

BEARING FAITH

The Limits of Catholic
Health Care for
Women of Color

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BEARING FAITH

THE LIMITS OF CATHOLIC HEALTH CARE FOR WOMEN OF COLOR

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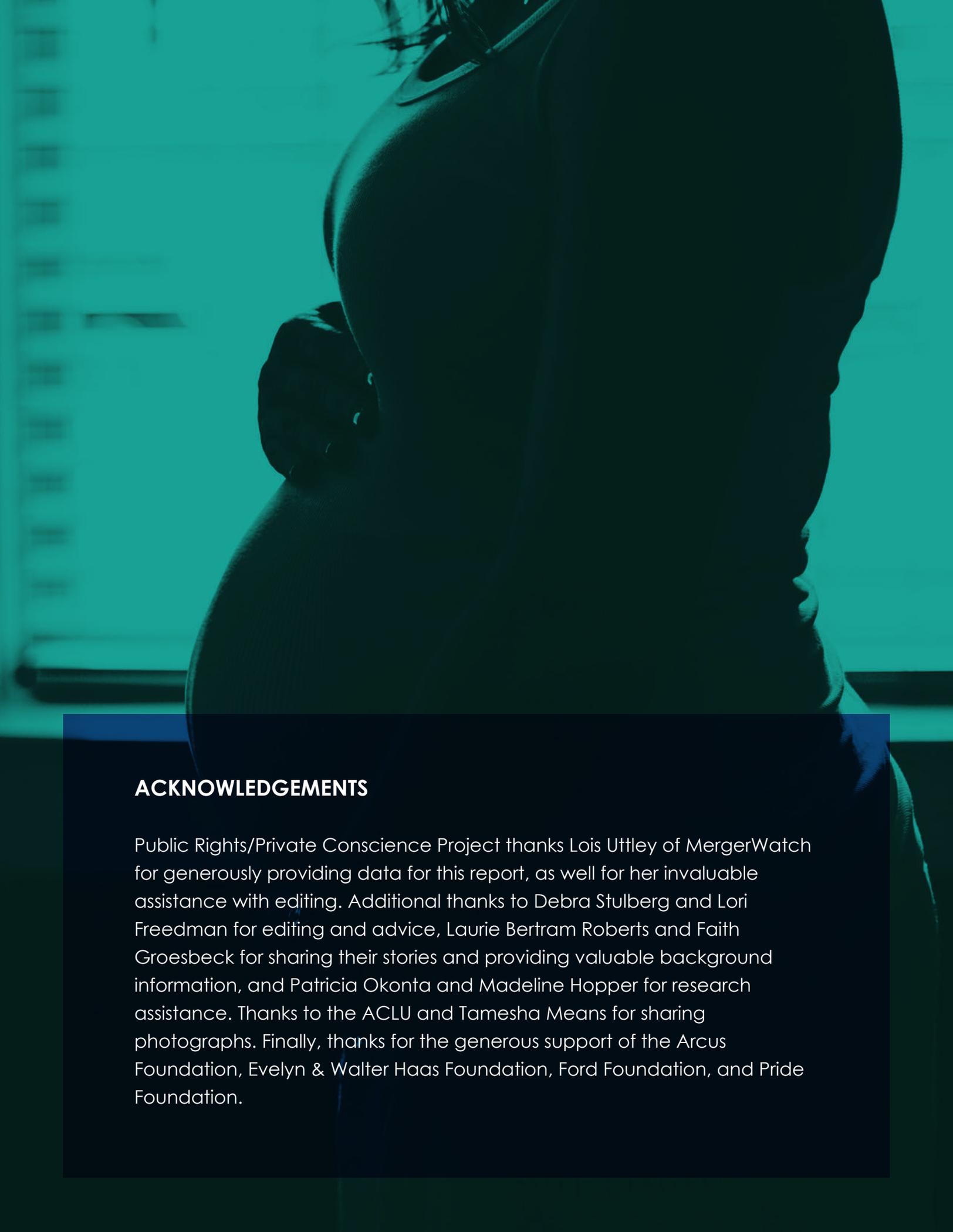
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Laurie Bertram Roberts (Photo Page 7)
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EXECUTIVE SUMMARY

As a result of consolidation and mergers in the health care industry, a significant and growing proportion of the U.S. population now receives “Catholic health care”—care at hospitals that are owned or affiliated with the Catholic Church.¹ These facilities are governed by strict guidelines that place religious beliefs above the medical needs of patients. The expansion of Catholic health care has had a disproportionate effect on the sexual and reproductive health care available to women of color in many communities.

“Bearing Faith: The Limits of Catholic Health Care for Women of Color” finds that in a majority of the states we studied, women of color² were more likely than white women to give birth at a Catholic hospital. In nineteen of thirty-three states and one territory, Catholic hospitals reported a higher percentage of births to women of color than did non-Catholic hospitals. These results indicate that pregnant women of color are more likely than their white counterparts to receive reproductive health care dictated by bishops rather than medical doctors. The religious guidelines governing care at Catholic-affiliated medical institutions prohibit a wide range of necessary services related to contraception, tubal ligation, and certain treatments for pregnancy complications. The restrictions depart significantly from standards of care established by the medical profession.³

These results are especially troubling given that women of color already face numerous health disparities, including disproportionately high rates of maternal and infant mortality,⁴ which increases their need to receive reproductive health care that meets the highest professional standards. The report ends by providing policy recommendations for limiting the risks to patients seeking care at Catholic hospitals, risks that in some communities can disproportionately impact women of color.

INTRODUCTION

Laurie Bertram Roberts was twelve weeks pregnant when, fearing that she was experiencing a miscarriage, she rushed to the only hospital in her community, a Catholic facility. After examining her, the doctors told her to go home, rest, and return if she started to bleed. When she began bleeding heavily the next day she returned to the hospital. This time, providers performed an ultrasound and told Roberts that she was, in fact, having a miscarriage and that the fetus would

...THE DOCTORS WHO ATTENDED TO ROBERTS TOLD HER THAT THEY COULD NOT DO ANYTHING TO HELP HER BECAUSE THE FETUS STILL HAD A HEARTBEAT. LAURIE WAS SENT HOME ONCE AGAIN. AT HOME, LAURIE CONTINUED TO EXPERIENCE HEAVY BLEEDING AND EVENTUALLY LOST CONSCIOUSNESS.

not survive. Despite this, the doctors who attended to Roberts told her that they could not do anything to help her because the fetus still had a heartbeat. Laurie was sent home once again. At home, Laurie continued to experience heavy bleeding and eventually lost consciousness. "I was on the phone with my mother when I passed out at my husband's feet," Laurie recalled. "All I can remember is honestly thinking this can't be how I die." Laurie was transported back to the same hospital a third time by ambulance. Finally, unable to detect a fetal heartbeat, the hospital provided Laurie with treatment for her miscarriage. At the time, Roberts was

18 years old, uninsured, and a low wage worker, so each visit imposed a significant financial burden. The experience nearly cost Laurie her life.

What Roberts did not know at the time was that her experience was not unique. **In hundreds of medical facilities across the country, health care providers are contractually obligated to place the religious beliefs of their employer above the health and safety of their patients.** Catholic hospitals are subject to a set of written policies called the "Ethical and Religious Directives for Catholic Health Care Services" (ERDs), promulgated by the U.S. Conference of Catholic Bishops, that set

A woman with dark hair pulled back, wearing a black t-shirt with white text. She is smiling slightly and looking off-camera. The text on the t-shirt reads: "WE ARE THE GRRRLS YOUR MOTHERS WARNED YOU ABOUT". She is also wearing a necklace with a small pendant and large hoop earrings.

**WE ARE THE
GRRRLS
YOUR MOTHERS
WARNED YOU
ABOUT**

Laurie Bertram Roberts, reproductive justice activist.
At 18 years old Laurie had a miscarriage that nearly cost her her life.

the parameters of “Catholic health care,” drawing from “the Catholic Church’s theological and moral teachings.”⁵ The ERDs prohibit health care providers from delivering a wide range of scientifically recognized and necessary health care services, often without patients’ knowledge or consent. This report shows that in many states women of color are more likely than white women to give birth at health care institutions affiliated with the Catholic Church and governed by the ERDs.⁶ They are, therefore, more likely than white women to receive medical treatment that is dictated by the religious beliefs of bishops rather than the medical judgment of doctors. The disparities uncovered in this report are especially concerning as women of color already face many health disparities, including lack of access to quality care, increased risk for pregnancy complications, and higher rates of unintended pregnancy, which increase their need for comprehensive reproductive health treatment.

The ERDs forbid hospitals owned by or affiliated with the Catholic Church (collectively referred to as “Catholic hospitals” in this report, although they include a variety of institutions⁷) from providing many forms of reproductive health care, including contraception, sterilization, many infertility treatments, and abortion, even when a patient’s life or health is jeopardized by a pregnancy. Catholic hospitals represent a large and growing part of the U.S. health care system. One in six hospital beds in the country is in a hospital governed by the ERDs.⁸ In some areas of the country more than 40% of all hospital beds are in a Catholic hospital, and entire regions have no other option for hospital care.⁹ In hospitals covered by the ERDs, patients – and women in particular – have been denied care for life-threatening conditions in violation of their best interests, prevailing medical standards of care, and ethical guidelines in the medical community. Furthermore, despite their reputation for providing charity care, Catholic hospitals “provide disproportionately less charity care than do public hospitals and other religious non-profit hospitals,”¹⁰ thereby debunking the myth that Catholic hospitals are doing a better job than other institutions of filling unmet health care needs.¹¹

This study finds that in nineteen out of the thirty-four states/territories that we studied, women of color are more likely than white women to give birth at hospitals bound

by the ERDs. Women of color's disproportionate reliance on Catholic hospitals in these states increases their exposure to restrictions that place religious ideology over best medical practices.

To determine whether women of color disproportionately give birth at hospitals operating under the ERDs, we compared the percentage of births to women of color at Catholic and non-Catholic hospitals. In over half of the states we studied (19 out of 33 states plus Puerto Rico) we found that women of color are more likely than white women to give birth at hospitals operating under the ERDs. ¹² The racial disparity in birth rates at Catholic hospitals is especially striking in some states. For example, in Maryland, three-quarters of the births in Catholic hospitals are to women of color, while women of color represent less than half the births at non-Catholic facilities. In New Jersey, women of color make up 50% of all women of reproductive age, yet represent 80% of births at Catholic hospitals.

INTRODUCTION TO ERDS

The ERDs are a set of theologically-driven rules that apply to all Catholic, and many Catholic-affiliated, health care institutions.¹³ The first edition of the guidelines was issued in 1949, however they were not widely adopted by Catholic hospitals until after the Supreme Court's 1973 decision in *Roe v. Wade*.¹⁴ The current fifth edition of the ERDs is broad in scope, providing theological principles, regulations, and guidance on a range of hospital matters including strict limitations on the provision of reproductive health care to patients, regardless of the patient's personal moral or religious beliefs, health and medical history, existing medical condition, or other relevant circumstances. The ERDs also outline the provision of pastoral care, provider-patient communications, and the treatment of employees at Catholic facilities. The limitations on health care services include the following:

- "Abortion (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 need to be concerned about the danger of scandal¹⁵ in any association with abortion providers."¹⁶
- "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion."
- "Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect."
- "Catholic health institutions may not promote or condone contraceptive practices."
- "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution."¹⁷
- "A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, 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. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."

Thus, the ERDs prohibit health care workers from providing contraceptives, emergency contraception, sterilization, some treatments for ectopic pregnancy, abortion, and fertility services. These services are prohibited regardless of patients' wishes, the urgency of a patient's medical condition, the provider's own medical judgment, or the standard of care in the medical profession. In some instances, Catholic hospitals do not provide referrals or even information about these services.¹⁸ Often, patients are not informed that the care they are receiving is governed by the ERDs, and it is not obvious that the hospital is affiliated with the Catholic Church – hospitals controlled by the ERDs can have names such as Affinity, Borgess, Memorial, AMITA, or OSF. While the ERDs are interpreted or enforced in a range of ways in facilities where they apply,¹⁹ their application has been shown to adversely affect patients' health and well-being.²⁰

WOMEN OF COLOR DISPROPORTIONATELY RECEIVE CARE GOVERNED BY THE ERDS

a. Summary of Results

This study finds that in nineteen states, women of color are more likely than white women to give birth in Catholic hospitals, and therefore to receive theologically-governed treatment required by the ERDs. Two states showed little disparity²¹ and twelve states plus one territory had Catholic hospitals that disproportionately served white women.²² An additional seven states had no Catholic birth hospital.²³ This report studied only hospitals that are governed by the Catholic Bishop's ERDs, and does not address the many other health care facilities that are religiously affiliated and may apply similar faith-based restrictions on health care. These providers include facilities affiliated with the Baptist Church, Seventh Day Adventist Church, Church of Jesus Christ of Latter Day Saints, and others. Indeed, the largest hospital in the country, Florida Hospital Orlando, is a faith-based health care organization and part of the Adventist Health System.²⁴

The effects of the ERDs in limiting access to adequate or necessary health care have the potential to amplify the already inadequate health care available to women of color. As will be discussed further below, women of color nationally face barriers in accessing reproductive health care and have significantly poorer outcomes during pregnancy and delivery than white women.²⁵

b. Methodology

To determine whether women of color (defined as any race/ethnicity other than non-Hispanic white) disproportionately give birth at hospitals operated under the ERDs, we compared the percentage of births to women of color at Catholic hospitals with the percentage of births to women of color at non-Catholic hospitals within each state. We hypothesized that women of color were disproportionately exposed to care governed by the ERDs if births to women of color represented a higher percentage of all births at Catholic hospitals than at non-Catholic hospitals. If we assume that the proportion of births at a hospital is similar to the proportion of pregnancy-related medical complications at the hospital, then those with pregnancy-related complications would be particularly affected by the ERDs, as they may not have had access to appropriate and/or necessary care during a medical emergency.²⁶

c. Results Demonstrate that Women of Color Disproportionately Give Birth in Hospitals Governed by the ERDs

Our analysis finds that across all thirty-three states²⁷ and one territory with available data combined, a higher proportion of births at Catholic hospitals are to women of color than at non-Catholic hospitals. Nationally, 49% of births at non-Catholic hospitals are to women of color while 53% of births at Catholic hospitals are to women of color. The potential impact of Catholic health care on women of color is more evident when the data are broken down on a state-by-state basis. A disparity exists at the individual state level in nineteen of these states, including many in the Northeast and Midwest. These states are: Alaska, Connecticut, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Michigan, Massachusetts, Missouri, New Hampshire, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Tennessee, and Wisconsin.

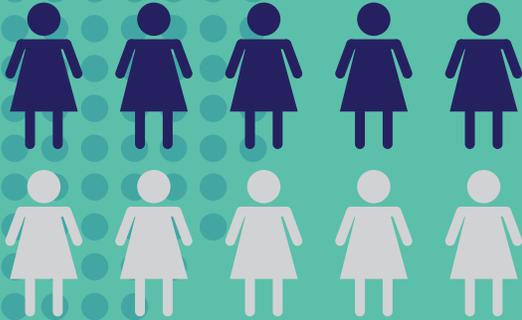
d. Racial Disparities by State

We outline the state-level disparities below in order of greatest to smallest racial disparity. We also highlight the state laws that may allow Catholic institutions to deny certain reproductive health care services without consequence. Many of these laws could be interpreted to prevent a patient who is denied necessary medical care by a Catholic hospital from bringing a successful claim for malpractice. Additional laws that provide special protections to religious hospitals and institutions will be discussed later in this report.

NEW JERSEY

53%

Women of color make up half of all women of reproductive age in New Jersey (50%), and just over half (53%) of births at non-Catholic hospitals.



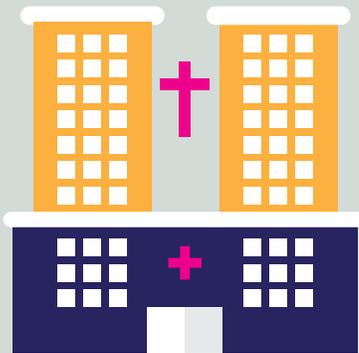
However, they represent an overwhelming 80% of births at Catholic hospitals. The disparity is especially significant for Hispanic women in the state. While approximately 1 in 25 births to white women occurs in a facility following the ERDs (4%), the number for Hispanic women is closer to 1 in 6 (17%). Despite the fact that white women had over 15,000 more births than Hispanic women overall, Hispanic women had over twice the number of births at Catholic hospitals than white women (4,714 vs. 1,735).



The right of medical providers, including Catholic hospitals, to withhold reproductive care from patients is explicitly protected under New Jersey law. Several statutes exempt private hospitals in the state from criminal or civil liability for refusing to provide abortions and sterilizations, with no clear exception for emergencies.²⁸

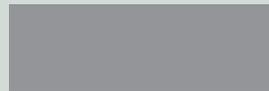
MARYLAND

At Catholic hospitals in Maryland three-quarters (75%) of births are to women of color, as compared with non-Catholic hospitals, where less than half (48%) of births are to women of color. In fact, black women in Maryland had almost 3,000 more births at Catholic hospitals than white women, despite the fact that they had over 10,000 fewer births overall. Examining the data in another way, 11% of white women, 28% of black women, and 31% of Hispanic women who give birth in Maryland did so in facilities operating under the ERDs.



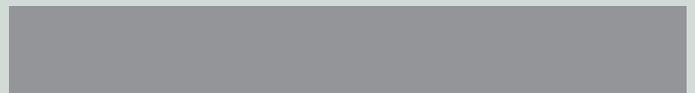
11%

WHITE
WOMEN



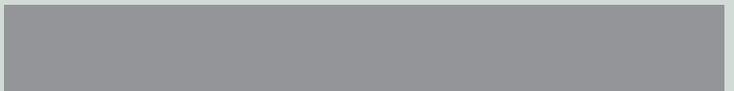
28%

BLACK
WOMEN



31%

HISPANIC
WOMEN



Maryland law protects from civil liability all hospitals that refuse to perform or provide referrals for “any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy.”²⁹ Health advocates have repeatedly opposed the expansion of Catholic facilities in Maryland due to fears over the loss of reproductive care.³⁰ Most recently, in 2011, state regulators faced with proposals from a Catholic and a secular facility to build a new hospital in Montgomery County selected the Catholic provider, despite community concerns regarding a lack of access to reproductive health care.³¹

MAINE

Maine is one of the least diverse states in the country; however it has one of the greatest disparities in Catholic hospital births between black and white mothers. Black women in Maine are nearly three times more likely than white women to give birth at a hospital governed by the ERDs: 11% of births to white women and 32% of births to black women occur at a Catholic hospital.

Maine law creates significant immunities from liability for any health care provider or institution that might be sued for malpractice or other torts related to the delivery of reproductive health care. Specifically, it states that anyone who refuses to perform an abortion may not be held liable for “damages allegedly arising from the refusal.”³² Furthermore, a hospital may not be held “civilly or criminally liable for refusing to participate in performing any sterilization procedure.”³³

DELAWARE

In Delaware, women of color are almost twice as likely as white women to give birth at a Catholic facility: 9% of births to women of color and 5% of births to white women take place in a hospital operating under the ERDs. Births to women of color accounted for about three of every five births at Catholic hospitals (61%) and only about two of every five at non-Catholic hospitals (44%).

Delaware law provides broad protections for health care providers and facilities that refuse to provide abortions to patients, stating that refusal to provide such care “shall not be grounds for civil liability to any person, nor a basis for any disciplinary or other recriminatory action against it by the State or any person.”³⁴

NEW MEXICO

While New Mexico has only one Catholic hospital—Christus St. Vincent Regional Medical Center—there are significant racial disparities in who seeks health care at that facility. Hispanic women represent about half (52%) of births at non-Catholic hospitals in the state, but three-quarters (75%) of births at Christus St. Vincent. This is particularly troubling as Christus St. Vincent is a sole community provider—meaning it is the only nearby option available for its patients.³⁵ Women who are denied reproductive health services at this hospital may not have other feasible options for care where they live, or may experience more inconvenience due to the time needed to travel to a non-Catholic facility. St. Vincent did not follow the ERDs until 2008, when it merged with Christus Health, a Catholic group from Texas.³⁶ The merger was approved by the state Departments of Health and Human Services despite community concerns about the merger’s impact on access to reproductive health care.³⁷

New Mexico law does not require any hospital to admit any patient for the purpose of performing an abortion³⁸ or sterilization.³⁹ Furthermore, health care facilities may decline to provide any medical service that is “contrary to a policy of the health-care institution that is expressly based on reasons of conscience,” so long as this policy is communicated to the patient.⁴⁰ A state bill proposed in 2017, the Put Patients First Act, would prohibit hospitals from “refus[ing] to provide a reproductive health service to a patient if withholding the reproductive health service would result in or prolong a serious risk to the patient’s life or health.”⁴¹ The bill would also prohibit hospitals from restricting a provider’s ability to provide comprehensive information to patients about their reproductive health condition and treatment options, offer referrals, or offer care during medical emergencies.⁴²

MASSACHUSETTS

While about one in twenty (5%) births to white women occur at Catholic hospitals in Massachusetts, one in ten (10%) births to black and Hispanic women take place at Catholic hospitals. Thus, women of color are twice as likely to give birth in a Catholic hospital in Massachusetts.⁴³

Massachusetts broadly protects the right of a hospital to refuse to provide care, referrals, or even information about services related to abortion, sterilization, or contraception in a section of the commonwealth's law designed to prohibit "Crimes Against Chastity, Morality, Decency and Good Order."⁴⁴ Both reproductive health advocates and some Catholic advocates have objected to partnerships between Catholic and secular health care providers in Massachusetts—the former out of fear that such partnerships would reduce access to reproductive health care and the latter out of concerns that it would implicate the Catholic Church in the provision of such care. In 2009, state regulators approved a partnership between Caritas Christi Health Care, a large Catholic hospital system, and Centene, a secular insurer, over the objections of several reproductive health groups.⁴⁵ The program was nevertheless abruptly terminated after the Archbishop of Boston determined that it would improperly associate Catholic hospitals with abortion providers.⁴⁶

CONNECTICUT

In Connecticut, women of color are more than twice as likely as white women to give birth at a Catholic facility. One quarter (25%) of births to black women occur in a Catholic facility, while just over one tenth (11%) of births to white women occur in a Catholic hospital.

In 2012, a planned merger between a Catholic and non-Catholic hospital was discontinued due to concerns about the impact of the ERDs on access to reproductive health care.⁴⁷ However the state agency that raised these concerns, the Connecticut Permanent Commission on the Status of Women,⁴⁸ has since been eliminated.⁴⁹



WISCONSIN

Out of the thirty-three states and one territory from which we collected data, Wisconsin displays the highest percentage of births at Catholic hospitals compared to non-Catholic hospitals for all racial groups, but especially for women of color. One in three births to white women is at a Catholic hospital (33%) while just over one in two (52%) births to black women is in a Catholic hospital. In fact, Wisconsin is the only state we studied where black women are more likely to give birth at a Catholic than a non-Catholic facility. Hispanic women are also more likely than their white counterparts to give birth at a Catholic hospital, with 45% of births to Hispanic women occurring at a hospital abiding by the ERDs. Notably, 1 in 4 birth hospitals in Wisconsin is a Catholic institution.

Medical providers who have worked in two Catholic hospitals in Milwaukee, Wisconsin—Wheaton Franciscan-St. Joseph, which is located in a majority black neighborhood, and Columbia St. Mary’s—recently revealed in a news article the numerous ways in which the ERDs impacted the care they could provide to patients.⁵⁰ In one instance, Dr. Jessika Ralph described being forced to wait more than twenty-four hours for her patient to deliver an eighteen-week fetus with no chance of survival rather than perform an abortion or induction.⁵¹ Dr. Ralph noted that she was bound by St. Joseph’s rule requiring her to wait until a patient “hemorrhaged or showed at least two signs of infection” before taking action.⁵² Wisconsin law allows hospitals to refuse to perform or admit patients for sterilizations or abortions without being held “liable for any civil damages resulting...if such refusal is based on religious or moral precepts.”⁵³

IDAHO

Idaho, a state with a largely white population, shows substantial racial disparities in rates of Catholic hospital births. While 15% of births to white women take place in a Catholic hospital, the rates are significantly higher for women of color—37% for black women, 21% for Hispanic women, and 26% for “other,” which includes Native American and Asian women.

Idaho immunizes Catholic hospitals from legal claims related to the refusal to perform or accept a patient for an abortion or sterilization.⁵⁴ Furthermore, individual providers have the right to decline to provide a range of reproductive health care, including “abortion, dispensation of an abortifacient drug, human embryonic stem cell research, treatment regimens utilizing human embryonic stem cells, human embryo cloning or end of life treatment and care.”⁵⁵ Unlike many other states, however, Idaho does not permit health care providers to refuse care—including abortion—“in a life-threatening situation where no other health care professional capable of treating the emergency is available.”⁵⁶

NEW HAMPSHIRE

In New Hampshire, 13% of all births to white women occur at a Catholic facility. That number is 22% for black women, 18% for Hispanic women, and 17% for “other” non-white women.

New Hampshire is one of few states that have not explicitly provided a right for hospitals to deny abortion care due to their religious or moral beliefs. Nevertheless, Catholic hospitals in the state comply with the ERDs, and past mergers between secular and Catholic hospitals have been contentious.⁵⁷ Furthermore, there is at least one reported incident of a women being denied emergency care while miscarrying at a Catholic hospital in Manchester, New Hampshire.⁵⁸

TENNESSEE

Black women in Tennessee make up a larger percentage of all births at Catholic hospitals than at non-Catholic hospitals: just under two in ten births at non-Catholic hospitals (19%) are to black women versus just under three in ten births at Catholic hospitals (29%).

Tennessee law holds that “No hospital shall be required to permit abortions.”⁵⁹ Hospitals are also allowed to withhold access to and information about contraception, without being held liable for this refusal, if motivated by religious or conscientious objection.⁶⁰ Abortion is especially difficult to access in Tennessee, as the state has passed numerous laws to curtail abortion care. In 2017, the state passed a ban on abortions performed after viability (although there is an exception for medical emergencies).⁶¹

ADDITIONAL STATES

Women of color are also disproportionately likely to give birth at Catholic hospitals as compared to white women in Missouri, Pennsylvania, Indiana, Alaska, Ohio, Illinois, Michigan, and Oregon. The disparities in these states are more modest. All of these states allow hospitals to decline to provide abortion care.⁶² A disparity is also present in a twentieth state—West Virginia—although the results are not statistically significant.⁶³

The disparities revealed in this study are especially troubling for states with poor birth outcomes or significant existing racial health disparities, as women of color in these states may have an especially urgent need for access to quality reproductive and maternal health care. For example, New Jersey has an extremely high maternal mortality rate⁶⁴ and Wisconsin has a large racial disparity in its infant mortality rate. Wisconsin ranks twenty-seventh highest in the nation for white infant mortality, but has the second highest mortality rate in the nation for black infants.⁶⁵ We do not intend to suggest causality or correlation between rates of Catholic hospital usage and rates of infant mortality; rather, we merely intend to highlight the clear need for comprehensive OB/GYN services among women, and especially women of color, in these states.

SCOPE OF CATHOLIC HEALTH CARE

The impact of the ERDs on access to health care is sweeping. As reported in a recent study by MergerWatch, one in six hospital beds in the U.S. is currently in a facility operating under the ERDs.⁶⁶ This is due in part to increased consolidation within the health care industry; starting in the 1990s, independent hospitals—including Catholic hospitals—began to merge into large health systems for a number of economic reasons.⁶⁷ In response to this trend, the U.S. Conference of Catholic Bishops (USCCB) expanded the reach of the ERDs. In 1994, the ERDs were updated specifically to place restrictions on partnerships between Catholic and non-Catholic institutions.⁶⁸ The ERDs now state that new partnerships “can help to implement the Church’s social teaching,” and require that “[a]ny partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline.”⁶⁹ In practice, this has led to the adoption of the ERDs by non-Catholic private and public health care institutions that are affiliated with, managed by, or have purchased land from Catholic health systems.⁷⁰

Consolidation in health care has only increased since the passage of the Affordable Care Act in 2010.⁷¹ In several instances, however, health care providers and community advocates have succeeded in negotiating creative solutions to maintain reproductive health care services in facilities merging with Catholic hospitals.⁷² This has led the USCCB to consider even stricter rules on mergers. In 2014, the USCCB revealed that it was considering updating the ERDs yet again to prevent such workarounds.⁷³

Catholic hospitals see millions of patients per year.⁷⁴ As consolidation continues, more and more hospitals may be forced to operate under some or all of the religious restrictions of the ERDs. This puts an astounding number of patients across the country at risk of having their health needs subordinated to the religious tenets of the Catholic Church.

IMPACT OF THE ERDS ON PATIENT CARE

The ERDs impede patients' ability to access a wide range of care, from emergency contraception after a sexual assault to tubal ligations (having one's "tubes tied") after birth, when this procedure is safest and therefore recommended.⁷⁵ Miscarriage management and care for pregnancy complications are a particular concern at hospitals operating under the ERDs. The directives have been interpreted in some hospitals to prohibit doctors from providing uterine evacuations or abortions whenever a fetal heartbeat can be discerned, regardless of its future chance of survival.⁷⁶ This leads providers to perform unnecessary testing to determine whether there is a heartbeat and to subsequently delay care until a patient's health, safety, and future fertility is jeopardized.⁷⁷

While the ERDs can be read to permit the prioritization of the health of a patient over their fetus, in practice even medically-indicated care is often prohibited. Some doctors at Catholic hospitals have reported being required to deny medically-indicated uterine evacuations or abortion care even during emergencies, either transferring patients to another hospital while they are unstable or waiting until their medical condition becomes critical.⁷⁸ Others have described the ERDs limiting their ability to appropriately treat patients with risky tubal/ectopic pregnancies; according to at least one provider at a Catholic hospital, such refusals have led to tubal rupture.⁷⁹ Patients have described being discharged from the emergency room without treatment while miscarrying and being forced to continue a non-viable pregnancy.⁸⁰

Perhaps even more problematically, some Catholic hospitals restrict physicians

PERHAPS EVEN MORE PROBLEMATICALLY, SOME CATHOLIC HOSPITALS RESTRICT PHYSICIANS FROM PROVIDING INFORMATION ABOUT ABORTION AND OTHER REPRODUCTIVE HEALTH CARE, LEAVING PATIENTS UNINFORMED ABOUT THEIR HEALTH NEEDS AND OPTIONS.

from providing information about abortion and other reproductive health care, leaving patients uninformed about their health needs and options.⁸¹ And while some Catholic hospitals are willing to assist in transferring patients to another facility for necessary care, others will not provide referrals for care banned by the ERDs or transfer patients' medical records.⁸²

Religious restrictions on care may be appropriate if patients were aware of these restrictions and fully shared the hospital's views on reproductive care. This is usually not the case, however. Hospitals operating under the ERDs often do not disclose this fact to their patients, or explain how their care is being impacted by the hospital's religious identity. According to a recent study, 37% of patients whose regular hospital was Catholic were unaware of its religious affiliation.⁸³ Furthermore, 67% believed Catholic hospitals provided tubal ligations upon request, 46% believed they would provide an abortion for life-threatening pregnancies and 30% believed they would provide an abortion in the case of fetal anomaly.⁸⁴

Even patients who share the hospital's Catholic identification may not fully understand or agree with the ERDs' limitations on care. Research shows that Catholic women are not significantly more likely to correctly identify their hospital as a Catholic facility.⁸⁵ Moreover, Catholic women have varied views regarding contraception and abortion: 85% of Catholics support abortion when a woman's health is seriously endangered and 53% say abortion should be legal in all or most cases—only slightly less than 57% among the general population.⁸⁶ Catholic women have abortions at about the same rate as do other women.⁸⁷ Sexually active Catholic women are as likely to have used contraception that is banned by the Catholic Church as women in the general population.⁸⁸ Thus, even those patients who share their provider's religious identity are unlikely to agree with the ERD's strict prohibition of contraception and ban on abortion even during emergencies.

Finally, patients who are aware of a hospital's restrictions on care may be unable to access another provider that is not governed by the ERDs. During an emergency, patients are often taken to the hospital closest to them, regardless of whether or not it operates under the ERDs. As discussed earlier, some women live in a

community with only one facility where they can obtain medical care, or are faced with choosing among hospitals all of which follow the ERDs. Catholic hospitals are increasingly the sole or primary health care provider in many communities; in 2016, there were over a million emergency room visits to sole community hospitals operating under the ERDs.⁸⁹ Even if other hospitals are nearby, some insurance companies will only cover care at particular hospitals. Furthermore, Catholic hospitals that refuse to make referrals or transfer patients' medical records make finding an alternate provider even more difficult.⁹⁰





Tamesha Means of Muskegan, Michigan.
In 2010, Tamesha was denied emergency treatment for a miscarriage.

LEGAL CHALLENGES TO THE ERDS

Several legal challenges have been filed over the past few years by patients who were denied medical treatment, including treatment for miscarriage, tubal ligations, and hysterectomies, at Catholic hospitals. One of the most significant challenges to the ERDs in recent years was brought by a woman whose life—like Laurie Bertram Roberts’—was put at risk by inadequate care at a hospital operating under the ERDs.

In 2010, Tamesha Means of Muskegon, Michigan was only eighteen weeks pregnant when her water broke and she began to experience contractions.⁹¹ She immediately went to the only hospital in her county, Mercy Health Partners (MHP), where she was given pain medication, discharged from the hospital, and told to return for an appointment with her regular doctor in eight days.⁹² Ms. Means did not know that MHP was bound by the ERDs, which prohibited MHP staff from terminating a pregnancy, even to assist a woman who is miscarrying. The doctors had diagnosed Ms. Means with conditions

THE DOCTORS HAD DIAGNOSED MS. MEANS WITH CONDITIONS INDICATING THAT HER FETUS HAD LITTLE CHANCE OF SURVIVAL... HOWEVER, THEY DID NOT INFORM MS. MEANS OF THESE CIRCUMSTANCES OR EXPLAIN THAT SHE COULD AVOID FURTHER COMPLICATIONS BY TERMINATING HER PREGNANCY.

indicating that her fetus had little chance of survival, and that continuing the pregnancy could jeopardize her health.⁹³ However, they did not inform Ms. Means of these circumstances or explain that she could avoid further complications by terminating her pregnancy. Instead, they misled Ms. Means by suggesting that she might be able to deliver a healthy child.⁹⁴ The following day, Ms. Means returned to the hospital in severe pain, bleeding, and with a high temperature. While her treating physician suspected that she had a bacterial infection, she was nevertheless discharged a second time without any explanation of the seriousness of her condition. Ms. Means returned to MPH a third time that evening, and was

in the midst of being discharged when she began to deliver. Her child died shortly after delivery.

Tamesha Means brought a negligence suit against two organizations—the United States Conference for Catholic Bishops (USCCB), that wrote and disseminated the ERDs, and the Chairs of Catholic Health Ministries (CHM), that required Mercy Health Partners to abide by the ERDs—for “promulgating and implementing directives that cause pregnant women who are suffering from a miscarriage to be denied appropriate medical care, including information about their condition and treatment options.”⁹⁵ CHM governs Trinity Health, a health care system that operates MHP and other hospitals.

After losing in the federal District Court, Ms. Means appealed the case to the 6th Circuit Court of Appeals. The circuit court found that Ms. Means did not suffer a “present physical injury,” and therefore could not make a negligence claim.⁹⁶ Since the circuit court’s decision relied on the (dubious) assertion that Ms. Means did not suffer an injury, it did not decide the more complex and significant issues of whether USCCB could be held responsible for the inadequate care that Means received, or whether its religious identity could protect it from suit.

Other recently-filed lawsuits challenge the denial of additional procedures barred by the ERDs. Rebecca Chamorro brought suit after being denied a tubal ligation at Mercy Medical Center, a Catholic hospital in California.⁹⁷ The safest way to perform this procedure is immediately after birth, to avoid a second surgical procedure under anesthesia.⁹⁸ When her physician asked for authorization from Mercy to perform the procedure after Ms. Chamorro gave birth, the hospital refused, citing the ERDs. The ERDs call vasectomies and tubal ligations “intrinsicly evil.”⁹⁹ Ms. Chamorro filed a lawsuit against Dignity Health, a large Catholic health system that required Mercy to abide by the ERDs. While the case is ongoing, Chamorro’s request for a preliminary injunction was denied.¹⁰⁰ The court found Chamorro was unlikely to succeed in her lawsuit because she could have “obtain[ed] the desired procedure at other hospitals that do not follow defendant’s directives.”¹⁰¹

In 2017 there have been two cases filed by transgender men who were denied gender affirming surgeries at Catholic hospitals. The first was brought by Jionni Conforti after he was refused a hysterectomy at a hospital in New Jersey.¹⁰² Mr. Conforti received an email from the hospital stating that “as a Catholic Hospital we would not be able to allow your surgeon to schedule this surgery here.”¹⁰³ Mr. Conforti filed a suit against the hospital under New Jersey’s anti-discrimination law, which prohibits discrimination based on sex and gender identity, as well as Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of sex in access to health care.¹⁰⁴ Similarly, Evan Michael Minton sued a Catholic hospital for refusing to perform a hysterectomy on him. Mr. Minton’s suit alleges that this denial violated California’s law prohibiting sex discrimination.¹⁰⁵ Both cases are pending.



Tamesha Means, left, with her children.

LEGAL AUTHORITY FOR THE ERDS

The ERDs as carried out by some hospitals violate legal standards of care including patients' common law right to informed consent,¹⁰⁶ informed consent requirements within federal law,¹⁰⁷ hospitals' duty to stabilize patients in emergency rooms,¹⁰⁸ and prohibitions on sex discrimination in health care.¹⁰⁹ Religious restrictions on health care are protected by a number of federal and state laws, however, that affirmatively grant health care providers and institutions the right to deny reproductive health care to patients. These laws, often called “religious refusals,” were first enacted in the wake of the Supreme Court's *Roe v. Wade* decision in 1973, and have since been expanded to cover a wider range of providers and services. While refusals are longstanding and widespread, their scope is not clear. For example, courts have yet to explicitly rule as to what should happen when a hospital's legal duty to stabilize a patient conflicts with a faith-based refusal permitted by state or federal law.

Below are several of the most notable reproductive health care religious refusal laws:

The **1973 Church Amendment** states that 1) health care providers who receive federal funds are not required to perform any sterilization procedure or abortion if this would be contrary to their religious beliefs or moral convictions, and 2) entities that receive federal funds may not “discriminate” against health care professionals because they have performed— or refused to perform— sterilizations or abortions, or because of their “religious beliefs or moral convictions respecting sterilization procedures or abortions.”¹¹⁰

While at first glance, this provision appears neutral with regard to opinions on abortion, it in fact favors religious objectors: Under the Amendment, a religious hospital can prohibit doctors from performing sterilizations and abortions, even if this goes against a doctor's religious, moral, or medical judgment, and still receive federal funds. A secular hospital that receives funding, however, may not require doctors to provide this care. Put another way, doctors who are morally opposed to performing a sterilization or abortion are protected regardless of where they work, while doctors who may feel morally obligated to provide such care can be prohibited from doing so by their employer.

The **1997 Balanced Budget Act** extended religion-based refusal protections to cover not just entities that provide health care, but entities that pay for it. The Act contained a provision stating that Medicare and Medicaid managed care programs need not “provide, reimburse for, or provide coverage of a counseling or referral service” if the organization offering the plan “objects to the provision of such service on moral or religious grounds.” Thus, the law allows health plans funded by Medicare and Medicaid to refuse to provide reproductive health services—including counseling and referrals for abortion-related services. This considerably reduces access to reproductive health care, as patients are rarely able to simply switch to a different insurance plan. Low-income women, who may be unable to pay for services out-of-pocket, are particularly harmed by health plans that object to coverage for comprehensive care.¹¹¹

The **Weldon Amendment** has been attached to an annual Labor, Health, and Education appropriations bill every year since 2004. The amendment prohibits federal agencies, federal programs, and state and local governments that receive money under the annual bill from “discriminating” against health care entities because they refuse to provide, pay for, provide coverage of, or refer for abortions. “Entities” is defined broadly to include “an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.” The provision therefore allows even large health insurance companies to refuse to provide abortion coverage, limiting governments’ ability to ensure access to comprehensive reproductive health care.¹¹²

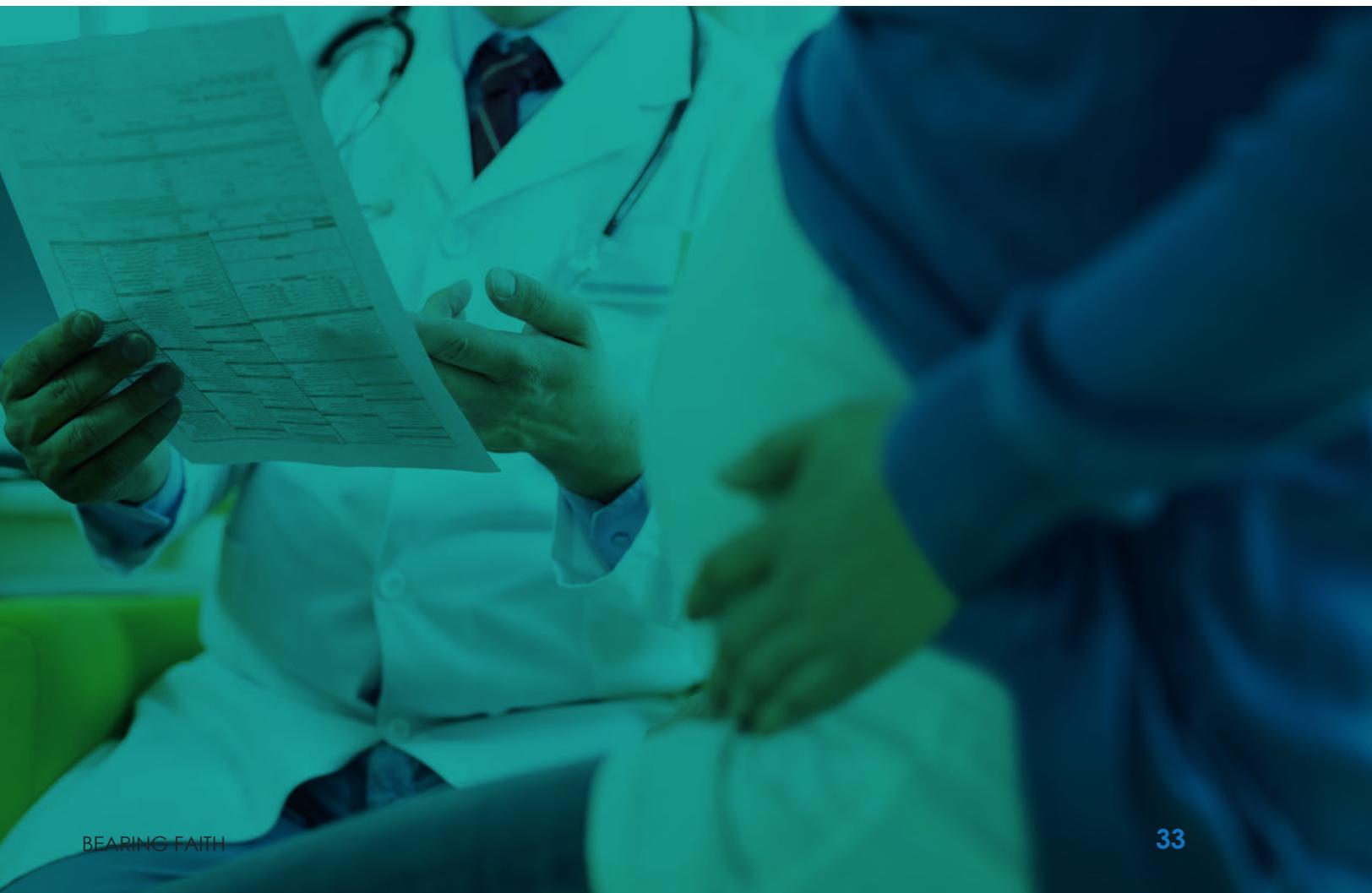
State **Reproductive Health Care Religious Refusals** are often even broader than federal laws. Almost every state has enacted refusal laws that provide legal cover to health care providers and/or institutions that deny reproductive health services to patients.¹¹³ Forty-five states have passed abortion refusal laws for individual providers, and forty-three have passed them for institutions. Moreover, eighteen states have passed refusal laws related to sterilization and twelve have passed refusals for contraceptive services.¹¹⁴ The language of state exemption laws is often sweeping, covering a far greater range of activities and many more people in the health care industry than federal provisions.¹¹⁵

Possibly the broadest religious refusal is now in Mississippi. In addition to providing extensive exemptions for health care providers and payers,¹¹⁶ it states that a “health-care institution that declines to provide or participate in a health-care service that violates its conscience shall not be civilly, criminally or administratively liable if the institution provides a consent form to be signed by a patient before admission...stating that it reserves the right to decline to provide or participate in a health-care service that violates its conscience.” So long as this general form is signed, hospitals may refuse to provide any type of counseling or care—not just reproductive care— even during medical emergencies.

While religious exemptions are already extremely broad, policymakers and advocates across the country are trying to expand them even further. On the federal level, the repeatedly-introduced Abortion Non-Discrimination Act would write the Weldon Amendment into permanent law, rather than being subject to annual renewal as part of an appropriations bill.¹¹⁷ It would also expand the Weldon Amendment by applying the requirement to *all* federal funds.¹¹⁸ On the state level, new and ever-broader reproductive health care refusal laws are introduced each year.

Despite the broad protections for Catholic hospitals under state and federal

religious refusal laws, courts have not clearly determined when and whether health care providers can withhold treatment due to their religious beliefs. While the ERDs are protected by federal and state religious refusal laws, there are nevertheless strong legal and constitutional arguments that health care providers should not be permitted to place their religious faith above the health and safety of their patients; to substitute theological standards of care for standards of care based in science; or to discriminate against patients based on religious doctrine. Courts have, on occasion, ruled that health care providers and institutions do not have an absolute right to refuse to provide reproductive health information and services to which they morally object.¹¹⁹ However this remains a largely under-litigated area and many questions remain regarding the validity of broad refusal laws¹²⁰ and when a provider's religious beliefs must yield to patients' health and safety.



EXISTING RACIAL DISPARITIES IN HEALTH CARE

The increased likelihood that women of color will seek reproductive health care at a hospital operating under the ERDs has the potential to exacerbate longstanding and pervasive racial disparities in health care, including reproductive health care. Lack of access to quality health care, economic inequality, higher levels of stress,¹²¹ historic mistreatment by the medical industry, and contemporary biases in health care have contributed to dramatic race-based health disparities. Women of color are more likely to be uninsured, and therefore to receive no or inadequate health care, including prenatal care.¹²² This in turn can contribute to pregnancy complications, including miscarriage as well as maternal mortality.¹²³ Even when they can access care, women of color experience lower quality health care and face poorer health outcomes than white women.¹²⁴ This report's findings, that in many states women of color disproportionately receive reproductive health care restricted by the ERDs, should be evaluated against the backdrop of vastly inferior health care delivered to women of color across the board.

The Catholic standard of care subjects women to theologically circumscribed sexual and reproductive health care as a matter of policy – policy that patients are often not informed of prior to, during, or after their treatment. For women of color, this type of misconduct continues a long history of inequalities in access to and treatment by reproductive health care providers, a history that has led many women of color to distrust medical practitioners.

The pervasive health disparities between white women and women of color can be traced back, in part, to a long legacy of coercive reproductive health policies

THE PERVASIVE HEALTH DISPARITIES BETWEEN WHITE WOMEN AND WOMEN OF COLOR CAN BE TRACED BACK, IN PART, TO A LONG LEGACY OF COERCIVE REPRODUCTIVE HEALTH POLICIES AND PRACTICES EXPERIENCED BY WOMEN OF COLOR.

and practices experienced by women of color. In many ways, the history of women of color in the United States has been a history of coercive regulation of their reproductive bodies and lives.

This history includes the **rape** and **forced pregnancy** of black women while enslaved, to the systematic forced **removal** of Native children from their parents' custody and care.¹²⁵

It includes the **forced sterilization** of black and Latina women during the 1960s and 1970s,¹²⁶ as well as more recent efforts by judges and legislators to force poor women, mostly women of color, to **use long-acting contraceptives** in order to receive public assistance or to avoid a jail sentence.¹²⁷

The institutional denial of women of color's reproductive freedom has been marked throughout U.S. history,¹²⁸ and has led many women of color to distrust those in the medical field. This ignoble history is continued through the ERDs' theological approach to health care that denies women the ability to make informed decisions concerning their care.

Especially in communities where they are far more likely than white women to receive Catholic care, **these policies expose women of color to some of the same oppressive treatment that many have fought against for decades**—treatment that devalues their lives and ignores their bodily autonomy.

The possibility that women of color may be denied crucial care is compounded by systemic racial bias and discrimination that exists throughout the medical industry. As part of a recent news series on maternal mortality, an article recounted “In the more than 200 stories of African-American mothers... collected over the

past year, the feeling of being devalued and disrespected by medical providers was a constant theme."¹²⁹ These stories are bolstered by numerous scientific studies. In 2003, the Institute of Medicine produced a study about the causes of racial health disparities in America.¹³⁰ It found that many disparities are rooted in historic and current racial inequalities, including implicit biases held within the medical community that lead to subpar treatment.¹³¹ Racial and ethnic minorities were found to receive a lower standard of care than non-minorities even when controlling for access-related factors such as income and insurance status.¹³² Another study found that false racial biases about biological differences between black and white people have contributed to black patients being systematically undertreated for pain relative to white patients.¹³³ A number of studies have shown that implicit racial biases among health care practitioners may play a role in racial health care disparities.¹³⁴

Women of color currently face significantly poorer outcomes during pregnancy and delivery than white women. Indeed, "according to the CDC, black mothers in the U.S. die at three to four times the rate of white mothers ... a black woman is 22 percent more likely to die from heart disease than a white woman, 71 percent more likely to perish from cervical cancer, but *243 percent more likely to die from pregnancy- or childbirth-related causes.*"¹³⁵ Not only are black women several times more likely to die from pregnancy-related causes than white patients,¹³⁶ they are also more likely to die from preventable causes. One study found that while 33% of maternal deaths among white women were preventable, 46% of maternal deaths among black women could have been prevented.¹³⁷ Other studies have found that black women with certain common pregnancy complications are more likely to die than white women with the same complication.¹³⁸ For example, black women with pregnancy induced hypertension (PIH) or preeclampsia (a serious condition resulting from PIH), are more likely to die than white women with the same condition.¹³⁹ Pregnancy induced hypertension is one of the leading causes of maternal mortality.¹⁴⁰ In addition, national data show that black women experience higher rates of infant mortality and fetal death than white, Hispanic, and Asian or Pacific Islander women.¹⁴¹



In addition to facing health disparities during pregnancy, women of color also face barriers in obtaining care to prevent pregnancy. One recent report found that the expansion of Catholic hospitals between the years 2001 and 2016 reduced the rate of tubal ligations by 31% in all recently merged hospitals.¹⁴² Moreover, the paper showed that the annual rate of inpatient abortions in recently merged hospitals was reduced by 30%. Given that women of color have greater rates of abortion¹⁴³ and tubal ligation¹⁴⁴ than do white women, the rise of Catholic hospitals is likely to prevent a substantial number of women of color from receiving the reproductive health care services they need.¹⁴⁵ When women are denied access to the full range of reproductive health care, they are more likely to have an unintended pregnancy. Births resulting from unintended pregnancies are, in turn, associated with a host of adverse outcomes, including premature birth and postponement of prenatal care.¹⁴⁶

One reason for racial health disparities before and during pregnancy is inadequate access to health insurance. African American and Hispanic women are more

likely to be uninsured than white women.¹⁴⁷ In 2015, 8.2 million reproductive age women were uninsured.¹⁴⁸ About 5.1 million—or 63%— were women of color, despite the fact that women of color only made up only 44% of all reproductive age women. Specifically, 24.7% of Hispanic and 14.1% of black reproductive age women were uninsured, while only 8.6% of white reproductive age women were uninsured.¹⁴⁹ Uninsured women are more likely to forgo medical services due to cost, and to receive a lower standard of care when they are in the health system.¹⁵⁰ Many uninsured women are not able to obtain proper prenatal care, which increases their risk of pregnancy-related complications.¹⁵¹ In these cases, ending the pregnancy might be the best way to preserve a woman's life, health, or future fertility.¹⁵²

Even women who have insurance are not always able to access care. While the Affordable Care Act has substantially decreased the number of low income people who are uninsured through the expansion of Medicaid, many low-income women who have or are eligible for Medicaid still cannot access quality prenatal care due to delays in obtaining coverage, a lack of providers willing to accept Medicaid, and other hurdles.¹⁵³ The rise of large Catholic health insurance plans may mean that some services, like contraceptives, are not covered or difficult to access.¹⁵⁴

Other women simply have no provider at all in their community. A recent study published in the health care journal *Health Affairs* showed that black women who live in rural communities that have low median household incomes were more likely to lose all obstetric care in their counties through the closure of health care facilities, as compared with their white counterparts.¹⁵⁵ The study noted that black women have less access to care even when they have high risk medical conditions, such as multiple or preterm births, which may call for specialized obstetric care.¹⁵⁶

Racial biases in the health care industry, limited access to providers, lack of insurance, and other socio-economic disparities showcase the various ways that women of color are shut out from quality reproductive health care. All of these factors may be compounded by religious restrictions on care. Under the ERDs, health care providers in many communities withhold crucial reproductive

health care services to a disproportionate number of one of the most vulnerable and marginalized groups in the U.S.— women of color. The ERDs restrict the ability of women of color in these communities to make decisions about their reproductive health, such as how and when to continue or end a pregnancy, take contraception, or undergo sterilization. Such treatment could exacerbate health care disparities and will likely increase the level of distrust that women of color have for the health care industry, distrust that developed after years of reproductive coercion and oppression

CONCLUSIONS AND RECOMMENDATIONS

This study shows that in a significant number of states across the country, women of color disproportionately obtain reproductive health care at Catholic hospitals, where theology trumps best medical practice. The ERDs' restrictions on care, including the refusal to provide contraception and tubal ligation, are likely to compound the racial health disparities that women of color already face throughout the U.S. health care system, and are likely to increase the level of distrust that women of color have for the medical industry.

Religious directives should not interfere with an individual's right to quality health care, and a hospital's religious affiliation should not excuse treatment that deviates from the accepted norms and standards of practice in the medical community. Below are a number of steps that policymakers, advocates, health care professionals, and the community-at-large can take to improve access to reproductive health care, particularly though not exclusively for women of color. While these recommendations will not remedy all of the problems associated with the ERDs, they provide a blueprint for options that would lessen their impact on patient care.



1. Reform laws and policies that allow health care providers to refuse services on the basis of religious or conscience objections. As outlined in this report, there are a number of laws and policies that allow Catholic and other religious hospitals to deny women important reproductive care. Provisions such as the Church and Weldon Amendments and similar state policies should be repealed or reformed. Local policymakers have recently taken modest steps in this direction. For instance, in 2017, Illinois added an amendment to their Health Care Right of Conscience Act, previously one of the broadest religious refusal laws in the country.¹⁵⁷ This amendment authorized health care providers to assert conscience based objections to health care only if they have protocols in place to ensure that patients are informed about medical treatment options and provided a referral or information about where to get the care they need.¹⁵⁸ The legislation was supported by The American College of Obstetricians and Gynecologists (ACOG), which has stated that doctors who deny services for religious or moral reasons should provide a timely referral.¹⁵⁹

Moreover, bills were recently proposed in New Mexico, Michigan, and Washington that would restrict health care institutions and providers from denying reproductive care if this would pose a serious risk to the patient's life or health; (Washington's bill goes further, and forbids medical institutions from limiting the care their employees can provide even during non-emergencies).¹⁶⁰ Policymakers should propose and enact similar laws to mitigate the harms caused by faith or conscience-based health care refusals, and to assure that all persons seeking medical care receive the same scientifically grounded standard of care.

2. Enact regulations that require health care providers to notify patients of faith or conscience-based health care refusals. As discussed previously, in many cases patients do not know if their health care provider has religious restrictions on care. Hospitals should be required to tell prospective patients about their faith-based health care refusals. A few states already have such requirements.¹⁶¹ In addition, the Centers for Medicare and Medicaid Services (CMS) require hospitals that receive Medicare and Medicaid funding to notify admitted patients about whether or not their health care providers can religiously object to a patient's end-of-life care directives.¹⁶² Similar rules should apply to faith or conscience-based health care refusals related to reproductive health care.

3. Ensure state oversight of proposed hospital mergers and acquisitions to prevent the loss of reproductive health care and other vital health services. A majority of states currently have Certificate of Need (CON) laws, which create government programs to assess whether a proposed health facility creation, expansion, merger, or acquisition fulfills the needs of the community.¹⁶³ However, only ten of these states have programs in place that require state regulators to review when a hospital is going to discontinue a vital service, such as reproductive health services, or close down altogether.¹⁶⁴ These programs require state regulators to assess how the community would be impacted by such a change, and to develop a plan to ensure that patients have access to all necessary services. Out of the nineteen states where this report found that women of color are more likely than white women to give birth at a Catholic hospital, only five have CON programs that require the state to review the discontinuation of health care services: Connecticut, Illinois, New Jersey, Tennessee, and Maryland. Community members and advocates living in states that do not have CON programs in place that address the current trend of mergers, downsizing, and closings should urge their state officials to implement such programs so that meaningful review of mergers can take place.

4. Expand and strengthen midwife laws and protections. Midwives can provide safe reproductive health care options to individuals seeking prenatal care, miscarriage support, and abortion services. Such care can be especially beneficial to women who live in an area where a Catholic hospital is the sole health care provider. However, such care is limited due to state laws that can make it extremely hard or even illegal for midwives to practice.¹⁶⁵ Such laws need to be reformed in order to expand the options available to individuals living in areas where the sole hospital is a Catholic hospital.

5. Implement trainings on racial biases at hospitals. As mentioned in this report, the impact of restrictions on sexual and reproductive care may be compounded by racial biases and disparities. For instance, studies have shown that some health care providers have undertreated black patients for pain under the false belief that they are able to withstand more pain than white patients.¹⁶⁶ Sub-standard treatment for pain and other ailments can exacerbate the harms suffered by individuals who are subjected to faith or conscience-based health care refusals. To ensure that health care providers are not acting under such biases, racial bias

trainings should be instated at all hospitals, including Catholic hospitals. Such trainings could increase the quality of care that people of color receive.

This report shows that women of color in many states are at increased risk of having their health needs subordinated to theological standards of health care. Such disparities threaten to compound the many disparities women of color already face in accessing quality reproductive health care. Policy reforms are necessary at the federal and state levels to ensure that patients, and especially patients of color, are not expected bear the burden of their hospital's religious beliefs.

APPENDIX

Methods

We hypothesized that the percentage of births at Catholic hospitals to women of color is higher than the percentage of births at non-Catholic hospitals to women of color within each state.

Data sources

Data for this analysis were obtained from two primary data sources. MergerWatch provided a list of Catholic hospitals that agree to abide by the Ethical and Religious Directives. Birth certificates contain the race of the mother and the hospital of birth. Vital statistics systems collect and aggregate this information. We obtained from state vital statistics systems the number of women of color (any race other than non-Hispanic white) who gave birth at all Catholic hospitals in the state (based on the MergerWatch list) out of the total number of women who gave birth at all Catholic hospitals in the state. We compared this to the number of women of color who gave birth at all non-Catholic hospitals in the state out of the total number of women who gave birth at all non-Catholic hospitals in the state. Where data were available we also compared the proportion of births at Catholic hospitals to non-Hispanic black women to the proportion of births at non-Catholic hospitals who were non-Hispanic black.

Analysis

The proportions of births by race of the mother were tabulated for each state. Chi-square tests were conducted and odds ratios obtained to determine whether differences between Catholic and non-Catholic hospitals were statistically significant ($p < 0.05$).

Limitations

We assumed that the proportion of women of color who gave birth at a hospital may be similar to the proportion of women of color who had pregnancy-related medical complications at a hospital and would therefore be particularly affected by the Ethical and Religious Directives. Data on pregnancy-related medical

complications are not readily available at the hospital level.

Data sources

MergerWatch provided a list of Catholic hospitals that agree to abide by the Ethical and Religious Directives. They also provided a list of Catholic hospitals that were designated the sole or primary providers of health care for a given region by the Centers for Medicare and Medicaid Services.

Results

Seven states had no Catholic birth hospitals (Hawaii, Mississippi, North Carolina, Rhode Island Utah, Vermont, and Wyoming). Eight states did not provide data (Arizona, Colorado, District of Columbia, Georgia, Kansas, Montana, North Dakota, and South Dakota). Data costs were prohibitive for three states (Kentucky, Nebraska, and Nevada).

White/non-White

Across all states with data available combined, Catholic hospitals had higher proportions of births to women of color than non-Catholic hospitals (Odds ratio [OR] 1.19, $p < 0.001$). In all Catholic hospitals combined, 53% of births were to women of color, while in all non-Catholic hospitals combined 49% of births were to women of color. In 19 states, Catholic hospitals had higher proportions of births to women of color than non-Catholic hospitals: New Jersey, Maryland, Maine, Delaware, New Mexico, Massachusetts, Connecticut, Wisconsin, Idaho, New Hampshire, Tennessee, Missouri, Pennsylvania, Indiana, Alaska, Ohio, Illinois, Michigan and Oregon (states ordered by odds ratio; alphabetical order within those with the same OR). In 2 states, West Virginia and Iowa, there were no significant differences between Catholic and non-Catholic hospitals in the proportion of births to women of color. In 11 states and one territory, Catholic hospitals had lower proportions of births to women of color than non-Catholic hospitals (California, Virginia, Florida, Puerto Rico, Arkansas, South Carolina, Oklahoma, Texas, Washington, Louisiana, Alabama, and New York).

White/Black

Across all states with data available combined, Catholic hospitals had lower proportions of births to black mothers than non-Catholic hospitals (OR 0.77, $p < 0.0001$). In 19 states, Catholic hospitals had higher proportions of births to non-Hispanic black mothers compared to non-Hispanic white mothers than non-Catholic hospitals (Maine, Maryland, Idaho, Connecticut, Massachusetts, New Jersey, Wisconsin, Delaware, New Hampshire, Tennessee, Missouri, Oregon, Illinois, West Virginia, Ohio, Iowa, Michigan, California and Indiana). In 12 states and one territory, Catholic hospitals had lower proportions of births to non-Hispanic black mothers compared to non-Hispanic white mothers than non-Catholic hospitals (Florida, Oklahoma, South Carolina, Arkansas, Texas, New Mexico, Pennsylvania, Washington, Louisiana, Alabama, New York, Puerto Rico, and Minnesota).

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ENDNOTES

1. "Catholic Church" in this report refers to the Roman Catholic Church.
2. Defined as any race/ethnicity other than non-Hispanic white.
3. AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, Committee Opinion No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine* (2015), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine> ("Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities.").
4. AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, Committee Opinion No. 649, *Racial and Ethnic Disparities in Obstetrics and Gynecology* (2015), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Racial-and-Ethnic-Disparities-in-Obstetrics-and-Gynecology> (noting racial disparities in reproductive health including preterm birth, cesarean delivery, and maternal and fetal death); Nina Martin and Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017), <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why?sc=17&f=1001>.
5. CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, *Ethical and Religious Directives* (last visited Dec. 29, 2017), <https://www.chausa.org/ethics/ethical-and-religious-directives>.
6. Unfortunately, data on patients who identify as transgender or gender non-conforming is not available.
7. The ERDs apply in a range of health care settings, not only historically Catholic hospitals. These include hospitals that are owned by a Catholic health system or diocese, hospitals affiliated with a Catholic hospital or system through a business partnership (including some public hospitals that are managed by Catholic health systems), and historically Catholic hospitals that continue to follow the Directives despite now being owned by a secular non-profit or for-profit health care system. For simplicity, we refer to this constellation of hospitals as "Catholic hospitals." See discussion of the expansion of contexts where the ERDs apply in "Scope of Catholic Health Care," below.

8. AMERICAN CIVIL LIBERTIES UNION, *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Womens' Health and Lives* 6, 22 (2016), https://aclunc.org/docs/20160505-aclu_catholic_hospital_report.pdf.
9. *Id.*
10. Lois Uttley, Sheila Reynertson, Lorraine Kenny & Louise Melling, *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, MERGERWATCH & THE AMERICAN CIVIL LIBERTIES UNION (2013), <https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf>.
11. *Id.*
12. These states are: Alaska, Connecticut, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Tennessee, and Wisconsin. In two states Catholic hospitals had similar proportions of births to non-white mothers (Iowa and West Virginia). In 12 states and one territory, Catholic hospitals had lower proportions of births to non-white mothers than non-Catholic hospitals (Alabama, Arkansas, California, Florida, Louisiana, Minnesota, New York, Oklahoma, Puerto Rico, South Carolina, Texas, Virginia, and Washington).
13. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *Ethical and Religious Directives for Catholic Health Care Services Fifth Edition, Fifth Edition* (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> [hereinafter, "ERDs"]. Hospitals affiliated with other religious denominations sometimes abide by similar policies. See Ramesh Raghavan, *A Question of Faith*, 297 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 1412 (2007), https://www.researchgate.net/publication/6415908_A_piece_of_my_mind_A_question_of_faith (discussing the denial of abortion services during a medical emergency at a Baptist hospital). However, as these policies are not well documented, we were unable to include them in this study.
14. Rev. Kevin D. O'Rourke, Rev. Thomas Kopfensteiner & Ron Hamel, *A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services*, *HEALTH PROGRESS* (2001), <https://www.chausa.org/docs/default-source/health-progress/a-brief-history-pdf.pdf?sfvrsn=0>.
15. Here, scandal is being used in the religious sense, not the popular sense. It refers to when a person or institution adopts an "attitude or behavior which leads another to do evil." *THE HOLY SEE*, *Catechism of the Catholic Church* (last visited Dec. 8, 2017), http://www.vatican.va/archive/ENG0015/_P80.HTM.
16. However, "Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child." ERDs, *supra* note 13 at 26, directive 47.
17. However, "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." *Id.* at 27, directive 53. While not the subject of this paper, end of life care is also impacted by the ERDs. *Id.* at 29-33.
18. Debra B. Stulberg, Rebecca A. Jackson and Lori R. Freedman, *Referrals for Services Prohibited In Catholic Health Care Facilities*, 48 *PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH* 111, 116 (2016) available at <https://www.ncbi.nlm.nih.gov/pubmed/27467888> (outlining physician's experiences providing information and referrals for reproductive health care at Catholic hospitals, and finding that some physicians "had to hide these referrals or make them outside of normal institutional channels"); NATIONAL WOMEN'S LAW CENTER, *Below the Radar: Health Care Provider's Religious Refusals Can Endanger Women's Lives and Health* 7 (2011) available at <https://www.nwlc.org/wp-content/uploads/2015/08/nwlcbelowtheradar2011.pdf> (finding that "some doctors do not disclose certain treatment options to their patients, or do so only surreptitiously, because their hospitals prohibit those treatments due to the Directives.").
19. Debra B. Stulberg, Yael Hoffman, Irma Hasham Dahlquist & Lori R. Freedman, *Tubal Ligation*

- in Catholic Hospitals: A Qualitative Study of ObGyns' Experiences, 90 *CONTRACEPTION* 422 (2014) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4154979/pdf/nihms-593764.pdf> (noting variations in the provision of sterilizations at Catholic hospitals); John Geyman, Catholic Hospital Systems: A Growing Threat to Access to Reproductive Services, *PHYSICIANS FOR A NATIONAL HEALTH PROGRAM* (2014) available at <http://pnhp.org/blog/2014/03/24/catholic-hospital-systems-a-growing-threat-to-access-to-reproductive-services/> ("It appears that there is some variation from one institution to another how these Directives are interpreted under specific circumstances"); Maryam Guiahi, Maryke Swartz, S. Huynh, G. Schiller, Jeanelle Sheeder, Women's Access to Family Planning Services is Highly Variable at Obstetrics and Gynecology Clinics Affiliated with Catholic Hospitals, 94 *CONTRACEPTION* 391 (2016) available at [http://www.contraceptionjournal.org/article/S0010-7824\(16\)30189-5/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(16)30189-5/fulltext) ("Women's access to family planning services is highly variable within and throughout ob-gyn clinics in the US that are affiliated with Catholic hospitals. Access mostly depends on the specific service and whether the clinic is Catholic owned or Catholic affiliated.").
20. See notes 76-82 and accompanying text.
 21. West Virginia and Iowa.
 22. Alabama, Arkansas, California, Florida, Louisiana, Minnesota, New York, Oklahoma, Puerto Rico, South Carolina, Texas, Virginia, and Washington.
 23. Hawaii, Mississippi, North Carolina, Rhode Island, Utah, Vermont, and Wyoming.
 24. Kelly Gooch, 25 Largest Hospitals in America, *BECKER'S HOSPITAL REVIEW* (Jan. 18, 2017), <https://www.beckershospitalreview.com/lists/25-largest-hospitals-in-america-jan-18.html>; Adventist Health System, <https://www.adventisthealthsystem.com/page.php?section=locations> (last visited Dec. 29, 2017).
 25. AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, Racial and Ethnic Disparities in Obstetrics and Gynecology, *supra* note 4 (noting racial disparities in reproductive health including preterm birth, cesarean delivery, and maternal and fetal death).
 26. We could not directly compare rates of pregnancy complications at Catholic and non-Catholic hospitals, as data on pregnancy-related medical complications are not as readily available as birth data.
 27. Because of the way the data was grouped, for one state—Minnesota—birth data was only analyzed for black and white women.
 28. N.J. STAT. ANN. § 2A:65A-2 ("No hospital or other health care facility shall be required to provide abortion or sterilization services or procedures"); N.J. STAT. ANN. § 2A:65A-1 ("No person shall be required to perform or assist in the performance of an abortion or sterilization."); N.J. STAT. ANN. § 2A:65A-3 (The refusal to perform, assist in the performance of, or provide abortion services or sterilization procedures shall not constitute grounds for civil or criminal liability, disciplinary action or discriminatory treatment).
 29. MD. CODE ANN., HEALTH-GEN. § 20-214(b)(1) ("A licensed hospital, hospital director, or hospital governing board may not be required: (i) To permit, within the hospital, the performance of any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy; or (ii) To refer to any source for these medical procedures. (2) The refusal to permit or to refer to a source for these procedures may not be grounds for: (i) Civil liability to another person; or (ii) Disciplinary or other recriminatory action against the person by this State or any person.").
 30. Diana K. Sugg, Medical Merger Uproar Cumberland Hospitals Unite, Causing Worry Over Layoffs, Services, *THE BALTIMORE SUN* (Oct. 25, 1997), http://articles.baltimoresun.com/1997-10-25/news/1997298004_1_memorial-hospital-sacred-heart-heresy (describing concerns about a proposed merger between secular Memorial Hospital and Catholic Sacred Heart Hospital, including that "women's health services prohibited by Catholic doctrine won't be available anymore"); Andrea K. Walker, St. Joseph Enters Into Agreement with University of Maryland Medical System, *THE BALTIMORE SUN* (Mar. 23, 2012), <http://www.baltimoresun.com/health/bs-hs-stjoe-umms-20120323-story.html>.
 31. Lena H. Sun, Holy Cross Wins Md.'s Approval for New Hospital, *THE WASHINGTON POST* (Jan. 21, 2011), <http://www.washingtonpost.com/wp-dyn/content/article/2011/01/20/AR2011012005898.html> ("A coalition of advocacy groups had urged the state to reject Holy Cross, citing concerns

about access to reproductive health care, especially for poor women and teenagers”).

32. ME. REV. STAT. tit. 22 § 1591 (“No physician, nurse or other person who refuses to perform or assist in the performance of an abortion, and no hospital or health care facility that refuses to permit the performance of an abortion upon its premises, shall be liable to any person, firm, association or corporation for damages allegedly arising from the refusal, nor shall such refusal constitute a basis for any civil liability to any physician, nurse or other person, hospital or health care facility nor a basis for any disciplinary or other recriminatory action against them or any of them by the State or any person.”). See also ME. REV. STAT. tit. 22 § 1592.

33. ME. REV. STAT. tit. 34-B § 7016.

34. DEL. CODE ANN. tit. 24, § 1791(b) (“No hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit such procedures shall not be grounds for civil liability to any person, nor a basis for any disciplinary or other recriminatory action against it by the State or any person.”).

35. 42 C.F.R. § 412.92 (Defining criteria for a sole community hospital, which is a hospital that is located between 25 and 35 miles of similar hospitals or meets certain other conditions.). However, another facility is being planned. Presbyterian Plans \$135 Million Medical Center in Santa Fe, ALBUQUERQUE JOURNAL (Mar. 16, 2016), <https://www.abqjournal.com/741431/presbyterian-plans-hospital-in-santa-fe.html>.

36. Sue Vorenberg, St. Vincent, Christus Seal Partnership, THE NEW MEXICAN (Apr. 9, 2008), http://www.santafenewmexican.com/news/local_news/st-vincent-christus-seal-partnership/article_7c0cf5cb-3245-5c96-9bf1-4408e237902f.html.

37. Id. (“critics have argued that through the deal, Christus, a Catholic organization, will force St. Vincent to follow the church’s ethical and religious directives, which could remove some services to the community in areas of family counseling, contraception and end-of-life care.”). See also ASSOCIATED PRESS, Santa Fe Hospital Would Follow Catholic Directives, ALBUQUERQUE JOURNAL (Dec. 10, 2007), <https://www.abqjournal.com/news/state/apcatholic12-10-07.htm>; SOUTHWEST WOMEN’S LAW CENTER, Past Work on Healthcare Denials (last visited Dec. 8, 2017), <http://www.swwomenslaw.org/our-programs/denial-of-healthcare-services-2/denial-of-healthcare-services/>. Since the merger, the burdensome process for approving abortion care has resulted in at least one doctor declining to send patients to Christus even for a medically-indicated abortion procedure. See Anne Constable, Access to Legal Abortions Increasingly Limited, THE NEW MEXICAN (Jan. 21, 2012), http://www.santafenewmexican.com/news/local_news/access-to-legal-abortions-increasingly-limited/article_37b54347-f4cf-5ff9-9057-34232d1f168c.html (explaining that one doctor “said she didn’t even approach Christus about terminating a pregnancy involving twins, one with no head, one with no heart, because one of the fetuses had a beating heart.”).

38. N.M. STAT. ANN. § 30-5-2 (“This article does not require a hospital to admit any patient for the purposes of performing an abortion.”).

39. N.M. STAT. ANN. § 24-8-6(A)(2) (“nothing in the Family Planning Act shall be construed to require any hospital or clinic that objects on moral or religious grounds to admit any person for the purpose of being sterilized.”).

40. N.M. STAT. ANN. § § 24-7A-7.

41. S.B. 282, 53rd Leg., 1st Sess. (N.M. 2017), <https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0282.pdf>.

42. Id.

43. The mother’s race is self-reported and, starting in 2011, informants can select all races and ethnicities that apply. The revised standards require federal data collection programs to allow respondents to select one or more race categories. In order to provide uniformity and comparability of the data during the transition period, before multiple-race data are available for all reporting areas, it is necessary to “bridge” the responses of those who reported more than one race to a single-race. The method used to bridge responses for those who report more than one race to a single race is based on a procedure whereby multiple races are assigned to the smallest minority group first (i.e., Asian and White becomes Asian, or Black and Native American becomes Native

American). All multiple races that include Hispanic are assigned as Hispanic, and this group also includes all respondents who reported Hispanic ethnicities as well.

44. MASS. GEN. LAWS. ANN. ch. 272, § 21B. There is a similar provision for individual providers. MASS. GEN. LAWS. ANN. ch. 112 § 12I (1981).

45. Kay Lazar, *Mass. Regulators OK Joint Caritas-Centene Healthcare Venture*, THE BOSTON GLOBE (Mar. 13, 2009), http://archive.boston.com/news/local/massachusetts/articles/2009/03/13/mass_regulators_ok_joint_caritas_centene_healthcare_venture/.

46. Michael Paulson and Kay Lazar, *Caritas Ends Joint Venture*, THE BOSTON GLOBE (June 27, 2009), http://archive.boston.com/news/health/articles/2009/06/27/catholic_hospital_system_ends_venture_out_of_concern_on_abortion/.

47. Arielle Levin Becker, *Waterbury Hospital Has New Plans to Be Purchased, Turn For-Profit*, THE CT MIRROR (May 5, 2015), <https://ctmirror.org/2015/05/05/waterbury-hospital-has-new-plans-to-be-purchased-turn-for-profit/>.

48. Official Statement, *Permanent Commission on the Status of Women, Proposed Hospital Merger, Waterbury* (Sept. 5, 2012) available at <https://ctpcsw.files.wordpress.com/2010/07/pcsw-official-statement-re-waterbury-hospitals-merger-9-5-12.pdf>.

49. Susan Campbell, *Who's Guarding Our Reproductive Rights In Hospital Mergers?*, CONNECTICUT HEALTH I-TEAM (June 14, 2016), <http://c-hit.org/2016/06/14/whos-guarding-our-reproductive-rights-in-hospital-mergers/>; *New Non-Profit Initiative Launched to Advance*

Work of Former CT Women's Commission, GREENWICH FREE PRESS (Sept. 28, 2016), <https://greenwichfreepress.com/news/government/new-non-profit-initiative-launched-to-advance-work-of-former-ct-womens-commission-73989/>.

50. Amy Littlefield, *Catholic Rules Forced This Doctor to Watch Her Patient Sicken—Now, She's Speaking Out*, REWIRE (Sept. 7, 2017), <https://rewire.news/article/2017/09/07/catholic-rules-forced-doctor-watch-patient-sicken-now-shes-speaking/>.

51. *Id.*

52. *Id.*

53. WIS. STAT. ANN. § 253.09(1) ("No hospital shall be required to admit any patient or to allow the use of the hospital facilities for the purpose of performing a sterilization procedure or removing a human embryo or fetus"); WIS. STAT. ANN. § 253.09(2) ("No hospital or employee of any hospital shall be liable for any civil damages resulting from a refusal to perform sterilization procedures or remove a human embryo or fetus from a person, if such refusal is based on religious or moral precepts.").

54. IDAHO CODE ANN. § 18-612 ("No refusal to accept a patient for abortion or to perform, assist or participate in any such abortion as herein provided shall form the basis of any claim for damages or recriminatory action against the declining person, agency or institution"); IDAHO CODE ANN § 39-3915 (2003).

55. IDAHO CODE ANN. § 18-611. While this provision is broad, some have argued for still broader exemptions; in one instance, an Idaho pharmacist refused on conscience grounds to dispense the drug methergine to a customer. Methergine is not an "abortifacient drug," but rather a medication used to control bleeding following childbirth or an abortion. See Sharon Strauss, *Complaint Targets Nampa Pharmacist*, IDAHO PRESS TRIBUNE (Jan. 13, 2011), https://www.idahopress.com/news/complaint-targets-nampa-pharmacist/article_d6a73c14-1eea-11e0-9f44-001cc4c03286.html.

56. IDAHO CODE ANN. § 18-611(6).

57. Shawn Rhea, *Can it Work?: Catholic, Secular Facilities Plan Affiliation in N.H.*, MODERN HEALTHCARE (Nov. 9, 2009), <http://www.modernhealthcare.com/article/20091109/MAGAZINE/911069993>.

58. Lois J. Uttley, *How Merging Religious and Secular Hospitals Can Threaten Health Care services*, 30 SOCIAL POLICY 4 (2000). The woman's doctor attempted to schedule her for an emergency abortion after her water broke at 14 weeks. The closest hospital had recently merged with a Catholic system, however, and therefore declined, citing its new abortion policy. Fearing

that his patient's condition could worsen, the doctor gave money to take a taxi to the nearest hospital, 80 miles away.

59. TENN. CODE ANN. § 39-15-204.

60. TENN. CODE ANN. § 68-34-104.

61. Anita Wadhvani and Jake Lowary, Gov. Bill Haslam Signs Strict Late-Term Abortion Ban, THE TENNESSEAN (May 12, 2017), <http://www.tennessean.com/story/news/2017/05/12/gov-bill-haslam-signs-strict-late-term-abortion-ban/320030001/>.

62. MO. REV. STAT. § 197.032; OR. REV. STAT. §§ 435.485; 435.475 ("No hospital is liable for its failure or refusal to participate in such termination if the hospital has adopted a policy not to admit patients for the purposes of terminating pregnancies. However, the hospital must notify the person seeking admission to the hospital of its policy."); 435.225; 127.885(4) (providing immunity from noncompliance with Oregon's Death With Dignity Act. However, the law requires providers to refer patients and transfer their records to a willing provider.); 127.625(1) (providing an exemption relating to end of life care); 43 PA. STAT. ANN. § 955.2; 18 PA. STAT. ANN. § 3213(d), (f)(1); 16 Pa. Code §§ 51.1 et seq.; IND. CODE §§ 16-34-1-3 et seq. ("No private or denominational hospital shall be required to permit its facilities to be utilized for the performance of abortions"); ALASKA STAT. ANN. §§ 18.16.010(b) ("Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section"); 13.52.060(e) ("A health care institution or health care facility may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution or facility that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient"); OHIO REV. CODE ANN. § 4731.91 ("No private hospital, private hospital director, or governing board of a private hospital is required to permit an abortion"); 745 ILL. COMP. STAT. ANN. 70/6 (a "physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience," however "Nothing in this Act shall be construed so as to relieve a physician or other health care personnel from obligations under the law of providing emergency medical care"); 720 ILL. COMP. STAT. 510/13 ("No physician, hospital, ambulatory surgical center, nor employee thereof, shall be required against his or its conscience declared in writing to perform, permit or participate in any abortion, and the failure or refusal to do so shall not be the basis for any civil, criminal, administrative or disciplinary action, proceeding, penalty or punishment. If any request for an abortion is denied, the patient shall be promptly notified"); 745 ILL. COMP. STAT. 70/6.1 ("All health care facilities shall adopt written access to care and information protocols that are designed to ensure that conscience-based objections do not cause impairment of patients' health..."); MICH. COMP. LAWS ANN. § 333.20181 et seq.

63. West Virginia has a hospital exemption for sterilization and end of life care. W. VA. CODE §§ 16-11-1; 16-30-12. It also has individual provider exemptions for end of life care and family planning services. W. VA. CODE §; 16-2B-4.

64. UNITED HEALTH FOUNDATION, 2016 Health of Women and Children Report: Maternal Mortality (2017), https://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/maternal_mortality/state/ALL (ranking New Jersey 47th in maternal mortality rates, with a rate of 37.3 per 100,000 live births, compared to 1st ranked Massachusetts with a rate of 5.8). Note that Alaska and Vermont are not listed.

65. THE HENRY J. KAISER FAMILY FOUNDATION, Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity (last visited Dec. 8, 2017), <https://www.kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22N on-Hispanic%20White%22,%22sort%22:%22desc%22%7D>.

66. Lois Uttley & Christine Khaikin, Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report 4, MERGERWATCH (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=PPoS9U3LHynRyCEpEsiQvHm%2B6D8%3D.

67. Miscarriage of Medicine, *supra* note 10 at 4.
68. ERDs *supra* note 13 at 34-37.
69. *Id.* at 34, 36. There was another movement to revise the ERDs in 2014 in response to new health care partnerships with diverse providers, such as physicians' practices. See Nina Martin, Catholic Bishops Vote to Revise Rules for Health Care Partnerships, PROPUBLICA (Nov. 11, 2014), <https://www.propublica.org/article/catholic-bishops-weigh-tightening-rules-for-health-care-partnerships>.
70. Elizabeth Sepper, *Zombie Religious Institutions*, 112 NW. U. L. REV. (forthcoming 2018) draft available at <https://ssrn.com/abstract=2932235>.
71. Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L.J. 2470, 2484 (2015), https://www.yalelawjournal.org/pdf/h.2470.Deutsch.2514_c5odq3wr.pdf ("Since the ACA's passage, hospital consolidation has intensified.").
72. MERGERWATCH, *Hospital Mergers: Creative Solutions* (last visited Nov. 30, 2017), <http://www.mergerwatch.org/creative-solutions/>.
73. Deutsch, *supra* note 71 at 2483 ("In November 2014, the USCCB announced that it would update the Ethical and Religious Directives for the first time in more than a decade. The revisions are targeted precisely at the rules governing Catholic hospitals' mergers with nonsectarian institutions, preventing workarounds that some hospitals have tried in order to preserve patient options.").
74. UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *Catholic Health Care, Social Services and Humanitarian Aid* (last visited Nov. 30, 2017) <http://www.usccb.org/about/public-affairs/backgrounders/health-care-social-service-humanitarian-aid.cfm> ("Over 5.2 million patients are admitted to Catholic hospitals annually.").
75. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *Committee Opinion No. 530, Access to Postpartum Sterilization* (2012), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co530.pdf?dmc=1&ts=20151217T0624165606> ("The immediate postpartum period is the ideal time following vaginal delivery or at the time of caesarian delivery is the ideal time to perform sterilization because of technical ease and convenience for the woman and physician.").
76. Lori R. Freedman, Uta Landy, & Jody Steinauer, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AMERICAN JOURNAL OF PUBLIC HEALTH 1774, 1774 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/> ("Catholic-owned hospital ethics committees denied approval of uterine evacuation while fetal heart tones were still present, forcing physicians to delay care or transport miscarrying patients.").
77. *Id.* See also Angel M. Foster, Amanda Dennis, Fiona Smith, *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study*, IBIS REPRODUCTIVE HEALTH, 21 WOMEN'S HEALTH ISSUES 24, 24 (2011), <https://www.ncbi.nlm.nih.gov/pubmed/21353977> (finding that physicians at Catholic hospitals "reported that, before initiating treatment, they were required to document nonviability through what they perceived as unnecessary paperwork, tests, and imaging studies.").
78. Freedman, Landy, & Steinauer, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, *supra* note 76 at 1775 ("The experiences of physicians in our study indicate that uterine evacuation may not be approved during miscarriage by [a Catholic hospitals'] ethics committee if fetal heart tones are present and the pregnant woman is not yet ill, in effect delaying care until fetal heart tones cease, the pregnant woman becomes ill, or the patient is transported to a non-Catholic owned facility for the procedure.").
79. Foster, Dennis & Smith, *supra* note 77 at 105 (finding that "some interpretations of the Directives are precluding physicians from providing women with ectopic pregnancies with information about and access to a full range of treatment options and are resulting in practices that delay care and may expose women to unnecessary risks."). See also *id.* at 106 (in a survey of doctors at Catholic hospitals, one "reported having seen 'some' ruptures because of delays in

treatment"); Lori R. Freedman & Debra B. Stulberg, *Conflicts in Care for Obstetric Complications in Catholic Hospitals*, 4 *AJOB PRIMARY RESEARCH* 1 (2013), <https://doi.org/10.1080/21507716.2012.751464>.

80. AMERICAN CIVIL LIBERTIES UNION, *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Womens' Health and Lives* 8-9 (2016) (reporting on Tamesha Means, who was repeatedly discharged from a Catholic hospital emergency room while miscarrying and Mindy Swank, who was forced to carry a nonviable pregnancy for seven weeks because of her hospital's compliance with the ERDs), https://aclunc.org/docs/20160505-aclu_catholic_hospital_report.pdf.

81. See note 18 and accompanying text. See also Foster, Dennis & Smith, *supra* note 77 at 108 (finding that "the interpretation of the Directives at some Catholic hospitals influences, and sometimes restricts...the information that women receive about their treatment options"). See also ERDs, *supra* note 13 at 27, directive 50 ("Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.").

82. See *supra* note 16 and accompanying text (discussing "the danger of scandal in any association with abortion providers."). See also Full Frontal with Samantha Bee, *Extended Interview: Mindy Swank*, YOUTUBE (Oct. 27, 2016), <https://www.youtube.com/watch?v=9finqZJJA8> (In this interview Mindy Swank, discussed *supra* in note 80, explains that the Catholic facility that she went to for care during her miscarriage did not transfer her medical records to a public hospital so she could terminate her pregnancy. Ms. Swank believes they did not transfer the records as this would make them "complicit" in the procedure.).

83. Debra Stulberg, Jocelyn Wascher, Can Geng, and Lori Freedman, *Do Women Know When Their Hospital is Catholic and How This Affects Their Care? Findings from the Patient Awareness of Religious Restrictions in Catholic Hospitals (PARRCH) National Survey*, ORAL ABSTRACT PRESENTED AT THE NORTH AMERICAN FORUM ON FAMILY PLANNING (Atlanta, GA Oct. 14, 2017). An earlier abstract of this research was published at Debra Stulberg, Jocelyn Wascher, Can Geng, and Lori Freedman, *Do Women Know When Their Hospital is Catholic and How This Affects Their Care? Findings from the Patient Awareness of Religious Restrictions in Catholic Hospitals (PARRCH) National Survey*, 97 *CONTRACEPTION* 268 (2017), [http://www.contraceptionjournal.org/article/S0010-7824\(17\)30235-4/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext). However, the data has since been updated.

84. *Supra* note 83. Another study on women's ability to identify what reproductive health services a Catholic hospital is likely to provide found similar results, See Maryam Guiahi, Jeanelle Sheeder, and Stephanie Teal, *Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care?*, 90 *CONTRACEPTION* 429-434 (2014): (women asked about getting care at a fictional hospital called St. Ignatius, 80.0% thought they could get a tubal ligation, 65.3% an abortion if the fetus had a lethal abnormality, 54.2% if the fetus had a genetic abnormality, and 47.9% thought they could get an abortion with a normal pregnancy (for personal reasons). None of these was statistically significantly different from the percent of women who thought they could get these services at a fictional hospital called Metropolitan).

85. *Supra* note 79. See also Lori Freedman, *Women's Perspectives on Receiving Care in Religiously-Affiliated Institutions*, PRESENTATION AT MACCLEAN CENTER FOR BIOETHICS, UNIVERSITY OF CHICAGO (Chicago, IL Apr. 12, 2017).

86. CATHOLICS FOR CHOICE, *The Facts Tell the Story: Catholics and Choice* (2014-2016), <http://www.catholicsforchoice.org/wp-content/uploads/2014/12/FactsTelltheStory2014.pdf>; PEW RESEARCH CENTER, *Public Opinion on Abortion* (2017) <http://www.pewforum.org/fact-sheet/public-opinion-on-abortion/>.

87. Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INSTITUTE (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf ("The abortion index for Catholic women showed that their relative abortion rate was nearly the same as that for all women").

88. CATHOLICS FOR CHOICE, *The Facts Tell the Story: Catholics and Choice*, supra note 86.
89. Uttley & Khaikin, supra note 66 at 5.
90. See supra notes 18 and 81 accompanying text.
91. Complaint at 2, *Tamesha Means v. United States Conference of Catholic Bishops*, 2015 WL 3970046 (W.D. Mich. 2015) (No. 1:15-CV-00353), available at <https://www.aclu.org/legal-document/tamesha-means-v-united-states-conference-catholic-bishops-complaint>.
92. *Id.* at 4-5.
93. *Id.* (“Plaintiff’s ultrasound report indicates Plaintiff had an amniotic fluid index of only 3.4 and a condition called oligohydramnios, which refers to a decreased volume of amniotic fluid due to the premature rupture of membranes....MHP also diagnosed Plaintiff with preterm premature rupture of membrane, a condition in which a woman’s amniotic sac ruptures with a gestation less than 37 weeks.”).
94. *Id.* at 5.
95. *Id.*
96. *Means v. U.S. Conference of Catholic Bishops*, 836 F.3d 643 (6th Cir. 2016). The court found that Ms. Means was only able to show that she suffered physical and mental pain, however could not show any physical injury.
97. Complaint for Declaratory and Injunctive Relief, *Chamorro v. Dignity Health*, No. CGC 15-549626 (Cal. Super. Ct., S.F. Cty. Dec. 28, 2015), available at https://www.aclunc.org/sites/default/files/20151228-aclu_chamorro_complaint.pdf.
98. See supra note 70.
99. ERDs, supra note 13 at 42, directive 44 (“While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization.”).
100. Order Denying Plaintiff Rebecca Chamorro’s Motion for Preliminary Injunction, *Chamorro v. Dignity Health*, No. CGC 15-549626 (Cal. Super. Ct., S.F. Cty. Jan 14, 2016) available at http://www.jurist.org/paperchase/REBECCA_CHAMORRO_ET_AL_vs._DIG_27.pdf.
101. *Id.*
102. Complaint for Declaratory, Compensatory, and Injunctive Relief, *Conforti v. St. Joseph’s Healthcare System*, No. 2:17-CV-00050 (D.N.J. Jan. 5, 2017), available at https://www.lambdalegal.org/in-court/legal-docs/conforti_nj_20170105_complaint.
103. *Id.* at 4.
104. *Id.* at 2-3.
105. Verified Complaint for Declaratory and Injunctive Relief and Statutory Damages, *Minton v. Dignity Health*, No. CGC 17-558259 (Cal. Super. Ct., S.F. Cty. Apr. 19, 2017), available at https://www.aclusocal.org/sites/default/files/complaint_minton.pdf. On December 20th, 2017, a third lawsuit that raised similar issues was brought in Washington state court. That case, *Robbins v. Swedish Health Services*, involved a transgender man who was denied chest reconstruction surgery at a specialty plastic surgery clinic. The clinic is legally affiliated with Providence Health & Services, a non-profit Catholic health care network and the largest health care provider.
106. AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, Committee Opinion No. 439, *Informed Consent* (2009, reaffirmed 2015), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent>. See also *Cruzan by Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 269 (1990) (“This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment.”).
107. See, e.g., 42 CFR 482.13(b)(2) (informed consent requirement under the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation); 42 CFR 59.5(a)(5) (information requirement under the Public Health Service regulations for Title X).
108. 42 U.S.C. § 1395dd (2011); 42 CFR 489.24 (2016); 42 C.F.R. § 482.55 (2012).
109. See *Deutsch*, supra note 71 (arguing that §1557 of the Affordable Care Act should be interpreted to prevent providers from discriminating against pregnant patients by denying them information about abortion care.).

110. 42 U.S.C. § 300a-7 et seq. (2000).
111. 42 U.S.C. § 1396u-2(b)(3)(B); 42 U.S.C. § 1395u-2(b)(3)(B).
112. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006, Pub.L. No. 109-149, § 508(d), 119 Stat. 2833, 2879-80 ("None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.").
113. GUTTMACHER INSTITUTE, Refusing to Provide Health Services (Dec. 1, 2017), <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>.
114. *Id.*
115. See Deutsch, *supra* note 71 at 2482 ("First, they expanded beyond abortion and sterilization to apply to contraception, then to end-of life care, stem-cell research, and even, in some cases, to any unspecified health service to which a religious or moral objection may be raised, including counseling or the provision of information to patients about their health status. Second, they granted religious accommodation to more kinds of entities.").
116. Miss. Code Ann. § 41-107-5(1) (2014). Under the law, medical providers are permitted to decline to provide "any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health-care providers or health-care institutions." The statute applies to "any individual who may be asked to participate in any way in a health-care service."
117. Legislative Tracker: Conscience and Refusal Clauses, REWIRE (last visited Dec. 2, 2017), <https://rewire.news/legislative-tracker/law-topic/conscience-and-refusal-clauses/>.
118. Abortion Non-Discrimination Act of 2015, S. 50, 114th Cong. (2015-2016).
119. See *Thomas v. Abdul-Malak*, No. 02-1374 (W.D. Pa. July 29, 2004 (physician held liable for failing to inform pregnant patient of her dangerous medical condition or of the potential benefit of obtaining an abortion)); *Brownfield v. Daniel Freeman Marina Hospital* 256 Cal. Rptr. 240 (Ct. App. 1989) (hospital may be held liable for failure to provide information about the morning-after pill to rape victim, despite its religious objection); *Spellacy v. Tri-County Hospital*, No. 77-1788, 1978 WL 3437 (Pa. Ct. Com. Pl. Mar. 23, 1978), *aff'd*, 395 A.2d 998 (Pa. Super. Ct. 1978) (state conscience clause did not apply to an admissions clerk who objected to typing lab and admission forms for patients seeking abortions); *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 223 (3d Cir. 2000) (hospital's duty to provide a reasonable accommodation to a nurse with religious objections to providing abortion care was satisfied by its offer to transfer her to another position); *St. Agnes Hospital of Baltimore v. Riddick*, 748 F. Supp. 319 (D. Md. 1990) (Catholic hospital's free exercise rights were not violated by loss of accreditation for failure to provide clinical training in family planning and abortion. This opinion was later nullified by the passage of the Coat's Amendment). Furthermore, cases that have ruled in favor of an objecting provider have sometimes noted the lack of harm to the patient. See *Swanson v. St. John's Lutheran Hosp.*, 597 P.2d 702 (Mont. 1979) ("There is no showing in the evidence that the hospital was unduly prejudiced, nor the patient was endangered.").
120. Religious refusal laws and policies have rarely faced direct legal challenges. They were, however, arguably authorized as a general matter in the lesser-known *Roe* companion case *Doe v. Bolton*, which noted in passing that under a Georgia conscience clause, "a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure"). *Doe v. Bolton*, 410 U.S. 179, 197-98 (1973). See also *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974) (upholding the Church Amendment against an Establishment Clause challenge); *Doe v. Mundy*, 378 F.Supp. 731, 736-37 (E.D. Wisc. 1974), *aff'd*, *Doe v. Mundy*, 514 F.2d 1179 (7th Cir. 1975) (Requiring a public hospital to allow willing providers to perform abortions but ordering that "doctors, nurses, and other personnel ... who have moral and

religious convictions against the performance of abortions not be forced to perform abortions"); *Watkins v. Mercy Medical Center*, 364 F.Supp. 799 (D. Idaho 1973), *aff'd*, *Watkins v. Mercy Medical Center*, 520 F.2d 894 (9th Cir. 1975) (finding that while under the Church Amendment a hospital cannot discriminate against providers who would like to perform sterilizations, it "has the right to adhere to its own religious beliefs and not be forced to make its facilities available for services which it finds repugnant to those beliefs."). More recently, the D.C. Circuit Court and a Federal District Court dismissed constitutional challenges to the Weldon Amendment on standing grounds. See *National Family Planning and Reproductive Health Ass'n, Inc v. Gonzales*, 468 F.3d 826 (D.C. Circ. 2006) (holding that Title X grantees did not face an imminent threat of injury under the Weldon Amendment); *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *1 (N.D. Cal. Mar. 18, 2008) (holding that there was no reason to believe that the Amendment conflicted with a California law requiring health care facilities that provide emergency care to provide emergency abortions.).

121. *Martin & Montagne*, *supra* note 4 ("An expanding field of research shows that the stress of being a black woman in American society can take a significant physical toll during pregnancy and childbirth.").

122. See *infra* notes 147-151 and accompanying text.

123. See CHILD TRENDS DATA BANK, *Late or No Prenatal Care: Indicators of Child and Youth Well-Being 1* (2015), https://www.childtrends.org/wp-content/uploads/2015/12/25_Prenatal_Care.pdf ("Mothers who receive late (defined as beginning in the third trimester of pregnancy) or no prenatal care are more likely to have babies with health problems. Mothers who do not receive prenatal care are three times more likely to give birth to a low-weight baby, and their baby is five times more likely to die."); GUTTMACHER INSTITUTE, *Maternal Mortality Risk Rises with Cesarean Birth, Falls with Prenatal Care* (2004) <https://www.guttmacher.org/journals/psrh/2004/maternal-mortality-risk-rises-cesarean-birth-falls-prenatal-care> ("pregnancy-related mortality was less likely among women who received any prenatal care than among those who did not").

124. Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin, and Paul L. Hebert, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 *AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY* 122.e1, 122.e1 ("Data indicate that blacks receive care in a concentrated set of hospitals and these hospitals appear to provide lower quality of care"); *AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY*, Committee Opinion No. 649, *Racial and Ethnic Disparities in Obstetrics and Gynecology*, *supra* note 4.

125. Surveys conducted in 1969 and 1974 by the Association on American Indian Affairs found that 25 to 35% of all Indian children were being placed in out-of-home care. A large number—one survey found up to 85%— of those children were being placed in non-Indian homes or institutions. See William Byler, *The Destruction of American Indian Families*, in *THE DESTRUCTION OF AMERICAN INDIAN FAMILIES* 1, 1-2 (Steven Unger, ed., 1977).

126. See, e.g., CENTER FOR CONSTITUTIONAL RIGHTS, *Douglas v. Holloman*, Historic Case (2007), <http://ccrjustice.org/home/what-we-do/our-cases/douglas-v-holloman>.

127. *AMERICAN CIVIL LIBERTIES UNION*, *Norplant: A New Contraceptive with the Potential for Abuse* (last visited Nov. 28, 2017), <https://www.aclu.org/norplant-new-contraceptive-potential-abuse>; Tamar Lewin, *Implanted Birth Control Device Renews Debate Over Forced Contraception*, *N.Y. TIMES* (Jan. 10, 1991), <http://www.nytimes.com/1991/01/10/us/implanted-birth-control-device-renews-debate-over-forced-contraception.html?pagewanted=all>.

128. DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 90-116 (1997).

129. *Martin & Montagne*, *supra* note 4.

130. BRIAN D. SMEDLEY, ADRIENNE Y. STITH & ALAN R. NELSON, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Institute of Medicine of the National Academies) (2003), <https://www.nap.edu/read/12875/chapter/1>.

131. *Id.* at 163-166.

132. *Id.* at 1.

133. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver, Racial Bias In Pain Assessment And Treatment Recommendations, And False Beliefs About Biological Differences Between Blacks And Whites, 113 PROCEEDINGS OF THE NATIONAL ACADEMY OF SCIENCES OF THE UNITED STATES OF AMERICA 4296, 4300 (2016), <http://www.pnas.org/content/113/16/4296.full.pdf> (“beliefs about biological differences between blacks and whites—beliefs dating back to slavery—are associated with the perception that black people feel less pain than do white people and with inadequate treatment recommendations for black patients’ pain.”).
134. Irene V Blair, John F Steiner, and Edward P Havranek, Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here? 15 THE PERMANENTE JOURNAL 71, 72-73 (2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/pdf/i1552-5775-15-2-71.pdf> (discussing studies on implicit bias in health care and finding that “the presence of implicit bias is generally consistent across the studies...The presence of implicit bias among clinicians further suggests that it could play a role in health care disparities just as it plays a role in differential outcomes elsewhere in society.”). An additional recent report showed that black women faced negative stereotyping and stigmatization when they sought reproductive health care in the South. See SISTERSONG, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, AND THE CENTER FOR REPRODUCTIVE RIGHTS, Reproductive Injustice, Racial and Gender Discrimination in U.S. Healthcare 15-22 (2014), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf.
135. Martin & Montagne, *supra* note 4 (emphasis added).
136. CENTERS FOR DISEASE CONTROL AND PREVENTION, Pregnancy Mortality Surveillance System (last updated Nov. 9, 2017), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>.
137. Cynthia J. Berg, Margaret A. Harper, Samuel M. Atkinson, Elizabeth A. Bell, Haywood L. Brown, Marvin L. Hage, Avick G. Mitra, Kenneth J. Moise Jr, & William M. Callaghan, Preventability of Pregnancy-Related Deaths Results of a State-Wide Review, 106 AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS 1228 (2005), <https://www.ncbi.nlm.nih.gov/pubmed/16319245>.
138. Myra J. Tucker, Cynthia J Berg, William M. Callaghan, & Jason Hsia, The Black-White Disparity in Pregnancy-Related Mortality From 5 Conditions: Differences in Prevalence and Case-Fatality Rates, 97 AMERICAN JOURNAL OF PUBLIC HEALTH 247, 249 (2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1781382/> (“The prevalence rates of these conditions [preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum hemorrhage] among Black women were not significantly greater compared to those among White women. However, for all 5 complications, Black women had case-fatality rates that were 2- to 3-times greater than those of White women.”).
139. Sajid Shahul, Avery Tung, Mohammed Minhaj, Junaid Nizamuddin, Julia Wenger, Eitezaz Mahmood, Ariel Mueller, Shahzad Shaefi, Barbara Scavone, Robb D. Kociol, Daniel Talmor, & Sarosh Rana, Racial Disparities in Comorbidities, Complications, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia, 34 HYPERTENS PREGNANCY 506, 512 (2015) (Finding that black “women with preeclampsia had higher rates of maternal and obstetric complications, and experienced higher unadjusted and adjusted odds of mortality when compared to white women with preeclampsia/eclampsia”), <https://www.ncbi.nlm.nih.gov/pubmed/26636247>; Deborah Rosenberg, Stacie E. Geller, Laura Studee, & Suzanne M. Cox, Disparities in Mortality Among High Risk Pregnant Women in Illinois: A Population Based Study, 16 ANNALS OF EPIDEMIOLOGY 26, 29 (2006) (finding that “African American and Hispanic women with a diagnosis of PIH were 9.9 (95% CI, 4.4–22.2) and 7.9 (95% CI, 3.2–19.6) times more likely to die than were White women with the same diagnosis.”), <https://www.ncbi.nlm.nih.gov/pubmed/16023371>.
140. Andreea A. Creanga, Carla Syverson, Kristi Seed, & William M. Callaghan, Pregnancy-Related Mortality in the United States, 2011–2013, 130 OBSTETRICS & GYNECOLOGY 366, 370 (2017), <https://www.ncbi.nlm.nih.gov/pubmed/28697109>.
141. CENTERS FOR DISEASE CONTROL AND PREVENTION, Fetal and Perinatal Mortality: United States, 2013, 64 NATIONAL VITAL STATISTICS REPORTS 1, 4 (2015), https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_08.pdf (“The fetal mortality rate of 10.53 for non-Hispanic black women was more

than twice the rate for non-Hispanic white women. The rate for AIAN [American Indian and Alaska Native] women (6.22) was 27% higher, and the rate for Hispanic women (5.22) was 7% higher, than the rate for non-Hispanic white women.”).

142. Elaine L. Hill, David Slusky, & Donna Ginther, *Medically Necessary but Forbidden: Reproductive Health Care in Catholic-owned Hospitals*, NATIONAL BUREAU OF ECONOMIC RESEARCH WORKING PAPER SERIES (2017), available at <http://www.nber.org/papers/w23768.pdf>.

143. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AMERICAN JOURNAL OF PUBLIC HEALTH 1904, 1908 (2017), <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042> (“women of color and those with family incomes less than 100% of the federal poverty level have higher rates of abortion than do White women and those with higher incomes.”); Christine Dehlendorf, Lisa H. Harris, & Tracy A. Weitz, *Disparities in Abortion Rates: A Public Health Approach*, 103 AMERICAN JOURNAL OF PUBLIC HEALTH 1772 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780732/>.

144. Sonya Borrero, Charity G. Moore, Li Qin, Eleanor B. Schwarz, MD, Aletha Akers, Mitchell D. Creinin, & Said A. Ibrahim, *Unintended Pregnancy Influences Racial Disparity in Tubal Sterilization Rates*, 25 JOURNAL OF GENERAL INTERNAL MEDICINE 122, 122 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837493/> (“Minority women in the United States are far more likely to rely on tubal sterilization as a method of contraception than white women”).

145. The study found that the decrease in the rate of tubal ligations accounted for 10,000 fewer tubal ligations each year, nationwide. See Hill, Slusky, & Ginther, *supra* note 142.

146. GUTTMACHER INSTITUTE, *Fact Sheet: Unintended Pregnancy in the United States* (2016), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states> (“Births resulting from unintended or closely spaced pregnancies are associated with adverse maternal and child health outcomes, such as delayed prenatal care, premature birth, and negative physical and mental health effects for children.”).

147. THE HENRY J. KAISER FAMILY FOUNDATION, *Women’s Health Insurance Coverage Fig. 3* (Oct. 31, 2017), <http://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>; GUTTMACHER INSTITUTE, *Uninsured Rate Among Women of Reproductive Age Has Fallen More Than One-Third Under the Affordable Care Act* (Nov. 17, 2016), <https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under>.

148. GUTTMACHER INSTITUTE, *Uninsured Rate Among Women of Reproductive Age Has Fallen More Than One-Third Under the Affordable Care Act*, *supra* note 147.

149. *Id.*

150. THE HENRY J. KAISER FAMILY FOUNDATION, *Fact Sheet: Women’s Health Insurance Coverage* (2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/6000-10.pdf> (“Uninsured women are more likely to have inadequate access to care, get a lower standard of care when they are in the health system, and have poorer health outcomes.”).

151. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *Committee Opinion No. 552, Benefits to Women of Medicaid Expansion Through the Affordable Care Act* (2013), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Benefits-to-Women-of-Medicaid-Expansion-Affordable-Care-Act> (“Uninsured pregnant women receive fewer prenatal care services than insured women and are more likely to experience adverse maternal outcomes such as pregnancy-related hypertension and placental abruption.”). See also *supra* note 123.

152. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *Response to Politician’s Inaccurate Abortion Comments* (Oct. 19, 2012), <https://www.acog.org/About-ACOG/News-Room/News-Releases/2012/Response-to-Politicians-Inaccurate-Abortion-Comments> (“abortions are necessary in a number of circumstances to save the life of a woman or to preserve her health.”).

153. See, e.g., U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Access to Care: Provider Availability In Medicaid Managed Care 8* (2014), <https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf> (“Medicaid managed care enrollees may not be able to make appointments with as many as half

of the providers listed by their plans...When providers listed as participating in a plan cannot offer appointments, it may create a significant obstacle for an enrollee seeking care."); U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Child Health USA 2013* 33 (2013), <https://mchb.hrsa.gov/sites/default/files/mchb/Data/Chartbooks/childhealth2013.pdf> ("Common barriers to getting prenatal care as early as desired (or at all) can include limited resources, transportation issues, and not knowing that one is pregnant."); Alina Salganicoff, Usha Ranji, Adara Beamesderfer, & Nisha Kurani, *Women and Health Care May 2014 in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey*, THE HENRY J. KAISER FAMILY FOUNDATION (2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf> (providing an overview of barriers to care for women, including women covered by Medicaid).

154. Amy Littlefield, *How a Catholic Insurer Built a Birth Control Obstacle Course in New York*, REWIRE (Jan. 26, 2017), <https://rewire.news/article/2017/01/26/catholic-insurer-built-birth-control-obstacle-course-new-york/>; Julie Rovner, *How Catholic Insurance Companies Outsource Contraceptive Coverage*, NPR (Sept. 17, 2014), <https://www.npr.org/sections/health-shots/2014/09/17/349237702/how-catholic-insurance-companies-outsource-contraceptive-coverage>.

155. Pelyin Hung, Carrie E Henning-Smith, Michelle M. Casey, & Katy B. Kozhimannil, *Access to Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14*, 36 HEALTH AFFAIRS 1663, 1667 (2017), <https://www.ncbi.nlm.nih.gov/pubmed/28874496> ("black women and Medicaid beneficiaries in rural areas have less access to nonlocal high-acuity obstetric care than do white or privately insured rural women.").

156. *Id.* at 1667; KB Kozhimannil, Casey P. Hung, M. M. Casey, and S.A. Lorch, *Factors Associated With High Risk Rural Women Giving Birth in Non-NICU Hospital Settings*, 37 JOURNAL OF PERINATOLOGY 510 (2016).

157. Dean Olsen, *Rauner Signs Bill Altering Health Care 'Right of Conscience' Law*, THE STATE JOURNAL-REGISTRAR (Aug. 2, 2016), <http://www.sj-r.com/news/20160802/rauner-signs-bill-altering-health-care-right-of-conscience-law>.

158. 745 ILL. COMP. STAT. 70/6.1. Shortly after the law was enacted, several anti-abortion crisis pregnancy centers filed federal court lawsuits challenging the amendment. On July 19th, the district court issued a preliminary injunction in one of the lawsuits preventing the state from enforcing the amendment. See *National Institute of Family and Life Advocates v. Rauner*, No. 3:16-cv-50310 (N.D. Ill. July 19, 2017) <http://www.adfmedia.org/files/OrderGrantingPrelimInjunction.pdf>.

159. AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, *Committee Opinion No. 385, The Limits of Conscientious Refusal in Reproductive Medicine*, *supra* note 3.

160. S.B. 282, 53rd Leg., 1st Sess. (N.M. 2017), <https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0282.pdf>; H.B. 5674, 98th Leg., Reg. Sess. (MICH. 2016) <https://www.legislature.mi.gov/documents/2015-2016/billintroduced/House/pdf/2016-HIB-5674.pdf>; H.B. 1787, 64th Leg., Reg Sess. (OR. 2015), <http://lawfilesexet.leg.wa.gov/biennium/2015-16/Pdf/Bills/House%20Bills/1787.pdf>.

161. See, e.g., OR. REV. STAT. § 435.475; IDAHO CODE ANN. § 18-611(6).

162. *Miscarriage of Medicine*, *supra* note 10 at 23.

163. CON Certificate of Need Laws, NATIONAL CONFERENCE OF STATE LEGISLATORS (Aug. 25, 2016); <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>; Christine Khaikin, Lois Uttley, and Aubree Winkler, *When Hospitals Merge: Updating State Oversight to Protect Access to Care*, MERGERWATCH (2016), https://static1.squarespace.com/static/568ad532cbced6b473f20732/t/57962bcc414fb5c7c3766775/1469459434906/MergerWatch_CON_report_June2016.pdf.

164. Khaikin, Uttley & Winkler, *supra* note 163 at 16. These states are: Connecticut, Hawaii, Illinois, Iowa, Kentucky, Maryland, New York, New Jersey, Rhode Island, and Tennessee.

165. Deborah Walker, Barbara Lannen, Debra Rossie, *Midwifery Practice and Education: Current Challenges and Opportunities*, 19 ONLINE JOURNAL OF ISSUES IN NURSING (2014), <https://www.ncbi.nlm.nih.gov/pubmed/26812270>; *Direct Entry Midwifery State-by-State Legal Status*, MIDWIVES ALLIANCE OF NORTH AMERICA AND THE NORTH AMERICAN REGISTRY OF MIDWIVES (Nov. 18, 2017),

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