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POLICY FORUM

Institutional Conscience and Access to Services: Can We Have Both?

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It appears, at times, that health care and religion do not mix. Consider the sterilization and contraception coverage mandate under the Patient Protection and Affordable Care Act. The mandate requires nearly all employers and health insurers to cover as "essential health care services" certain sterilization procedures and contraceptives, including emergency contraceptives [1]. Members of the Catholic, evangelical Christian, Mennonite, and Muslim faith communities [2] say that the mandate places them "in the untenable position of having to choose between violating the law and violating their consciences" [3].

The Obama administration made a series of attempts to meet this objection. Speaking for the White House, Domestic Policy Director Cecilia Munoz emphasized the administration's commitment to "both respecting religious beliefs and increasing access to important preventive services" [4]. The administration promised to delay enforcement of the mandate until at least August 1, 2013 [5-7], but critics dismissed the concession as "kicking the can down the road" [8]. The administration then proffered its controversial accommodation requiring insurers rather than objecting employers "to reach out and offer the woman contraceptive care free of charge without co-pays, without hassle" [9]. Objectors also found this accommodation "unacceptable," saying it hides a "grave violation" of religious liberty behind a "cheap accounting trick" [10].

The Obama administration followed through on its offer to accommodate objectors with proposed regulations that provide enrollees contraceptive coverage with no copays and reimburse insurers for costs of contraceptive coverage through credits on fees the insurers owe the government [11]; objectors covered by the regulation would not have to pay for the objected service or notify enrollees of it [11]. These proposed changes did not satisfy religious objectors, who still oppose the mandate [12, 13].

Objecting religious organizations—representing a host of faith groups [14]—have filed dozens of lawsuits opposing the mandate on religious liberty grounds [15]. These suits are slowly working their way through the courts [15]. On November 26, 2012, the U.S. Supreme Court directed a federal court of appeals to reconsider its decision in one lawsuit over the mandate in light of the Supreme Court's June 2012 decision upholding the constitutionality of portions of the federal health care reform law [16].

The collisions between faith and the demands of medical practice take a number of forms. They are often most in tension when institutions assert conscience objections. Nonetheless, policy makers have a number of options that allow them to respect moral and religious objections while preserving access to needed medical services.

Burgeoning Collisions between Conscience and Medical Access

Reaction to this mandate is not the only collision that religious objectors identify between the demands of faith and the need for services. More than a dozen nurses from two institutions filed suit after being punished, they say, for refusing on religious grounds to assist with or train for abortions—a procedure the nurses see as ending a life [17-19]. The nurses alleged that they were threatened with professional discipline and termination if they did not assist with the contested service despite federal conscience protections in place since *Roe v. Wade* [17, 20, 21]. In both suits, the nurses ultimately received the protection they were promised under federal and state laws [17-19]. Like these nurses, both facilities and individuals have strenuously opposed duties to dispense emergency contraceptives that objectors believe are "abortion-inducing drugs" [22, 23].

Religious objections are hardly limited to contraceptives and abortion, however. Clinicians have objected to an expanding number of practices, ranging from circumcising babies to participating in physician-assisted suicide and providing assisted reproduction services [24]. In any of these contexts, two very different parties may be asserting the need for accommodation of their religious beliefs: individual clinicians *and* health care institutions.

Institutions Have a Conscience

Abortion conscience clauses, dating back to *Roe v. Wade* [21] in 1973, have always insulated both individuals and institutions. While it is easy to understand how an individual may hold a religious or moral belief that can be in tension with the demands of the law, some find it difficult to fathom how an *institution* can have a moral conscience or "belief." Some commentators argue that "[a] vibrant liberty of conscience requires morally distinct institutions, not just morally autonomous individuals," and that, therefore, the state should recognize that institutions also have a conscience claim [25].

In two recent decisions, the U.S. Supreme Court has extended protections normally associated with individuals, like free speech and free exercise of religion, to institutions [26, 27]. In *Hosanna Tabor Evangelical Lutheran Church and School v. EEOC,* for example, the U.S. Supreme Court concluded that "the Free Exercise Clause...protects a religious group's right to shape its own faith and mission through its appointment" of ministers [27]. It noted that "[a]pplying the protection of the First Amendment to roles of religious leadership, worship, ritual, and expression focuses on the objective functions that are important for the autonomy of any religious group, regardless of its beliefs" [28]. Although these decisions are controversial, they show a great respect for institutions' rights and interests.

While protections for individuals and institutions both receive support in the law, protecting each requires markedly different tradeoffs by policy makers, as we explain next.

Balancing Conscience Protections with Access

When deciding to accommodate a conscience-based objection to providing a service that is legally available, legislators and agencies have to balance at least two equally compelling values: respect for conscience and access to needed services. Some assert a third value, patient choice. Patients only have a meaningful choice, patient-choice advocates say, when institutions can choose not to provide a specific contested service. Just think of the patient who seeks a clinician with common values—for instance a pro-life reproductive specialist [29]. While policy makers may want to foster diversity among clinicians, institutional providers who cannot—consistent with their faith commitments—provide services pose a special challenge because institutions control large swaths of the market. As we argue below, respect for conscience should never allow a provider to be in a "blocking position," which is far more likely to be the case with a large regional hospital than with an individual specialist.

An absolute, unfettered right to refuse to provide a contested service could significantly threaten the public's ability to receive services—especially if few or no others were willing to perform it [30, 31]. An unqualified institutional accommodation will almost always wipe out access for huge numbers of people because institutions serve huge numbers of people. Precisely because Catholic hospitals across the country account for 17 percent for all hospital admissions [32], many are rightly concerned when Catholic hospitals receive protection against dispensing emergency contraceptives [33]. Compounding this, many hospitals seeking religious protections possess monopoly power in their relevant communities. Indeed, Catholic hospitals are the sole hospital in 91 counties in the U.S. [34], a number that will surely grow as Catholic hospitals continue to acquire and merge with non-Catholic health systems [35].

Given all of these facts, one might believe that legislators would be loath to give institutional protections rather than individual conscience protections. Yet institutional accommodations may be easier to secure than individual accommodations because hospitals are powerful organizations that can lobby for their interests. Moreover, the market power that raises the specter of reduced access also favors the granting of institutional protections. Why? Many religious leaders have said they will close their institutions before violating their religious commitments. On the heels of the mandate, for instance, Cardinal Francis George, the Archbishop of Chicago noted that the Archdiocese's directory of holdings contains "a complete list of Catholic hospitals and health care institutions in Cook and Lake counties," and ominously warned, "two Lents from now, unless something changes, that page will be blank" [36].

Policy makers should take seriously institutions' threats of closing, which elsewhere we have described as the "nuclear option" [23]. In other contexts, religious objectors have acted on their promises to close. For example, Catholic Charities of Boston closed its adoption services after 103 years of placing kids for adoption when an exception to rules requiring them to place children with same-sex couples was not forthcoming [37, 38]. In Washington, D.C., Catholic Charities discontinued insurance coverage for spouses of new employees when faced with laws that would require them to cover spouses in same-sex marriages in violation of their religious beliefs [39]. Objectors are taking the nuclear option elsewhere, too [40-42].

Of course, threats of closure should not be the end of the analysis. Legislators and regulatory bodies would be wise to consider a range of factors when evaluating claims for an accommodation, including the existing market share, market concentration, the scarcity of other providers, the likelihood that the owner would sell a facility rather than shutter it, the likelihood of the government's or a private buyer's acquiring the facility in advance of any shut-down, how long any transition would take, and how likely it might be that the objector would bend to civil strictures rather than exit the market [43]. With Catholic-affiliated hospitals accounting for so many inpatient admissions nationally [44], and with many markets served exclusively by a sole Catholic-affiliated hospital [34, 35], policy makers may well be unwilling to engage in a high-stakes game of chicken [23].

Creative Methods for Balancing Access and Respect for Conscience

Importantly, most difficulties patients experience in getting a controversial health care service are not real access issues, as in "No accessible person or institution will perform an abortion (or other procedure) for me" [31]. Instead, they are information problems—in other words, the patient has no idea how to find the person who is willing to provide the abortion or other procedure for her. Such information problems pose a more significant hurdle for lower-income patients [45].

Many states have responded to precisely this kind of knowledge gap about access to controversial services through formal and informal "information networks." For example, Oregon and Washington give an unqualified right to refuse to participate in physician-assisted suicide to pharmacists, physicians, and hospitals that are religiously opposed to facilitating it. State policy makers did not stop there, however. They ensure patient access with lists of willing providers on the Internet, through hospice organizations and other information networks [46, 47]. Such information networks allow the patient seeking the service to get it without great dislocation, while allowing unwilling providers to live by their convictions [48].

A Qualified Right to Object

More fundamentally, policy makers can accommodate most religious objections while preserving access to needed services by giving a qualified right to object. In this scheme, religious objectors are permitted to step aside from a service they find morally or religiously objectionable when doing so would not cause hardship to patients—typically when another willing physician or institution can just as easily

provide the service. Federal conscience protection need not jeopardize patient access to abortions because an extensive network of abortion providers exists across the United States [31]. Qualifying conscience protections with hardship-minimizing requirements would prevent institutions with religious objections from acting as a choke point on the path to services. Instead it would require the institution to inform patients about where to obtain the service. For institutions, this may require advance research about where to refer patients so that medically necessary services are made available to all patients who need them. This scheme not only accommodates religious objections, but it promotes access to the necessary service, solving the informational problems that patients frequently face. A duty to refer respects institutions that say such interventions are contrary to their mission. While a religious objector may claim that providing information about an objectionable service facilitates the objectionable service, information in medicine is so central to patient care that the duty to provide accurate information should be nonnegotiable [49]. A Catholic hospital seeking to open in a rural community can abide by its conscience and ensure patient access by joining forces with another clinic that provides the objected-to services. A little creativity and planning can go a long way in respecting religious and moral objections *and* the legitimate needs of the public for services.

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