Notes

Ethical Implications of the Conscience Clause on Access to Postpartum Tubal Ligations

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Catholic health care systems in the United States have long limited women's access to reproductive care. Controlled by the Ethical and Religious Directives promulgated from the Church, Catholic hospitals are prohibited from performing abortions or sterilizations. In 1973, Congress codified the "Conscience Clause," legally protecting the individual and institutional right to refuse to perform or participate in abortion or sterilization procedures based on religious or conscience objection.

This Note argues that refusal to perform a postpartum tubal ligation based on the Conscience Clause violates medical best practices. However, in the case of an individual physician, possessing a conscience and direct connection with the patient, it is a permissible violation. An institution is fundamentally unable to form the deliberative process necessary to have a conscience. Therefore, using the Directives as a blanket institutional conscience objection impermissibly violates medical best practices. Finally, this Note proposes that an institutional denial of postpartum tubal ligations may violate the standard of care and be susceptible to a legal attack.

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INTRODUCTION

In 2015, Jessica Mann planned to give birth to her third child at Genesys Regional Medical Center ("Genesys") in Grand Blanc, Michigan, under the care of her OB-GYN of the last sixteen years.[1] Mrs. Mann had a pre-existing medical condition and her doctor recommended a postpartum tubal ligation immediately following her cesarean section because, under the circumstances, any further pregnancies could be life-threatening.[2] Genesys refused to provide the procedure over her doctor's strong objection because of the religious ban on sterilization imposed by Genesys' parent organization, Ascension Health.[3]

This decision forced Mrs. Mann, just weeks before her due date, to choose between giving birth at Genesys with her doctor, who would not be able to perform her tubal ligation immediately after surgery, and finding a different hospital and physician that would allow her to have the procedure immediately following the cesarean section.[4] In its response to Mrs. Mann's request for an explanation, Genesys said the procedure violated its Catholic religious values.[5]

Similarly, Rebecca Chamorro, a resident of Redding, California, was denied access to a postpartum tubal ligation during the scheduled cesarean section of her third child.[6] Ms. Chamorro was a patient of Dignity Health's Mercy Medical Center, the only maternity ward in her city.[7] Together with her husband and her doctor, she decided she would undergo a tubal ligation immediately after her cesarean section delivery.[8] When her doctor sought authorization from the hospital for the procedure, Dignity Health refused her request, citing its "sterilization policy and the Ethical and Religious Directives for Catholic Health Services."[9] The closest facility that took Ms. Chamorro's insurance and would perform the procedure postpartum was seventy miles from her home, effectively forcing her to undergo a second a second procedure weeks after giving birth.[10]

These are just two examples of the significant burdens placed on women trying to exercise their right to reproductive choice in the context of the growing dominance of the Catholic health care system in the United States. All Catholic institutions abide by a set of guidelines issued by the United States Conference

1. *OCR Complaint on Behalf of Jessica Mann*, ACLU 2 (Oct. 25, 2016), https://www.aclu.org/sites/default/files/field_document/section_1557_complaint_on_behalf_of_jessica_mann_and_the_aclu_oct._25_2015.pdf.

2. *Id.*

3. *Id.*

4. *Id.* at 2–3.

5. *See id.* at 11–12.

6. Complaint for Declaratory & Injunctive Relief at 4, Chamorro v. Dignity Health, No. CGC 15-549626 (Cal. Super. Dec. 28, 2015), 2015 WL 9584140 [hereinafter Chamorro Complaint].

7. *Id.* at 8–9.

8. *Id.* at 4.

9. *Id.* at 2 (internal quotation marks omitted).

10. *Id.* at 9.

of Catholic Bishops (USCCB) called the Ethical and Religious Directives for Catholic Health Care Services (the "Directives"), which include, among other things, restrictions on providing abortion, contraception services, and sterilization.[11] As the reach of the Catholic health care system has expanded across the country, absorbing small, secular hospitals and clinics along the way, fewer and fewer women have been left with access to these vital services.[12]

In the face of this threat, this Note reviews the responsibilities of physicians and hospitals to provide reasonable care for their patients in a respectful and medically sound manner, while also allowing space for the physician's individual ethical and moral identities and patient care in Catholic institutions.

Part I of this Note provides the medical, social, and legal background necessary to understand where tubal ligations fit in the broad range of reproductive health care procedures legally available to women. Tubal ligation is a form of permanent contraception through sterilization, which has a complicated and disquieting history. A woman seeking the procedure faces significant procedural, regulatory, and instructional barriers to access based on this legacy.[13]

Part II explores the increasing dominance that Catholic health care systems exercise in the United States and how an amendment to the 1973 omnibus health care funding plan known as the Church Amendment created an additional barrier to abortion and contraceptive care.

Part III discusses the first half of the Church Amendment, known as the "Conscience Clause," which codifies physicians' and hospitals' right to refuse to provide or participate in abortions or sterilization procedures.[14] This Note argues that, while an individual provider's conscientious refusal to participate in these procedures embodies the correct application of the religious objection, the extension of the concept of "conscience" to the whole institution is inappropriate.

Finally, Part IV argues that refusing to perform postpartum tubal ligations based on a conscience objection, whether by an individual or an institution, violates medical best practices for the procedure. This Note proffers that when an individual doctor, capable of reasoned, deliberative thought, reaches a conscience based refusal, this is an ethically *permissible* violation. On the other hand, when an institution, which is *not* capable of such deliberative thought, creates a blanket refusal, the violation is ethically *impermissible.* Such institutional policies impede physicians' ability to provide care and create unacceptable barriers to reproductive health care that should be legally

11. Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 137 (2003).

12. *Id.* at 138.

13. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON ETHICS, OPINION NO. 695, STERILIZATION OF WOMEN: ETHICAL ISSUES AND CONSIDERATIONS 3 (2017) [hereinafter COMM. ON ETHICS].

14. 42 U.S.C. § 300a-7 (2000).

actionable. Though conscience-based exemptions to medical best practices apply to all health care practitioners with respect to specific procedures, this Note focuses solely on physicians. Additionally, any mention of Catholic hospitals includes both the individual hospital entity and the broader Catholic system.

I. BACKGROUND

A. MEDICAL BACKGROUND

Tubal ligation, colloquially known as "getting one's tubes tied," is the preferred birth control method for more than thirty percent of married women of reproductive age in the United States.[15] The process is a form of permanent contraception wherein the fallopian tubes are cut and tied so the ovum cannot reach the uterus for fertilization.[16] If a pregnant woman requests a tubal ligation,[17] the medically ideal time to provide the procedure is during delivery, if performed by cesarean section, or immediately postpartum in the case of a vaginal birth because it presents minimal risk to the new mother and eliminates the need for a second procedure under anesthesia.[18]

According to the American College of Obstetricians and Gynecologists (ACOG), "[t]he immediate postpartum period following vaginal delivery or at the time of cesarean delivery is the ideal time to perform sterilization [tubal ligation] because of technical ease and convenience for the woman and physician."[19] During this time, it is easier for the obstetrician to access the fallopian tubes because the uterus is enlarged and positioned directly below the

15. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, PRACTICE BULLETIN, BENEFITS AND RISKS OF STERILIZATION 1 (2013), [hereinafter PRACTICE BULLETIN NO. 133] (replaced in 2019 by Practice Bulletin 209).

16. 1 Joseph B. Babigumira et al., *Surgery for Family Planning, Abortion, and Postabortion Care, in* DISEASE CONTROL PRIORITIES: ESSENTIAL SURGERY 113 (Haile T. Debas et al. eds., 3d ed. 2015), http://documents.worldbank.org/curated/en/655391468130824512/pdf/953590PUB0978100Box385362B00PUBLIC0.pdf.

17. For simplicity's sake, this Note will refer to a tubal ligation performed during a cesarean section and one immediately following a vaginal birth together as "postpartum" tubal ligations.

18. *See* Martin v. Berthier, 39 So. 3d 774, 784 (La. Ct. App. 2010) (recounting extensive discussion of the standard of care surrounding a bilateral tubal ligation including timing, procedure and informed consent). In relevant portion the court states:

> Dr. Berthier explained that to do it afterwards would require a separate anesthesia and a procedure that was more dangerous. He emphasized that "it is the safest time to perform that procedure if the patient wants it." Dr. Berthier acknowledged that "in strict terms, it was not an emergency that the tubal ligation be done." He explained that "[t]he tubes were tied because Mrs. Martin had requested that that be done. There was no reason not to tie them at that time."

Id.; see also AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, OPINION NO. 530, ACCESS TO POSTPARTUM STERILIZATION 1 (2012) [hereinafter ACOG OPINION NO. 530].

19. ACOG OPINION NO. 530, *supra* note 18, at 1.

abdominal wall.[20] If a woman is unable to receive the postpartum tubal ligation, she must wait six weeks until her uterus and fallopian tubes have returned to normal size and her body has recovered from labor.[21] When the tubal ligation is not performed in conjunction with child birth, it requires a second surgery called an *interval procedure*.[22] The surgery is generally performed using a laparoscope inserted through several small incisions and necessitates the use of an anesthetic,[23] which carries additional risks.[24] ACOG defines a postpartum tubal ligation as an "urgent surgical procedure" because of the relative ease of the procedure following labor versus the difficulties and heightened medical risks of undergoing a second surgery six weeks later.[25]

B. SOCIAL BACKGROUND

In the United States today, tubal ligations are performed alongside of ten percent of all hospital births, and women throughout the country rely on the procedure to plan their families.[26] In fact, of women ages forty to forty-four who use contraception, fifty percent have undergone a sterilization.[27] Sterilization as a contraceptive, however, has a complicated history that is rife with abuse.[28] While some women struggle to obtain the procedure, others, usually low-income women or women of color, have experienced forced sterilization at the hands of their physicians.[29]

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20. *Frequently Asked Questions–Contraception: Postpartum Sterilization*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (May 2016), http://www.acog.org/Patients/FAQs/Postpartum-Sterilization.

21. PRACTICE BULLETIN NO. 133, *supra* note 15, at 2.

22. *Id.* The risks of an abdominal laparoscopic surgery include injury to the bowel, bladder, and major blood vessels. *Id.* at 3.

23. *Minimally Invasive Surgery*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/minimally-invasive-surgery/home/ovc-20256733 (last visited July 27, 2019).

24. *General Anesthesia*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/anesthesia/home/ovc-20163578 (last visited July 27, 2019) (stating that typical risks include nausea, vomiting, dry mouth, sore throat and shivering, however more severe risks include postoperative confusion, pneumonia, or even stroke and heart attack).

25. ACOG OPINION NO. 530, *supra* note 18, at 1.

26. *Id.*

27. Debra B. Stulberg et al., *Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences*, 90 CONTRACEPTION 422, 422 (2014).

28. COMM. ON ETHICS, *supra* note 13, at 3.

29. *Id.* Historically, the courts have also struggled with the concept of compulsory sterilization. For example, in 1927, the Supreme Court upheld a Virginia statute authorizing the mandatory sterilization of intellectually disabled, incarcerated women. Writing for the Court, Justice Holmes argued:

> It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.

Buck v. Bell, 274 U.S. 200, 207 (1927). In 1942, The Court examined an Oklahoma statute authorizing mandatory sterilization for "habitual criminals" or persons convicted for more than two felonies involving "moral turpitude." Without considering whether the law was generally unconstitutional as cruel and unusual punishment or a violation of the due process clause, the Court held that because it treated larceny differently

Throughout the 1970s, gynecologists routinely used a woman's age multiplied by her *parity* (the number of births she had carried to full term) to determine if sterilization was appropriate.[30] If the number was below 120, sterilization was inappropriate.[31] For example, if a twenty-seven-year-old woman had carried two children to term, she would be barred from having a tubal ligation because her "number" equaled only fifty-four. During this same time period, women of color or low socioeconomic status were subjected to state and federal programs designed to limit their fertility.[32] "Between 1909 and 1979, physicians performed more than 60,000 forcible sterilizations in government-organized programs."[33] These drastically divergent experiences created a "stratified" access structure based on race, ethnicity, class, and intellectual ability that greatly impacted the development of health care law in this field.[34]

C. LEGAL BACKGROUND

In the late 1970s, the Department of Health, Education and Welfare (HEW)[35] created Medicaid regulations aimed at protecting low-income women from forced sterilization and other nonconsensual procedures.[36] The regulations restricted sterilization to women over the age of twenty-one and established a mandatory thirty-day waiting period after a woman requests sterilization before she can undergo the procedure.[37] Though HEW may have had benevolent

than embezzlement (fundamentally the same crime), it violated the equal protection clause of the Fourteenth Amendment. Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 536, 538–40 (1942). Thirty years later, the court heard the story of two African American sisters, twelve and fourteen years old respectively, who were involuntarily sterilized by tubal ligation in a federally funded medical clinic. The girls' mother, who was illiterate, signed an "X" on a consent form thinking it was for birth control shots. The Southern Poverty Law Center filed suit on their behalf, ultimately resulting in a ban on federal funding for involuntary sterilization and in the revelation that between 100,000 and 150,000 poor individuals were sterilized annually based on federal funding. *Landmark Case:* Relf v. Weinberger, S. POVERTY LAW CTR., https://www.splcenter.org/seeking-justice/case-docket/relf-v-weinberger (last visited July 27, 2019).

30. COMM. ON ETHICS, *supra* note 13, at 3.

31. *Id.*

32. *Id.*

33. *Id.*

34. *See id.*

35. HEW is now separately the Department of Health and Human Services and the Department of Education. *HHS Historical Highlights*, U.S. DEP'T OF HEALTH & HUMAN SERVS., https://www.hhs.gov/about/historical-highlights/index.html (last visited July 27, 2019) ("The Department of Education Organization Act was signed into law [in 1979], providing for a separate Department of Education. The Department of Health, Education, and Welfare (HEW) became the Department of Health and Human Services (HHS) on May 4, 1980.").

36. COMM. ON ETHICS, *supra* note 13, at 3.

37. *Consent for Sterilization*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Oct. 2012), https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf (explaining that, when requesting a tubal ligation, a woman's physician must explain all risks and benefits of the procedure, and the patient must demonstrate her informed consent before the thirty days begins tolling). Notably, however, the thirty-day waiting period applies only to Medicaid patients; women with private insurance are not required to follow the same consent rules. *See* ACOG OPINION NO. 530, *supra* note 18, at 2.

intentions in regulating sterilization, the regulation created immediate access issues, especially for low-income or at-risk women genuinely seeking sterilization procedures.[38] Subsequent California state laws also attempted to protect women from exploitation, oppression, and coercion, but created similar access barriers.[39]

During this time period the Supreme Court heard and decided two cases regarding the legal protections for contraceptive care. In 1965, in *Griswold v. Connecticut*, the Supreme Court struck down a law prohibiting married couples from using birth control because the law violated their constitutional right to privacy.[40] Seven years later, in *Eisenstadt v. Baird*, the Court confirmed that unmarried people have the same right to access contraception as married couples, concluding that anything different would be a violation of the Equal Protection Clause.[41] Together, these cases confirmed the constitutional right to access contraceptive care free from state interference.[42] Although the Supreme Court has not explicitly discussed tubal ligation, the case law indicates the same protection from state interference should apply to a woman seeking a tubal ligation for contraceptive purposes.[43] However, given the limitations on the extension of the constitutional protection for contraception in case law today, it is speculative to infer any specific protections for tubal ligations or how courts would rule should they face this issue directly.[44]

While I am cognizant of the regulatory and constitutional issues surrounding sterilization, including tubal ligations, they are not the focus of this Note. Moreover, as discussed in Part II, Catholic hospitals and health systems are not considered state actors, despite receiving funding from the federal government. Rather than attacking the constitutional validity of the Conscience Clause, this Note presents a discussion and analysis of *who*, if anyone, *should* be allowed to deny a woman's access to her desired, and legally protected care.

II. THE IMPACT OF CATHOLIC DOCTRINE ON THE UNITED STATES HEALTH

38. *See generally* Melissa Gilliam et al., *A Qualitative Study of Barriers to Postpartum Sterilization and Women's Attitudes Toward Unfulfilled Sterilization Requests*, 77 CONTRACEPTION 44 (2008).

39. *See* CAL. FAM. CODE §§ 6920, 6922 (1994); CAL. CODE REGS. tit. 22, § 70707.1(a)(4) (1981).

40. 381 U.S. 479, 485 (1965). ("Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a 'governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.'" (quoting *NAACP v. Alabama*, 377 U.S. 288, 307 (1964))).

41. 405 U.S. 438, 446–55 (1972).

42. *Id.* at 453. ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.").

43. *See generally* Alex Kandalaft & Maddie Doucet Vicry, *Access to Contraception*, 17 GEO. J. GENDER & L. 55 (2016). The constitutional discussion of contraception is a vast one and well outside the bounds of this Note, but Kandalaft and Vicry's article on access to contraception offers a good starting point.

44. *See, e.g.*, *id.* at 60.

CARE SYSTEM

A. BRIEF HISTORY OF THE CATHOLIC CHURCH IN THE HEALTH CARE SYSTEM

Religious organizations have long been a force in the health care field in this country.[45] The first Catholic hospital in the United States opened more than 150 years ago, led by the Sisters of Mercy.[46] Prior to the second half of the twentieth century, Catholic hospitals generally operated independently of one another without any centralized affiliation.[47] The 1980s saw a surge of Catholic hospital mergers, largely in response to increased pressure from health management organizations for cheaper health care as well as federal and state cuts to Medicare provider payments.[48] In the following decade, and in the face of severe financial pressures, Catholic hospitals began acquiring non-religious institutions. Between 1993 and 2003, 170 non-religious hospitals merged into religious organizations.[49] Specifically, between 1990 and 1998, there were 127 mergers between Catholic and non-Catholic institutions.[50] This flurry of corporate activity did not go unnoticed. In 1994, the United States Conference of Catholic Bishops published instructions for these mergers entitled "Forming New Partnerships with Health Care Organizations and Providers."[51] This promoted additional growth: between 2001 and 2011, the number of Catholic hospitals grew sixteen percent while public hospitals and non-Catholic religious hospitals declined in number.[52]

Today the Catholic Church is one of the largest health care providers in the country, operating 649 hospitals and 1614 continuing care facilities across the country, and providing care for one in six patients receiving medical attention every day.[53] Said another way, the Catholic Church owns, runs, and regulates

45. Lawrence E. Singer, *Does Mission Matter?*, 6 HOUS. J. HEALTH L. & POL'Y 347, 351 (2006).

46. *Id.*

47. *See* Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1093 (1996) (explaining that Catholic hospitals began merging during the 1980s).

48. Alison Manolovici Cody, *Success in New Jersey: Using the Charitable Trust Doctrine to Preserve Women's Reproductive Services When Hospitals Become Catholic*, 57 N.Y.U. ANN. SURVEY AM. L. 323, 326 (2000); *see also* Eisenstadt, *supra* note 11, at 138 (explaining that, in response to financial pressures, Catholic hospitals merged with each other creating "Catholic health care 'mega systems.' . . . [L]eaving smaller, non-sectarian institutions vulnerable to exclusion from the market altogether.").

49. Eisenstadt, *supra* note 11, at 138.

50. Monica Sloboda, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140, 142 (2001).

51. Heather L. Carlson, *Freedom at Risk: The Implications of* City of Boerne v. Flores *on the Merger of Catholic and Non-Catholic Hospitals*, 17 ST. LOUIS U. PUB. L. REV. 157, 159 (1997).

52. Stulberg et al., *supra* note 27, at 423.

53. *U.S. Catholic Health Care: The Nation's Largest Group of Not-for-Profit Health Care Providers*, CATHOLIC HEALTH ASS'N OF THE U.S., https://www.chausa.org/docs/default-source/default-document-library/cha_2017_miniprofile.pdf?sfvrsn=0 (last visited July 27, 2019).

nearly fifteen percent of all hospital beds in the United States.[54] Additionally, six of the ten largest non-profit hospitals are Catholic institutions.[55]

Under canon law, the Catholic Church views its involvement in the health care field as an extension of its ministry, governed by the same ethical, moral, and spiritual principles.[56] All institutions under the moniker of the Catholic Church must have a "sponsor" who is responsible for carrying out the charitable work of the organization.[57] Accordingly, this person typically sits on the board of directors and has authority in making large decisions such as board appointments, spending limits, mergers and acquisitions, or any other changes to the structure of the organization.[58] It is the Church's involvement directing actual medical care rather than its business functions that typically garners the most attention and controversy.

All Catholic health care institutions are governed by the Directives, which are the ethical and religious guidelines that articulate how to run a hospital and care for patients in accordance with the Catholic faith.[59] The goal of the Directives is, first and foremost, to "reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; and, second, to provide authoritative guidance on certain moral issues that face Catholic health care today."[60] The Directives cover a broad range of sensitive topics including the social responsibility of the Catholic religion in health care, the doctor-patient relationship, and patient care issues at the beginning and end of life.[61] For each topic, the Directives provide a theological and moral discussion of the issues and a set of instructions on how to implement that theology in the medical arena, including both hospitals and outpatient facilities.

Particularly germane to this discussion are the instructions related to "Issues in Care for the Beginning of Life."[62] Directive 53, regarding tubal ligation and other sterilization procedures, reads: "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available."[63] Tubal ligations do not fall within this

54. Singer, *supra* note 45, at 351.

55. *Id.*

56. *Id.* at 353.

57. *Id.*

58. *Id.* at 355.

59. *Id.* at 357.

60. *Id* (internal quotation marks omitted) (citation omitted).

61. *See generally* U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

62. *Id.* at 23–28.

63. *Id.* at 27.

exception; the procedure is solely for contraceptive purposes,[64] and Directive 53 therefore effectively prohibits the procedure. While the Directives initially functioned as corporate rules, they became partially codified in 1973 when the Church Amendment was enacted.[65]

B. SENATOR CHURCH'S AMENDMENT AND THE CONSCIENCE CLAUSE

The Directives derive their legal protection from a late amendment to the Health Program's Extension Act of 1973,[66] an omnibus funding bill providing grants and other financial support for healthcare institutions and providers.[67] Named after its sponsor, Senator Frank Church of Idaho,[68] the Church Amendment was a direct response to the Supreme Court's landmark decision in *Roe v. Wade*, which constitutionally protected a woman's right to a first term abortion under her right to privacy.[69] In the wake of *Roe*, numerous congressmen proposed laws and constitutional amendments that sought to limit federal funding for reproductive services and carve out due process rights for unborn fetuses.[70] The Conscience Clause at the beginning of the Church Amendment sought to do so by addressing the religious motivations of the providers themselves.[71]

The Amendment reads in relevant part:

> (b) The receipt of any [federal funding] . . . by any individual or entity does not authorize any court or any public official or other public authority to require –
>
> (1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or
>
> (2) such entity to –
>
> (A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or
>
> (B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the

64. Chamorro Complaint, *supra* note 6, at 6.

65. 42 U.S.C. § 300a-7 (2000).

66. 42 U.S.C.A. § 201 (West 2017) (creating and extending funding for health care providers and related facilities); *see also* Eisenstadt, *supra* note 11, at 144 n.42. One of the major sections of funding was the Hill-Burton Act, 60 Stat. 1040 (1946), which specifically focused on hospital and health care facilities. Established in the wake of World War II to prop up the hospital industry, during the first two decades of the program, over half of the hospitals in the country received Hill-Burton Funding.

67. Eisenstadt, *supra* note 11, at 145.

68. *Id.*

69. 410 U.S. 113 (1973).

70. Eisenstadt, *supra* note 11, at 145–46 (citing Harriet F. Pilpel & Dorothy E. Patton, *Abortion, Conscience and the Constitution: An Examination of Federal Institutional Conscience Clauses*, 6 COLUM. HUM. RTS. L. REV. 279, 280-83 (1975)).

71. *Id.* at 146.

> performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.[72]

This section is commonly referred to as the "Conscience Clause" because it provides for individual and institutional conscience-based refusal to perform, provide, or participate in abortion and sterilization procedures.[73] Senator Church proposed the Conscience Clause specifically in response to *Taylor v. St. Vincent's Hospital*,[74] a Montana case decided just after *Roe* in October 1973.[75] In *Taylor*, the court issued a preliminary injunction requiring the hospital to perform a tubal ligation on Mrs. Taylor over the hospital's religious and moral objections.[76] The court concluded that because the hospital received Hill-Burton federal funding, St. Vincent was functioning as a state actor and therefore had unconstitutionally denied the plaintiff her right to the procedure.[77]

The hospital appealed, using the newly passed Church Amendment to argue that, by granting it federal funding, Congress did not intend to force the hospital to violate its sincerely held beliefs and perform sterilizations or abortions.[78] The district court in Montana agreed and affirmed its preliminary injunction.[79] When *Taylor* reached the Ninth Circuit on appeal, the court adhered

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72. 42 U.S.C. § 300a-7 (2000). Whereas subsection (b) of the statue articulates protections for religiously based refusals, subsection (c) conditions federal funding on two antidiscrimination provisions, stating that these facilities may not discriminate in employment, privileging, or other hospital matters based on an employee's participation in a lawful abortion or sterilization or refusal to perform those services for religious or moral reasons. Subsection (c) states:

> (c) Discrimination prohibition
>
> (1) No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act [], the Community Mental Health Centers Act [], or the Developmental Disabilities Services and Facilities Construction Act [] after June 18, 1973, may—
>
> (A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or
>
> (B) discriminate in the extension of staff or other privileges to any physician or other health care personnel, because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions.

Id.

73. *Id.*

74. 369 F. Supp. 948 (D. Mont. 1973), *aff'd*, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976).

75. 119 CONG. REC. 4252 (1973) (statement of Sen. Church):

> Given the injunction issued by the court against St. Vincent's Hospital in Billings, together with the possible administrative ramifications of the recent Supreme Court decision on abortions, it should be evident that a provision needs to be written into the law to fortify freedom of religion as it relates to the implementation of any and all Federal programs affecting medicine and medical care.

Id.

76. 369 F. Supp. at 949.

77. *Id.* at 950.

78. *Id.*

79. *Id.* at 951.

to the Conscience Clause, removed the injunction, and denied the plaintiff any relief.[80] The Ninth Circuit stated that the Church Amendment "properly permits denominational hospitals to refuse to perform sterilizations."[81] With this ruling the judicial branch affirmed the Amendment's intended interpretation and solidified a legal barrier to the procedure.[82]

In the years following its inception, both federal and state laws have dramatically extended the reach of the Conscience Clause in the United States. Today, the definition of "health care entity," a key phrase in the statute,[83] has expanded from traditional patient care facilities to include "provider-sponsored organization[s], a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."[84] Separately and additionally, Congress granted Medicaid and Medicare-based insurance plans the right to refuse coverage for objectionable procedures.[85] Finally, medical residency programs are protected if they choose not to train their students on abortion or sterilization procedures based on a moral or religious objection.[86]

Nearly all fifty states have adopted a conscience clause of their own to supplement the federal Church Amendment's stance on abortion, contraception, and sterilization.[87] Particularly relevant to this Note, as of July 27, 2019, seventeen states permit physicians to refuse to perform sterilization procedures and twelve states afford that same right to religious institutions.[88]

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80. Taylor v. St. Vincent's Hosp., 523 F.2d at 77; s*ee* Eisenstadt, *supra* note 11, at 147 n.55 (pointing out several cases that the Supreme Court could have used to justify a writ of certiorari). As in Eisenstadt's article, discussions of these decisions are outside the scope of this essay. In a footnote, Eisenstadt wrote:

> The Supreme Court denied cert in [*Taylor*] over the objections of Justice White and the Chief Justice who dissented, arguing that there was a clear conflict between the circuits on this issue. *See* Taylor v. St. Vincent's Hosp., 424 U.S. 948, 949 (1976). While the Seventh, Tenth, and Sixth Circuits all agreed with the *Taylor* decision, *see* Doe v. Bellin Memorial Hosp., 479 F.2d 756 (7th Cir. 1976), Ward v. St. Anthony Hosp., 476 F.2d 671 (10th Cir. 1973), Jackson v. Norton-Children's Hosp., Inc., 487 F.2d 502 (6th Cir. 1973), the Fourth Circuit in *Doe v. Charleston Area Med. Ctr.*, 529 F.2d 638 (4th Cir. 1975), had decided to the contrary.

Eisenstadt, *supra* note 11, at 147 n.55.

81. *Taylor*, 523 F.2d at 77.

82. *See* Eisenstadt, *supra* note 11, at 147.

83. Consolidated Appropriations Act, 2008, Pub. L. No. 110–161, § 508(d), 121 Stat. 1884, 2209 (West 2007) [hereinafter Consolidated Appropriations Act]. The Consolidated Appropriations Act also states that federal funds are not meant to fund abortions, except in cases where the mother's life is in danger. Consolidated Appropriations Act § 507. It also provides further protection against discrimination claims against health care entities that refuse to "provide, pay for, provide coverage of, or refer for abortions." Consolidated Appropriations Act § 508(d)(1).

84. Consolidated Appropriations Act § 508(d)(2).

85. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001(j), 111 Stat. 251, 295 (1997) (codified as amended at 42 U.S.C.A. § 1395w-22(j)(3)(B) (West 2018)).

86. Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104-134, § 515(1), 110 Stat. 1321, 1321–45 (1996) (codified as amended at 42 U.S.C. § 238n (1996)).

87. *See Refusing to Provide Health Services*, GUTTMACHER INST. (Apr. 1, 2019), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

88. *Id.*

Given the aforementioned laws, institutionally held moral or religious values limit a woman's right to access contraceptive care at the medically ideal time.[89] Thus, federal and state conscience clauses present many questions to grapple with. First and foremost, are they constitutional given the right to choose if and when to have children? Are they ethical? And, assuming *arguendo* that conscience clauses are constitutionally and ethically permissible, how do they impact reproductive freedom and patient care?

III. ETHICAL, MORAL, AND LEGAL CONSIDERATIONS OF A CONSCIENCE CLAUSE

A. PHYSICIAN'S CONSCIENCE

The express purpose of the Conscience Clause is to protect practitioners from participating in procedures that the patient requests, and are within the accepted standard of medical care when those procedures conflict with their sincerely held religious and moral beliefs.[90] Essentially, in the medical context, the Conscience Clause allows practitioners to "opt out" of a procedure that the medical community has deemed safe and effective. This type of exception therefore must be viewed with an eye towards its original purpose—to protect the provider's sincere beliefs—and should be rejected if and when the exception no longer achieves this goal.[91]

Webster's Dictionary defines "conscience" as: (1) "the sense or consciousness of the moral goodness or blameworthiness of one's own conduct, intentions, or character together with a feeling of obligation to do right or be good," (2) "conformity to what one considers to be correct, right, or morally good: conscientiousness" and (3) "sensitive regard for fairness or justice."[92] Moreover, the legal definition according to Black's Law Dictionary mimics Webster's, defining conscience as "[t]he moral sense of right or wrong; esp., the moral sense applied to one's own judgement and actions" and "[i]n the law, the moral rule requires justice and honest dealings between people."[93]

89. *See, e.g.*, Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 245 (Cal. Ct. App. 1989) (holding that a Catholic hospital could be liable for medical malpractice when it failed to provide a rape victim with "information concerning and access to" the morning-after pill, if the plaintiff demonstrated such information and access was the standard of care in the medical community); *see also* Hummel v. Reiss, 589 A.2d 1041, 1045 (N.J. Super. Ct. App. Div. 1991), *aff'd*, 608 A.2d 1341 (N.J. 1992) (holding that during a life threatening pregnancy, failure to provide the option to abort the fetus at the facility or inform the patient that an abortion was medically indicated, based on religious objection, violated the standard of care and could be grounds for a malpractice suit).

90. *See Refusing to Provide Health Services*, *supra* note 87.

91. *See* Spencer L. Durland, *The Case Against Institutional Conscience*, 86 NOTRE DAME L. REV. 1655, 1668–69 (2011).

92. *Conscience*, MERRIAM WEBSTER (2019).

93. *Conscience*, BLACK'S LAW DICTIONARY (8th ed. 2004).

The commonality among these definitions is self-inquiry, which focuses on individual awareness and deciding, acting upon, and taking responsibility for one's own beliefs, morals, and actions. According to the renowned bioethicists, Tom Beauchamp and James Childress, conscience is a version of integrity and self-reflection on one's actions.[94]

A person "acts *conscientiously* if he or she is motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right, and exerts an appropriate level of effort to do so."[95] The specific type of integrity enshrined and protected by the Conscience Clause is what Beauchamp and Childress call "personal integrity," which, when expressed as a physician's refusal to participate in a procedure, could create "morally troublesome situations" in which the physician and patient do not agree.[96] The physician may have to compromise her moral commitments or leave the patient without the desired treatment.[97] Beauchamp and Childress argue that, though the difficulty of this type of compromise cannot be completely ameliorated, it can be softened by adherence to "the virtues of patience, humility, and tolerance,"[98] which are at the very heart of the doctor-patient relationship, discussed here and more fully in Subpart IV.A below.

The concept of conscience in a medical sense reflects not only a physician's willingness to perform a procedure as discussed above, but extends to her medical decision making, ethical responsibilities as a physician, and the relationship with her patient.[99] The American Medical Association articulates that relationship as fundamentally "based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest . . . ."[100] Professor of law at Wake Forest University and bioethicist, Mark Hall, defines trust as "the core, defining characteristic of the doctor-patient relationship—the 'glue' that holds the relationship together and makes it possible."[101]

B. PHYSICIAN'S LEGAL DUTY

However, a physician's duty to her patients is not only an ethical responsibility, it is a legal one. In treating a patient, a physician must meet the

94. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 41, 44 (6th ed. 2009).

95. *Id.* at 43.

96. *Id.* at 42–43.

97. *Id.*

98. *Id.* at 43.

99. *See* Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 243 (2002).

100. *Chapter 1: Opinions on Patient-Physician Relationships*, AM. MED. ASS'N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, https://www.ama-assn.org/system/files/2019-01/code-of-medical-ethics-chapter-1_0.pdf (last visited July 27, 2019).

101. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470 (2002).

medical standard of care in any given circumstance.[102] Today, under the modern application of the accepted medical standard of care, the expectation is when a doctor treats a patient, she "takes on an obligation enforceable at law to use minimally sound medical judgment and render minimally competent care."[103] The standard of care for a given procedure is not a fixed medical checklist, rather it changes with the state of technology through time and based on the circumstances of the particular patient.[104] In practice, this means the physician's treatment must be reasonable in light of what other physicians would do in similar circumstances.[105] This means, based on a patient's illness or condition, the physician must follow the accepted methods of treatment and provide any testing, medications, and procedures that the patient's condition demands at the time of treatment.[106] Failure to meet the standard, that is, to provide the appropriate level of care which subsequently results in an injury, could potentially result in malpractice liability. This Note does not argue that conscience refusal to perform a tubal ligation postpartum is automatically a breach of the standard of care; rather this Note argues that failure to perform the procedure at the ideal time is a breach of medical best practices. However, institutional "conscience" limits access to care, under some circumstances articulated below, this could constitute a breach of the legal standard of care.

C. INSTITUTIONAL CONSCIENCE

Institutional conscience as discussed here is the extension of an individual conscience to an organization and the people within it. Here, the Directives serve as "conscience" of the Catholic health care system as a whole. There are two fundamental problems with this assertion. First, the central problem of a hospital, or hospital chain, possessing a "conscience," is the complete lack of the personal relationship to the patient that allows the reasoned compromises discussed above. Extension of the Conscience Clause exemption from an individual moral actor—the physician—to an institution, primarily a hospital or hospital system, is problematic, especially when the exemption becomes a mandate on providers who do not espouse any personal conscientious objection, and may, in fact, believe the institution's position is a failure to provide proper

102. Hall v. Hilbun, 466 So. 2d 856, 871 (Miss. 1985).

103. *Id.* at 866. It is outside the scope of this article to discuss in detail how the doctor-patient relationship is first established, and thus the duty of care attaches, but when treating a woman seeking a tubal ligation, the strong presumption is that the relationship is clearly established.

104. *See id.* at 871. As Judge Spina of the Massachusetts Supreme Court eloquently stated in *Palandjian v. Foster*, "because the standard of care is determined by the care customarily provided by other physicians . . . what the average qualified physician would do in a particular situation *is* the standard of care." 842 N.E.2d 916, 921 (Mass. 2006).

105. *See* Hales v. Pittman, 576 P.2d 493, 498 (Ariz. 1978).

106. *Hall*, 466 So. 2d at 871 ("In the care and treatment of each patient, each physician has a non-delegable duty to render professional services consistent with that objectively ascertained minimally acceptable level of competence he may be expected to apply given the qualifications and level of expertise he holds . . . .").

patient care.[107] In essence, the institutional Conscience Clause exemption allows individuals with no medical training to usurp the doctor's decision making in the course of treating her patients.

Given the definitions of "conscience" discussed earlier, which hinge on self-inquiry and individual awareness,[108] is an institution truly capable of inhabiting the necessary innate human characteristics to activate the exemption? Ryan Meade, professor of Health Care and Policy at Loyola University Chicago School of Law, argues that it is not.[109] Professor Meade takes the classical view of conscience—that conscience is not a thing a person possesses but rather an *act*—specifically, the "application of knowledge to particular facts."[110] A person, capable of both intellectual thought and willful conduct, gathers life experiences, expertise, and moral and ethical convictions to reach an act of conscience in choosing what is right. This is a singularly human process and is therefore misapplied to corporations.[111]

Meade states that the idea that a chief executive officer or a board of directors can exercise the conscience choice for a company is an improper substitution for that of an individual person.[112] Though the board may move a company to take an action, each board member is acting within his or her own moral and ethical codes, and therefore it is not the same as an individual decision because there is disparity between the intellectual processes involved.[113] For Meade, the "key and central feature" of the human person is the individual ability to make choices based on one's personal conscience.[114] Foisting that choice on a *group* of people therefore "endangers the very concept of conscience."[115] Similarly, the mere aggregation and distillation of the morals and beliefs of all the individual members of that institution does not result in an institutional conscience.[116] Even a small company, where each opinion is heard and valued, will ultimately face some decisions that incite disagreement, and one individual or viewpoint will prevail.[117]

In a Catholic hospital, the Directives are equivalent to corporate regulations. The regulations must be followed whether the individual agrees

107. *See* Durland, *supra* note 91, at 1677.

108. *See supra* Subpart III.A.

109. Ryan Meade, *The Natural Person as the Limiting Principle for Conscience: Can a Corporation Have a Conscience if It Doesn't Have an Intellect and Will?*, *in* LAW, RELIGION, AND HEALTH IN THE UNITED STATES 103, 112 (Holly Fernandez Lynch et al. eds., 2017).

110. *Id.* at 106. "Conscience seems to be an act, for it is said to accuse and excuse. But one is not accused or excused unless he is actually considering something. Therefore, conscience is an act." *Id.* at 106 n.11 (quoting Thomas Aquinas, *Questiones Disputate de Veritate*, q. 17, a. 1).

111. *See id.* at 107.

112. *Id.* at 111.

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

117. *See id.*

with them or not. This is very different from a physician's individual decision-making process.[118] Within this structure of misapplied corporate conscience, the Directives take priority over individual conscience. The non-Catholic obstetrician in a Catholic hospital is not free to follow her medical and ethical conscience in the treatment of her patient as she would be without the overlay of religion in the institution. It is also possible that the obstetrician may arrive at the same conclusions mandated by the Directives through her own deliberative acts. The first of these two situations robs a physician of her rightful conscientious choice;[119] the second respects the physician's rights. Beauchamp and Childress argue that the first situation creates deep internal conflict for the physicians, because they can "feel violated by having to abandon their personal commitments to pursue moral objectives created by the conduct of others," [120] in this case, the so-called morals of the Catholic institution. Both of these situations impact a patient's access to a desired and safe procedure, pitting religious objection against the physician's expert opinion as to what is best for her patient based on the widely-accepted understanding that it is safest to perform a sterilization procedure during or just after childbirth.

IV. CONSCIENCE CLAUSES AS APPLIED TO POSTPARTUM TUBAL LIGATIONS VIOLATE MEDICAL BEST PRACTICES

When a pregnant woman requests a postpartum tubal ligation, the medical best practice is to perform the tubal ligation during the cesarean section or immediately following vaginal birth, as the procedure is easiest and safest at this time.[121] Therefore, when an obstetrician refuses to perform a postpartum tubal ligation at the time of delivery, based on her moral or religious beliefs, a tension arises between community practices, the practitioner's beliefs, and the patient's desired care that can be alleviated through the doctor-patient relationship.[122] However, when the decision to refuse care on moral grounds is made at an organizational level, as opposed to by an individual health care provider, it is an incurable violation of medical best practices.

A. PHYSICIAN'S PERMISSIBLE VIOLATION OF MEDICAL BEST PRACTICES

There is a difference between a physician individually refusing to provide treatment to her patient, and the hospital or hospital system's administration automatically doing so. On the individual provider level, the Church Amendment correctly protects the right of refusal because, as a society, we need doctors to engage in the mental and emotional processes that go into making a

118. *See id.* at 107.
119. *See* BEAUCHAMP & CHILDRESS, *supra* note 94, at 42.
120. *Id.*
121. *See supra* text accompanying notes 18–21.
122. *See supra* text accompanying notes 18–21.

conscientious choice on a case-by-case basis. As Beauchamp and Childress indicate, when the physician and the patient are at different moral extremes, there may be no clear middle ground; but because there is a personal relationship, the situation can and should be met with professionalism, patience, humanity, and tolerance.[123] In such a case, a patient could decide to find a new provider whose values are more in line with her own, thus maintaining the patient's autonomy and respecting the wishes of the objecting provider.

Not surprisingly, patience, humanity, and tolerance are the types of characteristics that form the foundation of a meaningful doctor-patient relationship. In a first-of-its-kind study conducted by the Mayo Clinic in 2006, researchers distilled seven ideal physician "behavioral themes" or characteristics that patients valued most in the relationship with their doctor.[124] The findings are summarized in Table 1, below. The seven characteristics were "confident, empathetic, humane, personal, forthright, respectful, and thorough."[125] The study gave each trait a definition and provided representative quotations taken from interviews with patients at the hospital.[126] Especially pertinent here are Bendapudi's definitions of "thorough," "humane," and "personal" as they represent the same concepts Beauchamp and Childress identify as the social mechanisms for making compromise function in a medical setting.[127]

TABLE 1. IDEAL PHYSICIAN BEHAVIORS, DEFINITIONS, AND SUPPORTING QUOTES[128]

Ideal Physician Behaviors	Definitions	Representative Quotations*
Confident	The doctor's assured manner engenders trust. The doctor's confidence gives me confidence.	"You could tell from his attitude that he was very strong, very positive, very confident that he could help me. His confidence made me feel relaxed."
Empathetic	The doctor tries to understand what I am feeling and experiencing, physically and	"One doctor was so thoughtful and kind to my husband during his final days. He also waited to tell me personally when he found a polyp in me, because my

123. *See* BEAUCHAMP & CHILDRESS, *supra* note 94, at 43.

124. Neeli M. Bendapudi et al., *Patients' Perspectives on Ideal Physician Behaviors*, 3 MAYO CLINIC PROC. 338, 339 (2006).

125. *Id.*

126. *Id.*

127. *Id.* at 340.

128. *Id.*

	emotionally, and communicates that understanding to me.	husband died from small bowel cancer and he knew I would be scared."
Humane	The doctor is caring, compassionate, and kind.	"My rheumatologist will sit and explain everything, medication, procedures. I never feel rushed. He is very caring. If I call, he always makes sure they schedule me. He told me he knows when I call, it is important. I appreciate his trust."
Personal	The doctor is interested in me more than just as a patient, interacts with me, and remembers me as an individual.	"He tries to find out not only about patients' health but about their activities and home life as well."
Forthright	The doctor tells me what I need to know in plain language and in a forthright manner.	"They tell it like it is in plain English. They don't give you any Mickey Mouse answers and they don't beat around the bush."
Respectful	The doctor takes my input seriously and works with me.	"She checks on me. She also lets me participate in my care. She asks me when I want tests, what works best for my schedule. She listens to me. She is a wonderful doctor."
Thorough	The doctor is conscientious and persistent.	"My cardiac surgeon explained everything well. The explanation was very thorough. He was very concerned about my recovery after the surgery. I thought it was special how well he looked after me following the surgery. Not all surgeons do that. They are not interested in you after you are done with surgery."

* The quotations in this table are excerpts of longer quotations in the transcripts. Respondents commonly mentioned multiple attributes in describing

their best physician experience. For example, the quotation used to illustrate "humane" also incorporates "respectful" and "thorough" and was coded accordingly.

When an individual physician invokes her rights under the Conscience Clause and refuses to perform a tubal ligation, she *permissibly* violates medical best practices—provided, of course, that she does so based on a sincerely held moral or religious belief. In such cases, the objection is the result of a personal and valuable mental process that we, as a society, need to encourage rather than penalize. The health care industry is an inherently personal one; physicians have intimate relationships with their patients, who are physically and emotionally invested in their physician's decision-making processes.[129] As the Mayo Clinic study demonstrates, it is important to patients that doctors—who know their patients on a personal level—rather than institutions engage in individualized decision-making processes.[130] Thus, laws need to protect a doctor's deliberative process, ensuring that she is able to make her own conscientious choices so she can feel free and able to practice medicine ethically and effectively.

This does not mean, however, that the physician's moral positions automatically take precedence over the patient's rightful claim to self-determination. As Edmund Pellegrino, acclaimed Catholic bioethicist, stated, "[b]oth the physician and the patient as human beings are entitled to respect for their personal autonomy. Neither one is empowered to override the other. The protection of freedom of conscience is owed to both."[131] Within the context of the doctor-patient relationship, discussions of differing religious, moral, and ethical viewpoints can take place, and both doctor and patient can come to a fair and mutually agreed upon care plan that takes into account both parties' individual consciences.

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129. *See id*.

130. Bendapudi and her team offer one final patient quote as a fitting end to their article, which paints a similarly poignant picture here, illustrating why it is important for doctors to be honest and open with their patients. I argue that the Conscience Clause is one way some doctors can accomplish this task. The patient said:

> We want doctors who can empathize and understand our needs as a whole person. We put doctors on a pedestal right next to God, yet we don't want them to act superior, belittle us, or intimidate us. We want to feel that our doctors have incredible knowledge in their field. But every doctor needs to know how to apply their knowledge with wisdom and relate to us as plain folks who are capable of understanding our disease and treatment. It's probably difficult for doctors after many years and thousands of patients to stay optimistic, be realistic, and encourage us. We would like to think that we're not just a tumor, not just a breast, not just a victim. Surely, if they know us, they would love us.

Id. at 343.

131. Pellegrino, *supra* note 99, at 241.

B. INSTITUTION'S IMPERMISSIBLE VIOLATION OF MEDICAL BEST PRACTICES

These conversations are not possible when the concept of conscience is extended to an institution as a whole. In this context, refusing to allow postpartum tubal ligations within a Catholic hospital is a systematic and *impermissible* violation of the best practice for tubal ligations because it is an inappropriate application of the Conscience Clause, which causes substantial downstream consequences. As previously discussed, an institution is unable to make the deliberative, conscientious choice that an individual could because such a process is inherently human.[132] Accordingly, the extension of such protections to institutions is inappropriate.[133]

If, in the current political and legal climate, we *must* find that a hospital or hospital system *can* have a conscience, then it should be on equal footing with that of the individual provider; in other words, one should not take primacy over the other.[134] However, when the two conflict, currently the Catholic institutional "conscience" seems to be winning out.[135] This is a miscarriage of what the Conscience Clause purports to protect and creates ethically troublesome situations for many providers. For example, one physician described her own conflict of conscience between providing care for her patient and abiding by the Catholic rules:

> You know, if you're doing a c-section on somebody that wants a tubal and has had six other previous c-sections and, you know, if I tie her tubes I'm going to get kicked off the staff. And I just don't think that's right, but, you know, instead of benefitting my patients, I benefit myself and don't do the tubal and stay on staff. So that's difficult sometimes.[136]

In situations like these, an institutional conscience created by a third party separated from the practice of medicine overrides and negates the physician's expert medical opinion and prevents her from engaging in the deliberative process of applying her clinical, moral, and ethical knowledge to the situation at hand.[137] In a very real sense, this system values a carte blanche rule over medically-based opinions at the patient's bedside.

The conflict between institutions and physicians is especially clear when the Directives suppress Catholic physicians' expression of their faith. For example, Dr. Willie Parker is a physician and ardent Christian who believes that he is doing "God's work" as an abortion provider in the Southern United

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132. *See supra* text accompanying notes 109–117.

133. However, the Supreme Court, in 2014, held the opposite. In the landmark case, *Burwell v. Hobby Lobby*, the Supreme Court held that closely held corporations are not required to provide contraceptive care to employees because a "corporation is simply a form of organization" that ultimately mirrors the values and beliefs of its owners. 134 S. Ct. 2751, 2768 (2014).

134. Durland, *supra* note 91, at 1680.

135. *Id.*

136. Stulberg et al., *supra* note 27, at 425.

137. *Id.*

States.[138] Dr. Parker did not start his career feeling this way; initially he did not question the tenets of his faith against abortion.[139] However, through his practice as a physician, his life experiences, and the words of Martin Luther King Jr.'s final sermon, Dr. Parker decided it was morally right, responsible, and necessary to help women in need.[140] This is the deliberative and thoughtful process the Conscience Clause should protect because it embodies how we, as a society, need our physicians to behave.

1. Institutional Denial of Postpartum Tubal Ligation as a Standard of Care Violation

In the current corporate and political climate, redefining "conscience" to exclude organizations and reshaping decades of legislation are not likely to change the legal landscape.[141] However, framing the issue as a violation of the standard of care, based on women's lack of access, could make headway. When a religious doctor in a secular hospital refuses to perform a postpartum tubal ligation, the woman has access to other physicians who can and will perform the procedure. However, in a hospital controlled by the Directives, she has no such option. The threat to access increases daily in the face of the ever-expanding system of Catholic health care.[142] For example, on February 1, 2019, Dignity Health and Catholic Health Initiatives finalized their $29 billion merger agreement, creating CommonSpirit Health, a 142 hospital system which will operate in twenty-one states.[143] Concerned that the merger could limit care, California's Department of Justice specifically stipulated that in order to operate its thirty hospitals in the state, CommonSpirit must maintain the current women's healthcare services in all locations for ten years after the deal closed.[144]

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138. Nicholas Kristof, *Meet Dr. Willie Parker, a Southern Christian Abortion Provider*, N.Y. TIMES (May 6, 2017), https://www.nytimes.com/2017/05/06/opinion/sunday/meet-dr-willie-parker-a-southern-christian-abortion-provider.html?_r=0.

139. *Id.*

140. *Id.*; *see also* John H. Richardson, *The Abortion Ministry of Dr. Willie Parker*, ESQUIRE (July 30, 2014), https://www.esquire.com/news-politics/a23771/abortion-ministry-of-dr-willie-parker-0914/.

141. In 2016, the Department of Health and Human Services issued two new rules rolling back the federal requirement that employers must include birth control coverage within their health insurance plans. The new regulations broadened the exemption from religious institutions to any business with a morally based objection to providing birth control. Robert Pear, Rebecca R. Ruiz & Laurie Goodstein, *Trump Administration Rolls Back Birth Control Mandate*, N.Y. TIMES (Oct. 6, 2017), https://www.nytimes.com/2017/10/06/us/politics/trump-contraception-birth-control.html.

142. *See* Alex Kacik, *Catholic Health Initiatives, Dignity Health Combine to Form CommonSpirit Health*, MOD. HEALTHCARE (Feb. 1, 2019), https://www.modernhealthcare.com/article/20190201/NEWS/190209994/catholic-health-initiatives-dignity-health-combine-to-form-commonspirit-health.

143. *Id.*; *see also* Tara Bannow & Alex Kacik, *CHI-Dignity Mega-Merger to Test Co-CEO Model*, MOD. HEALTHCARE (Dec. 9, 2017), https://www.modernhealthcare.com/article/20171209/NEWS/171209851/chi-dignity-mega-merger-to-test-co-ceo-model.

144. Tara Bannow, *California DOJ Greenlights CHI-Dignity Merger, with Conditions*, MOD. HEALTHCARE (Nov. 21, 2018), https://www.modernhealthcare.com/article/20181121/NEWS/181129974/california-doj-greenlights-chi-dignity-merger-with-conditions; *see also* Letter from Xavier Becerra, Attorney General,

The concept that lack of access to secular care could create grounds for legal action is not an entirely new one. Though there is relatively little case law on the matter, the following two cases provide the legal framework for this argument. In the 1989 case *Brownfield v. Daniel Freeman Marina Hospital*,[145] a Los Angeles court stated that a Catholic hospital could be liable for medical malpractice when it failed to provide a rape victim with "information concerning and access to" the morning-after pill, if the plaintiff demonstrated such information and access was the standard of care in the medical community.[146] Similarly, in the pre-*Roe* abortion case *Hummel v. Reiss*, the Court indicated that during a life threatening pregnancy, failure to provide the option to abort the fetus at the facility or inform the patient that an abortion was medically indicated, based on religious objection, violated the standard of care and could be grounds for a malpractice suit.[147]

The fundamental issue in both of these cases is access—in *Brownfield*, access to information and contraception, and in *Hummel*, access to information and a medically indicated procedure. I posit that neither of these situations would have occurred in a secular hospital. If an individual provider objected to the procedure or medication based on his or her conscience, the patient could still have access to the medical standard of care in her moment of need. The violations the courts identified in both cases here are *systematic* and therefore impermissible. Even the Catholic Church itself recognizes there are areas in which doctrine must fold to medicine. In the 1994 edition of the Directives, USCCB conceded that rape victims should be afforded emergency contraception, even within a Catholic institution.[148] In the previous 1971 version of the Directives, the guidance on contraception reads "every action which, either in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an end or as a means to render procreation impossible" is impermissible.[149] In contrast, the

California DOJ, to Rick L. Grossman, Executive Vice President & General Counsel, Dignity Health (Nov. 21 2018), https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/dignity-ag-decision-112118.pdf.

145. 256 Cal. Rptr. 240 (Cal. Ct. App. 1989).

146. *Id.* at 245; s*ee also* Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OR. L. REV. 625, 641–42 (2003).

147. 589 A.2d 1041, 1045 (N.J. Super. Ct. App. Div. 1991), *aff'd*, 608 A.2d 1341 (N.J. 1992). In *Hummel*, the plaintiff, suffering from blood poisoning from a uterine infection had severe complications during labor when she delivered a stillborn fetus and the obstetrician subsequently discovered she was still carrying a second fetus. Her condition worsened, endangering her life, but she was not informed that an abortion was medically indicated. When she delivered the second fetus, it was less than two pounds and severely disabled. Mrs. Hummel's claims were not timely, however, because the case preceded *Roe*, and there was no established doctor-patient relationship between the doctor and the fetus.

148. KEVIN D. O'ROURKE & PHILIP BOYLE, MEDICAL ETHICS: SOURCES OF CATHOLIC TEACHINGS 138 (3d ed. 1999).

149. Catholic Physicians' Guild, *Ethical and Religious Directives for Catholic Health Facilities*, 39 LINACRE QUARTERLY 8, 11 (1972), http://epublications.marquette.edu/cgi/viewcontent.cgi?article=1240&context=lnq.

1994 Directive states that in a case where a woman has been raped or sexually assaulted, "[i]f, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation or fertilization."[150] This small change indicates there is room to attack the Directives and thus, institutional conscience clauses.[151]

Tubal ligations provide an excellent test case: as discussed above, denial of postpartum tubal ligations may result in unnecessary additional surgeries including risks from anesthesia, and therefore could constitute a violation of the standard of care.[152] Tubal ligations also do not come with the emotional and political baggage that clings on so tightly to the abortion discussion. At least here, there is hope for true headway.

CONCLUSION

Conscience is an innate human characteristic that is essential to who we are as individuals. Our consciences help us make *good* choices and engage in society in meaningful ways. The medical profession demands conscientious decision-making and, while the Church Amendment rightfully protects individual physicians' conscientious autonomy by allowing them to refuse to perform medical procedures to which they are morally opposed, it also inhibits physicians' conscientious autonomy by allowing non-physicians to usurp the conscientious decision-making process, requiring them to abstain from performing consensual sterilization procedures.

Conscientious objection to postpartum tubal ligations violates medical best practices, regardless of whether the objector is an individual or an organization. However, the individual provider makes this objection by applying expert knowledge, morals and religious values in real situations involving actual, rather than hypothetical, patients. The institution may reach the same conclusion, but it does so by adhering to bright line rules without conscientious deliberation. Because of this, the Conscience Clause is misapplied to the institution as a whole and creates an incurable barrier to women's health care, impermissibly violates medical best practices, and systemically suppresses the conscientious practice of physicians within Catholic institutions.

The non-litigious solution to both the patient access and physician moral disenfranchisement concerns is to simply enforce uniform application of the Conscience Clause, allowing secular doctors to object to the Directives when their conscience tells them to perform a prohibited procedure in a Catholic

150. O'ROURKE & BOYLE, *supra* note 148, at 138.

151. Though the change from the 1971 Directive on contraception to the 1994 version was not shaped by *Brownfield* alone, I argue that litigation is at least partially responsible for instigating change within the doctrine.

152. Though Directive 53 states sterilization may be performed to alleviate a present and serious pathology, this is not a reasonable situation as tubal ligations are performed for contraceptive purposes only. *See supra* text accompanying note 64.

hospital. Slowly, women like Rebecca Chamorro and Jessica Mann, together with their physicians and lawyers insisting on the application of the medical standard, should build on legal precedent and chip away at Catholic health care's systematic denial of women's reproductive rights.

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