When Physicians Perform Abortions Outside the Catholic Hospital

BY PETER LEIBOLD, JD, & CHARLES S. GILHAM, JD, LLM

The *Ethical and Religious Directives for Catholic Health Care Services* state that "[a]bortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted . . . . Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation."[1] This language makes it crystal clear that Catholic healthcare facilities are not to allow abortion procedures to be done within their walls.

The CHA legal department fields several inquiries each month regarding a related, albeit much more difficult, issue: Is a hospital legally permitted either to refuse admitting privileges to a physician or terminate the privileges of a staff physician who is engaged in abortion activities *outside* the hospital's facilities? The issue is highly charged and has been relevant for Catholic healthcare providers since the 1973 *Roe v. Wade* decision.

Federal statutory law is clear[2]: Catholic healthcare providers may not discriminate against physicians who perform abortions outside the Catholic healthcare facility. Although the law in this area has been stable over the past several years, neither its clarity nor the passage of time has diminished the deep concern held by many regarding the inability of Catholic hospitals to refuse privileges for physicians performing abortions elsewhere.[3] Because of this depth of feeling and the law's apparent clarity, we thought it important to explain our understanding of the legal requirements on Catholic hospitals in this area.

Mr. Leibold is general counsel and Mr. Gilham is associate general counsel, Catholic Health Association, St. Louis.

Federal Conscience Protection

In 1973 a Montana district court issued an injunction against a Catholic hospital precluding it from refusing to allow a sterilization procedure to be performed in its facility. In *Taylor v. St. Vincent's Hospital*,[4] a couple successfully challenged the refusal of St. Vincent's Hospital to perform a tubal ligation on Ms. Taylor immediately after she gave birth at the hospital.

In direct response to *Taylor*, Sen. Frank Church, D-ID, introduced the Church amendment of the Health Programs Extension Act of 1973.[5] On enactment in 1973, the measure protected facilities that received federal funds and their staffs from being forced to provide sterilization and abortion services in violation of their religious or moral beliefs. In 1974 Congress expanded the measure to prohibit entities that participate in programs funded by the Department of Health and Human Services or receive grants from HHS for biomedical or behavioral research from discriminating against physicians and healthcare personnel who perform or refuse to perform abortions or sterilizations.[6]

Congress expanded the Health Programs Extension Act again in 1979 to prohibit healthcare entities receiving federal money under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act from discriminating against an applicant for training or study (including internships and residencies) because of the applicant's willingness or refusal to counsel, assist, or participate in abortions or sterilizations.[7]

Thus, the measure protects healthcare facilities and the healthcare professionals who staff the facilities from participating in procedures that violate their religious beliefs or moral convictions. However, as is obvious from the wording of the amendments added in 1974 and 1979, this protection is two-sided and can be used as a shield to protect Catholic healthcare or as a sword against it.

Healthcare facilities that receive federal money under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act cannot be required to make their facilities available for sterilization or abortion procedures that are contrary to their religious beliefs or moral convictions.[8] Although a facility need not allow the performance of abor-

tions or sterilizations on its premises, it may not discriminate either *in favor of* or *against* a physician or other healthcare provider because of the individual's views on activities related to sterilization and abortion outside the facility.[9]

With respect to individuals, the Health Programs Extension Act prohibits discrimination in the employment or promotion of, or extension of staff privileges to, any physician or other healthcare personnel because he or she "performed or assisted [or *refused* to perform or assist] in the performance of a lawful sterilization procedure or abortion."[10] Other sections of the measure provide additional protections for individuals participating in research, training, or study who object to (or choose to participate in) procedures contrary to or consistent with their religious beliefs or moral convictions.[11] These provisions have the ameliorative effect of protecting physicians and other healthcare personnel at non-Catholic hospitals who refuse to perform or assist in the performance of a sterilization or abortion procedure in violation of their religious beliefs or moral convictions (the shield). However, they also protect a physician who abides by Catholic teaching within a Catholic hospital but refuses to abide by those directives when practicing medicine at non-Catholic facilities (the sword).

Interpretation of the Federal Conscience Clause

The Church amendment clearly permits a Catholic hospital receiving federal funds to prohibit physicians and other healthcare professionals from performing abortion or sterilization procedures on the hospital premises. However, the clear meaning of the Church amendment (as amended) limits a Catholic hospital's ability to respond to a staff physician performing abortions *outside* the facility.

Because of the dearth of case law interpreting the Church amendment, the most frequently cited legal authority is a 1975 case, *Watkins v. Mercy Medical Center*.[12] In *Watkins*, Mercy Medical Center, a Catholic hospital, failed to renew a staff physician's privileges because he refused to agree to abide by the *Directives*, which was required by the hospital as part of its application for staff privileges. Watkins sought injunctive relief, demanding reinstatement of his privileges in addition to compensatory damages of $100,000. Watkins alleged that the hospital's adherence to the *Directives* denied him his own religious beliefs as well as his right to practice medicine without due process of law.

The district court of Idaho ruled that for Watkins to succeed on his First Amendment free exercise of religion claim and his Fourteenth Amendment due process claim, he would have to show that his denial of reinstatement involved some significant state action. The court concluded, correctly in our view, that the receipt of Hill-Burton funds and the hospital's tax-exempt status did not transform the hospital into a state actor.

The most frequently cited legal authority is a 1975 case, Watkins v. Mercy Medical Center.

The court reasoned further that even if the Catholic hospital had been acting under color of state law, federal statutes, specifically the Church amendment, permitted Mercy Medical Center to adhere to its own religious beliefs. In short, a religious hospital could not be forced to make its facilities available for procedures repugnant to its beliefs. However, in dicta, the court stated that Watkins was free to perform sterilization and abortion procedures outside Mercy Medical Center.

The district court denied Watkins's demand for both a preliminary and permanent injunction but ordered his staff privileges reinstated on the condition that he not perform abortions or sterilizations contrary to hospital rules. The Ninth Circuit upheld the district court's ruling that no state action was involved.[13] It also upheld the court's requirement that Watkins be reinstated as long as he did not perform the procedures in question at the hospital.

The *Watkins* decisions seem consistent with a straightforward reading of the Church amendment. Mercy Medical was protected because it was not required to allow procedures in violation of the *Directives* to be performed on its premises. However, Watkins was also protected because Mercy Medical could not continue to deny him staff privileges on the basis that he performed prohibited procedures elsewhere.

Difficulties for Catholic Facilities

This seemingly well-settled area of the law causes a potential problem for Catholic facilities. Directive 45 states that "Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers." Scandal has been defined as "a sinful or seemingly sinful word, action or omission which tends to incite or tempt another to sin."[14]

Consequently, an abortion provider may be so notorious and outspoken concerning his or her abortion practice that association with the provider through a staff appointment could cause scandal. For example, a physician may invest in abortion clinics in the area of a Catholic hospital and advertise their services, be an outspoken advocate of abortion rights, or politically lobby for greater access to abortion-related procedures. Having such a physician on staff at a Catholic hospital certainly creates the danger of scandal,

LAW

Continued from page 13

even though no abortion procedures are being performed on the premises of the hospital. However, a Catholic facility faced with this type of situation must tread carefully before considering termination of the physician's staff privileges in order not to give the physician a viable, federal cause of action.

If the individual is so notorious in the community that his or her activities give rise to scandal, as that term is used in the *Directives,* then perhaps the healthcare provider can argue that its constitutional right to the free exercise of religion supersedes the statutory protection provided to the physician. However, winning this kind of case would be extremely difficult, time-consuming, and expensive. Close scrutiny of the facts of the situation by counsel is strongly encouraged to minimize the negative legal ramifications of any decision. □

NOTES

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services.* U.S. Catholic Conference, Washington, DC, 1995, Directive 45.
2. Statutory law is distinquished from constitutional analysis. See note 3, below, and the article's final paragraph.
3. See Rice, Charles E., "Catholic Hospitals and Abortionists," *The Wanderer,* January 8, 1998, arguing that Catholic hospitals should challenge the constitutionality of laws that require them not to discriminate against a physician based on the physician's performance of abortions.
4. 369 F. Supp. 948 (D. Mont. 1973).
5. 42 U.S.C. 300a-7.
6. 42 U.S.C. 300a-7(c)(2).
7. 42 U.S.C. 300a-7(e).
8. 42 U.S.C. 300a-7(b).
9. 42 U.S.C. 300a-7(c).
10. 42 U.S.C. 300a-7(c) (italics added).
11. 42 U.S.C. 300a-7(d)(e).
12. 364 F. Supp. 799 (D. C. Idaho 1973), *aff'd* 529 F.2d 894 (9th Cir. 1975).
13. *Watkins v. Mercy Medical Center,* 520 F.2d 894 (9th Cir. 1975).
14. Edwin F. Healy, *Moral Guidance,* Loyola University Press, Chicago, 1960, p. 112.

ADVOCACY AGENDA

Continued from page 11

fundamental question is whether there should be broad federal legislation governing managed care or whether states alone should retain this authority. CHA, along with other provider-based advocacy groups, took a leadership role on managed care legislation by issuing "Principles for Accountable Managed Care" in 1997. In consultation with Catholic providers and health plans, we are now reviewing several legislative proposals on managed care and determining what provisions to support or oppose.

Last year's Balanced Budget Act enacted major changes in Medicare's managed care program, establishing Medicare+Choice, which includes a new option for provider-sponsored organizations (PSOs). In April, HCFA will publish rules for PSOs and in June will roll out Medicare+Choice contracting standards. CHA has assisted HCFA in developing solvency and other requirements for PSOs, with a focus on assuring opportunities for Catholic and other not-for-profit healthcare organizations.

The Balanced Budget Act also revised Medicare payments to managed care plans. It reduced geographic inequity and required that funds for graduate medical education be paid directly to the hospitals. CHA supported these changes but more needs to be done to ensure fairness. CHA will support legislative efforts to channel disproportionate-share hospital funds directly to hospitals and to further reduce the variation in Medicare managed care payments across geographic areas.

CHA will also seek to scale back the Balanced Budget Act's Medicare "transfer" provisions, which expanded the definition of "transfers" to include patients sent from hospitals to a rehabilitation facility, skilled nursing facility, or home health agency. The transfer provision is estimated to cost hospitals $1.3 billion over the next four years.

Successful coordinated care increasingly relies on adequate long-term care. CHA will focus its long-term care advocacy on the following:

- HCFA rules on managed care that account for the unique needs of "dual eligibles," that is, persons eligible for both Medicare and Medicaid
- A Chronic Care Act to establish a national chronic care policy and streamline Medicare and Medicaid requirements for care of chronically ill persons
- Senior housing as part of the continuum of care

Congress and the president will continue to compete to see who is tougher on healthcare fraud and abuse. CHA provided input to the Health and Human Services department's Inspector General for the development of the Model Corporate Compliance Program for hospitals, and we will strongly encourage Catholic hospitals to adopt compliance measures. At the same time, CHA will support legislative and regulatory efforts to prohibit inappropriate use of the False Claims Act by the federal government.

Theme 4: Healthcare is a public good that is best delivered in a not-for-profit setting. *CHA will support measures that strengthen not-for-profit healthcare and enhance its mission to provide high-quality care and serve the community's needs.* Over the past few years, many states have more closely scrutinized the distinction between for-profit and not-for-profit organizations. Therefore it is imperative that Catholic healthcare providers be able to clearly justify their not-for-profit, tax-exempt status. CHA will continue to promote the significance of the community benefits not-for-profits provide and will serve as a clearinghouse for Catholic organizations' community benefits policies. We will use this information for advocacy on behalf of the Catholic healthcare ministry at both state and federal levels. We will also pursue clarification of federal policy on tax-exempt bonds and tax questions regarding integrated delivery networks. □