims of Rape,* Chi. Trib., Apr. 12, 2001, at 22; Rebecca Simons, M.D., Emergency Contraception for Sexual Assault Survivors: A Survey of Hospital Emergency Rooms in Pennsylvania (2000) (unpublished M.P.H. thesis, The Johns Hopkins School of Hygiene and Public Health) (on file with the Clara Bell Duvall Reproductive Freedom Project of the ACLU of Pennsylvania).

2 *See, e.g.,* Catholic Directives, *supra* note 1, Directive 53; Leslie Laurence, *The Hidden Health Threat That Puts Every Woman at Risk,* Redbook, July 2000, at 112, 115; Pam Squyres, *Pro Life, No Choice,* Mother Jones, June 2000, http://www.motherjones.com./news_wire/hospitals.html.

3 *See, e.g.,* Catholic Directives, *supra* note 1, Directive 52; *2 Aids Programs' Work Forcing Them Out of Center,* Orlando Sentinel Trib., Aug. 9, 1992, at A14.

4 *See, e.g., Catholic Charities v. Superior Court,* 109 Cal. Rptr. 2d 176 (Ct. App.), *petition for review granted,* 31 P.2d 1271 (Cal. 2001); Catholic Directives, *supra* note 1, Directive 52; Alan Guttmacher Inst., Issues in Brief: U.S. Policy Can Reduce Cost Barriers to Contraception (2000), http://www.agi-usa.org/pubs/ib_0799.html.

5 *See, e.g.,* Susan A. Cohen, *Objections, Confusion Among Pharmacists Threaten Access to Emergency Contraception,* The Guttmacher Report on Public Policy (Alan Guttmacher Inst., New York, NY) June, 1999, at 1, 1-3; Marie McCullough, *Abortion Debate Spreads to Pharmacy Counter,* Phila. Inquirer, Mar. 28, 1999, Front Page; *Brauer v. K-Mart Corp.,* No. C-1-99-618 (S.D. Ohio Jan. 23, 2001) (order denying summary judgment).

6 *See* 42 U.S.C. § 1396u-2(b)(3)(B); Catholic Directives, *supra* note 1, Directive 52; Miriam Hess & Robert Jaffe, NARAL/NY Found., When Religion Compromises Women's Health Care: A Case Study of a Catholic Managed Care Organization 24-26 (2001).

7 *See, e.g., St. Agnes Hosp. v. Riddick,* 668 F. Supp. 478 (D. Md. 1987); Catholic Directives, *supra* note 1, Directives 45, 52, 53.

8 Sophie Smith is a pseudonym.

9 Neb. Rev. Stat. § 28-237.

10 Susan Johnson is a pseudonym.

11 Ex. B to Def.'s Br. Submitted in Supp. of Def.'s Mot. for Summ. J. at 1-2, *Shelton v. Univ. of Med. & Dentistry,* No. 97-2689, 1999 WL 706160 (D.N.J. June 15, 1999); *see also* ACLU Reprod. Freedom Project, Conflicts Between Religious Refusals and Women's Health Care: How the Courts Respond (2002).

12 *Shelton v. Univ. of Med. & Dentistry,* 223 F.3d 220, 222 (3d Cir. 2000).

13 Trisha Williams is a pseudonym.

14 *Shelton,* 1999 WL 706160, at *1; Ex. G to Pl.'s Br. Submitted in Opp. to Def.'s Mot. for Summ. J. at 110-111.

15 *Shelton,* 223 F.3d at 228.

16 Laurence, *supra* note 2, at 139.

17 *See* Catholic Directives, *supra* note 1, Directive 45.

18 N.H. Att'y Gen. Rep. on Optima Health (Mar. 10, 1998), http://www.state.nh.us/nhdoj/CHARITABLE/optima1.html.

REFUSAL CLAUSES: WHERE THE PUBLIC STANDS

Recent research shows that Americans overwhelmingly oppose allowing health care providers to deny services on the basis of religious or moral objections. Americans want to protect individuals' access to medical care generally, and women's access to reproductive health services in particular.

In the summer of 2001, the ACLU Reproductive Freedom Project – with the help of the public interest polling firm Belden Russonello & Stewart – completed the most comprehensive public opinion research to date on religious objections to providing reproductive health services.[1] This research demonstrates that the public opposes allowing health care institutions, professionals, employers, or insurance companies to interfere with an individual's access to basic reproductive health care. The ACLU's research confirms and expands upon similar research carried out by Catholics for a Free Choice, the Reproductive Health Technologies Project, and the NARAL Foundation. Below is an overview of some of the key findings from this research.

Refusal Clauses Threaten Access to Health Care

According to Catholics for a Free Choice, nearly nine in ten American women believe that access to health care should be a right in this country.[2] Few are aware, however, that access to reproductive health care is threatened by refusal clauses, laws that permit entities and/or individuals to refuse to provide or cover services because of religious or moral objections. For example, none of the participants in the ACLU's focus groups initially knew what refusal clauses or "conscience clauses" were, and of the registered voters polled in NARAL's nationwide survey, only 15% had heard of them.[3]

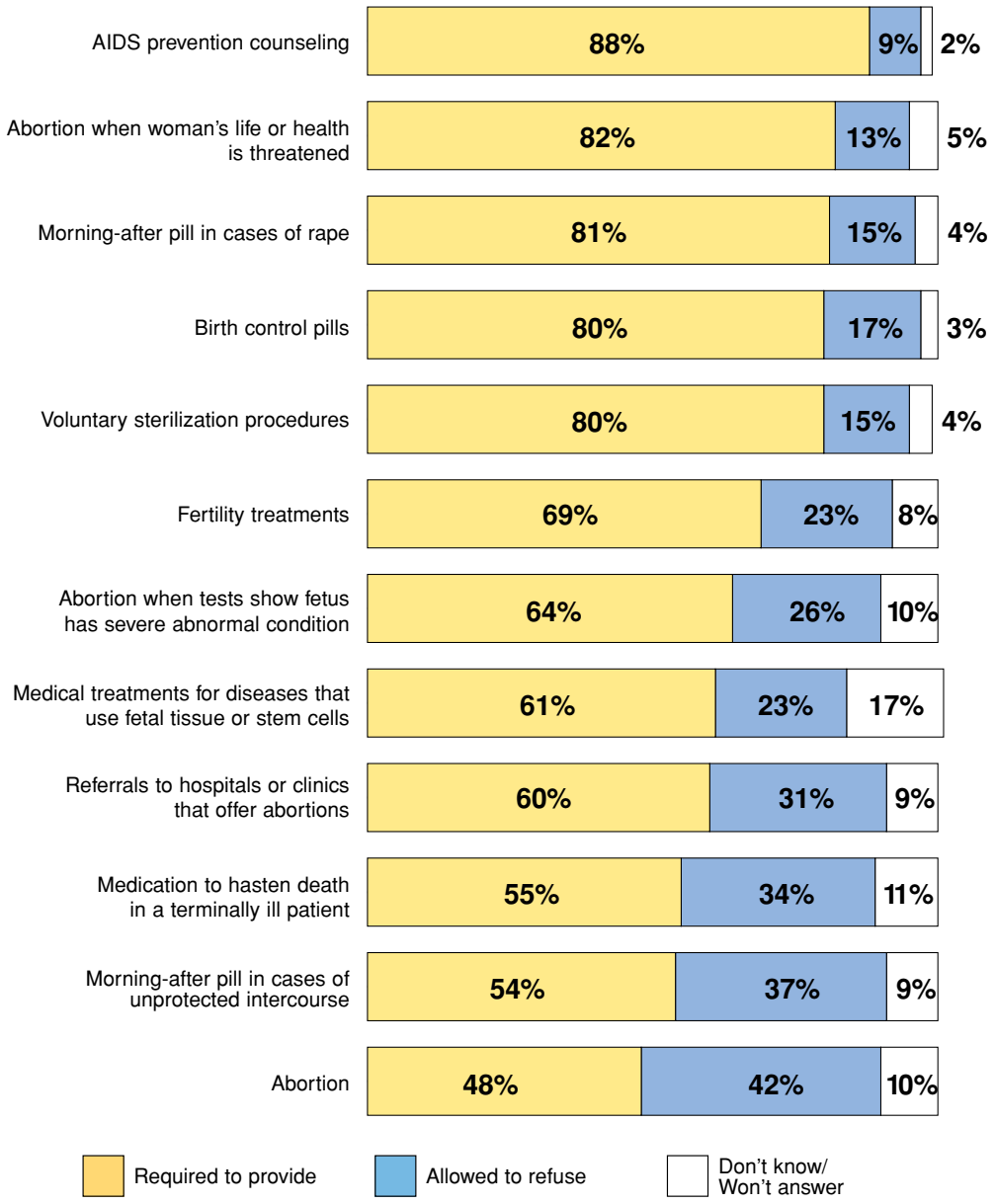
Yet when asked whether they "favor or oppose giving hospitals an exemption from the law allowing them to refuse to provide medical services they object to on religious grounds," 76% of those polled by the ACLU opposed such exemptions. The margins of opposition increased when the public was asked about other kinds of institutions that might claim exemptions.

- 89% opposed "allowing insurance companies to refuse to pay for medical services they object to on religious grounds";
- 88% opposed "allowing pharmacies to refuse to fill prescriptions they object to on religious grounds"; and
- 86% opposed "allowing employers to refuse to provide their employees with health insurance coverage for medical services the employer objects to on religious grounds."[4]

Refusal Clauses Jeopardize Women's Health and Lives

Americans oppose refusal clauses in large part because they fear that, by limiting access to health care, the clauses will jeopardize women's health and lives. Seven in ten Americans, for example, are concerned that if "religiously affiliated hospitals

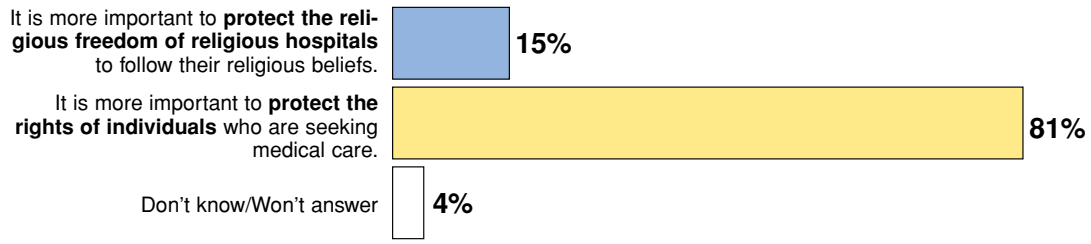
are allowed to limit access to medical services, the health and lives of many women will be threatened." Consistent with this view, the public feels strongly that hospitals should be required to provide many critical reproductive health services. For example, overwhelming majorities believe that, despite religious objections, hospitals should not be allowed to deny "counseling regarding the prevention of AIDS, including information about condom use" (88%); "abortion when a woman's life or health is threatened" (82%); "pills called the 'morning-after pill' to prevent pregnancy resulting from rape" (81%); and birth control pills and voluntary sterilization procedures for men and women (80%). In the public's view, religious objections are not grounds for hospitals to deny patients this care or, as the chart illustrates, a host of other health services.

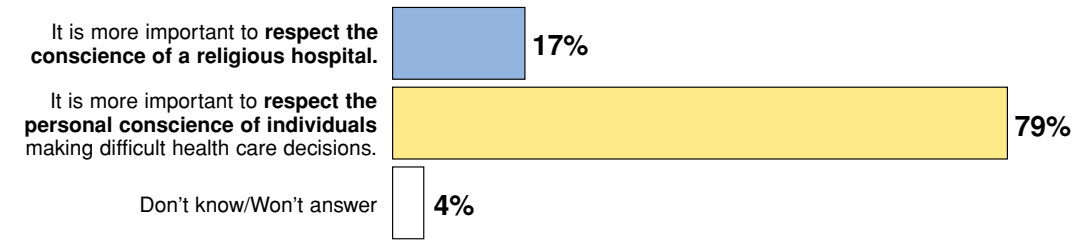


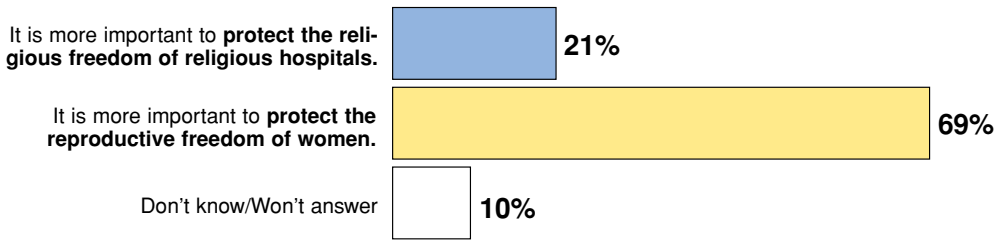
Individuals Must Be Allowed To Make Health Care Decisions for Themselves

While proponents of refusal clauses often cast the issue as one in which religious liberty is pitted against reproductive rights, the public sees this dichotomy as false. Seventy-two percent of those polled agreed with the following statement: "Religious liberty is not threatened by requiring hospitals to provide basic medical care. We are not talking about limiting a person's ability to worship, but access to basic health care." Indeed, the overwhelming majority of Americans do not believe that religiously affiliated health care institutions have any right to come between a woman, her doctor, and the health care she needs. Seventy-nine percent, for example, found the following statement convincing: "Religiously affiliated hospitals should not be allowed to force their religious beliefs on other people."

As the charts below illustrate, even when the issue is presented as a choice between the religious interests of institutions and the health care decisions of individuals, the public overwhelmingly supports protecting an individual's right to make health care decisions and obtain health services.







The Government Must Protect the Public Health

Consistent with their strong interest in ensuring access to health care, Americans firmly believe that the government has an obligation to protect the public health in the face of religious objections. Seventy-two percent of those polled said they were more concerned that the government hold "all hospitals – whether religiously affiliated or not – to the same standards" than they were about keeping "the government from forcing religious hospitals to violate their beliefs." Americans feel even more strongly about this when they understand that most religiously affiliated hospitals receive government funding. Eighty-three percent believe that "if a hospital receives government funds, it should be required to provide basic, legal medical services, regardless of the hospital's religious objections." Similarly, 85% of the women polled by Catholics for a Free Choice agreed that "if a Catholic hospital receives government funds, it should be required to allow doctors working there to provide any legal, medically sound service the doctors believe is needed."[5]

The public is somewhat more willing to accommodate religious beliefs if this can be done without harming patients' health or interfering with their access to health care. For example, Catholics for a Free Choice found that 83% of women are willing to support policies that permit an individual pharmacist to refuse to dispense birth control pills if the pharmacy has an obligation to assign another employee to provide the pills.[6] Without these protections, 83% oppose allowing individual pharmacists to let their personal religious beliefs stand in the way of fulfilling their professional obligations.[7] Likewise, in a poll conducted by the Reproductive Health Technologies Project, 79% of voters in New Jersey and 69% in Oregon said they oppose broad refusal clauses for pharmacists, but opposition to refusal clauses dropped by 19 percentage points in New Jersey and 16 points in Oregon if the legislation also required the pharmacy to have a procedure for ensuring that patients are not denied care.[8] Even with patient protections, however, the majority of voters in both states still oppose refusal clauses.

✦

Public opinion research on refusal clauses shows that Americans are deeply troubled by the idea that religious interests could come between them and their health care needs. They see health care and religious practices as separate and object to allowing health care providers to deny essential care based on religious objections. Overall, the research shows that Americans first and foremost want to preserve access to health care. They believe that denying reproductive health care in the name of religion is wrong: it jeopardizes women's health and lives and goes against the American tradition of religious freedom by forcing religious beliefs on people who do not share them.

Notes

1 In March 2001, Belden Russonello & Stewart (BRS) convened six focus groups: two in Philadelphia; two in San Francisco; and two in New York. Then, in July, BRS conducted phone interviews with 1,001 adults, aged eighteen years and older, residing throughout the United States. The demographic characteristics of the polling sample mirror the latest census figures. The margin of sampling error for the survey is plus or minus 3.1 percentage points at the 95% level of tolerance.

2 Catholics for a Free Choice, Religion, Reproductive Health and Access to Services: A National Survey of Women 4 (conducted by Belden, Russonello & Stewart, 2000).

3 NARAL Found., *Topline, in* Contraceptive Coverage and "Conscience" Clauses: Message Toolkit 2 (2001).

4 Our results mirror findings in the Catholics for a Free Choice poll, in which 83% of those polled said they would oppose legislation allowing pharmacists to refuse to fill prescriptions that they object to on religious or moral grounds, and 79% said they would oppose legislation allowing hospitals to refuse to provide care. Catholics for a Free Choice, *supra* note 2, at 15.

5 *Id.* at 17.

6 *Id.* at 16.

7 *Id.* at 15.

8 Reprod. Health Tech. Project, A Survey Among the General Public and Licensed Pharmacists in New Jersey and Oregon 5, 7 (conducted by Peter D. Hart Research Assocs., 2000).

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