
HEALTH CARE DENIED

PATIENTS AND PHYSICIANS SPEAK OUT ABOUT CATHOLIC HOSPITALS
AND THE THREAT TO WOMEN'S HEALTH AND LIVES



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Written by:

Julia Kaye, Brigitte Amiri, Louise Melling, and Jennifer Dalven
American Civil Liberties Union

Data Provided by:

MergerWatch

Data Analysis by:

Patricia HasBrouck
Madison Healthcare Advisors



NATIONAL OFFICE
125 Broad Street, 18th Floor
New York, NY 10004
(212) 549-2500
www.aclu.org

Cover photo: Tamesha Means, March 2016. Credit: Danna Singe/ACLU

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INTRODUCTION

In the spring of 2015, Dr. AuTumn Davidson was called in to the University of Illinois Hospital in the early hours of the morning to perform an emergency abortion. The patient was 19 years old and about 19 weeks pregnant, with a subchorionic hemorrhage causing heavy bleeding. The patient had sought emergency care at two different Catholic hospitals¹ during the previous week, but neither would perform an abortion—even though she was bleeding so heavily that one of the hospitals gave her a blood transfusion before sending her home.

“She told us that someone at the second hospital had whispered to her that if she wanted an abortion, she could go to another hospital,” Dr. Davidson recalled. “When we admitted her, her hemoglobin was at 6 instead of at 11 or 12, where it should have been. She and her partner just kept saying that they thought she was going to die.”

Unfortunately, this patient’s experience is not unique.

This report recounts stories told to the ACLU by women who were denied medically indicated reproductive health care at Catholic hospitals, where religion too often takes precedence over medical standards. Some of these women described rushing to a nearby Catholic hospital when something went horribly awry with their pregnancies, only to be turned away because of the hospital’s religious restrictions on care. Others were forced to undergo an additional surgery after recovering from childbirth because a Catholic hospital refused to let their doctor perform a tubal ligation (commonly known as “getting your tubes tied”) at the time of delivery, when the procedure is safest. We also heard from doctors at Catholic hospitals who are forbidden from providing essential reproductive health care to their patients, and from physicians at secular hospitals, like Dr. Davidson, who treat these very sick women after they are denied care at a Catholic hospital. The stories summarized here are presented as they were told to the ACLU.²

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The goal of this report is to shine a light on the harm and discrimination occurring at hospitals across this country and call for a change in our laws to ensure that these stories are not repeated. We note that while this report focuses on denials of reproductive health care to cisgender women,³ men who are transgender and gender-non-conforming patients who may not identify as women



A statue outside of Presence Saint Francis Hospital in Evanston, Illinois. Credit: Danna Singe/ACLU

suffer similar harms when seeking reproductive health care. These patients often face additional discrimination on the basis of their gender identity when seeking this and other kinds of care at Catholic hospitals. We note also that reproductive health services are provided by a broad array of clinicians, all of whom would be subject to a Catholic hospital's religious restrictions on care. This report emphasizes the experiences of physicians only because those are the stories that arose most often in our investigation.

Today, one in six hospital beds in the United States is in a Catholic hospital. In some places, such as Washington State, more than 40 percent of all hospital beds are in a Catholic hospital, and entire regions have no other option for hospital care. Catholic hospitals also receive billions in taxpayer dollars.⁴ These hospitals should not be permitted to turn away patients seeking emergency medical care, to discriminate against women by refusing to provide critical reproductive health services, or to force their values on patients who may not share them. Religious freedom in America means that we all have a right to our religious beliefs. But it does not give us the right to use our religion to discriminate against and impose those beliefs on others who do not share them—especially when doing so comes at the expense of women's health and lives.

CATHOLIC HOSPITALS: A PRIMER

Hundreds of hospitals across this country adhere in part or in full to a set of policy prescriptions known as the Ethical and Religious Directives for Catholic Health Care Services (“the Directives”), which are issued by the United States Conference of Catholic Bishops (USCCB).⁵ 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.”

The Directives prohibit a range of reproductive health services, including contraception, sterilization, many infertility treatments, and abortion, even when a woman’s health or life is jeopardized by a pregnancy. For example, the Directives plainly state:

- “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted”⁶
- “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution”⁷
- “The free and informed health care decision of the person . . . is to be followed so long as it does not contradict Catholic principles.”⁸

There is variation in how Catholic hospitals implement the Directives. Nevertheless, as the stories in this report illustrate, many Catholic hospitals comply with the Directives by prohibiting their physicians from performing an abortion or sterilization even when this denial of care puts a patient at serious risk, and others will deviate from the Directives only after the patient has already been harmed. Moreover, deviation can sometimes carry penalties—including the loss of the hospital’s “Catholic” status—even when the hospital acts to save a woman’s life.

MISCARRIAGE MISMANAGEMENT

Women Denied Emergency Abortions at Catholic Hospitals

Across the country, many Catholic hospitals are violating both medical standards and their legal obligations by denying necessary care to patients who are in the midst of a miscarriage or experiencing other pregnancy complications prior to viability—and who face increased risks with each passing day.

Mindy Swank and her husband were thrilled to learn that they had a second child on the way. Their joy quickly dissipated, however, when Mindy's water broke prematurely at 20 weeks and they learned through testing that the fetus, because of health conditions, could not survive. Waiting for Mindy's body to complete the miscarriage on its own could expose her to infection and hemorrhaging; nevertheless, in accordance with the Directives, the Catholic hospital in Illinois where Mindy had received the genetic testing would not perform an abortion while there was still a fetal heartbeat. For nearly two weeks, Mindy struggled with the emotional strain of continuing a pregnancy when she knew her baby could not survive. Then, one morning, she woke



Mindy Swank, March 2016. Credit: Danna Singe/ACLU

up bleeding. In a panic, Mindy and her husband rushed to their local hospital to ask them to complete the miscarriage. But that hospital also adhered to the Directives,⁹ and refused to induce labor. Mindy returned to that hospital multiple times over the next five weeks and was repeatedly turned away—without even being told that she could get the abortion if she went elsewhere. Finally, when she was 27 weeks pregnant and severely hemorrhaging, they induced labor. The baby died shortly after delivery.

Mindy is not alone. Indeed, countless women have turned to Catholic hospitals when something went terribly wrong with a pregnancy—and when their own health was endangered as a result—only to have their care severely delayed, or outright denied, because of religion.

Tamesha Means is one of them. Tamesha was 18 weeks pregnant with her third child when her water broke. She rushed to the nearest hospital, which is operated by Mercy Health Partners in Muskegon, Michigan. Because she was only 18 weeks along, the pregnancy was not viable. Ending the pregnancy would have been the safest course of action, but the hospital's religious policies forbade it—so they gave Tamesha two Tylenol and sent her home

Ending the pregnancy would have been the safest course of action—but they gave Tamesha two Tylenol and sent her home instead.



Tamesha Means, March 2016. Credit: Danna Singe/ACLU



Tamesha Means and family, March 2016. Credit: Danna Singe/ACLU

was only when Tamesha began to deliver that the hospital provided care. The baby died within hours.

without telling her that there was virtually no way she could give birth to a healthy baby. When Tamesha returned the next morning, she was bleeding, in severe pain, and showing signs of an infection; again, she was turned away. Even after she returned a third time, in excruciating pain, the hospital staff began filling out the discharge paperwork. It

Maria (a pseudonym), a health care professional and mother of two in Washington State, was six to seven weeks along in her second pregnancy when she began experiencing heavy vaginal bleeding. She knew she was miscarrying and sought emergency care at the Catholic hospital where she was then working. Although she was aware of the hospital's religious affiliation, her insurance coverage extended only to that hospital, and she could not afford thousands of dollars in out-of-network costs to go elsewhere.

Maria's physician explained that the pregnancy was no longer viable and that her uterus needed to be evacuated in order to stop the bleeding. But, because the Directives prohibit an abortion if the fetus still has cardiac activity, her physician advised "expectant management," i.e., waiting to see if Maria's body would complete the miscarriage on its own.

The hospital staff delayed performing an abortion for hours while they attempted to verify through ultrasound that the fetus did not have a heartbeat, as required by the Directives. Finally, after seven hours, the hospi-

Finally, after seven hours, the hospital completed the miscarriage. By then, Maria's iron levels were so low that she needed a blood transfusion.

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It was not without consequence.

All blood transfusions carry risks, such as blood-borne infections and allergic reactions. But what happened to Maria was particularly dangerous. She was transfused with blood carrying Kell antigens and developed anti-Kell antibodies. Because her husband was Kell positive, this meant that their next pregnancy would be at risk for sudden fetal demise. When Maria became pregnant again several years later, she and her husband were terrified throughout that she would suddenly lose the pregnancy. Thankfully, their baby survived. But Maria and her family could have avoided significant emotional trauma if the Catholic hospital had provided her with the care she needed without hours of needless delay.

The ACLU has spoken with health care providers at Catholic hospitals who are deeply committed to providing medically appropriate care to their patients, but straight-jacketed by the religious affiliation of the facilities in which they work.

Dr. Rupa Natarajan was working in a Catholic hospital in New England when she encountered a 19-year-old pregnant woman experiencing preterm premature rupture of membranes at 17 weeks. The pregnancy was doomed, and the patient was getting very sick, so Dr. Natarajan determined that the best course would be to perform an abortion. But the hospital prohibited her from doing so. The patient was admitted but not treated, and over the next day, her temperature and heart rate climbed. By the time Dr. Natarajan could arrange to have her transferred to another hospital to save her life, the patient's fever had reached 104 degrees.

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Another OB-GYN on the East Coast recalled, "We had a woman experiencing preterm premature rupture of membranes at 16 weeks, but there was still a fetal heartbeat. The patient had to look into going elsewhere to get care because we weren't

permitted to deliver her. This puts a burden on the patient to go to a new doctor and have to relive everything [all] over again. Because of the delay in getting to another provider, the patient ended up delivering the [umbilical] cord at home—when the membranes rupture so early in pregnancy, sometimes the cord can be delivered first.”

Doctors at non-Catholic facilities also told us about the patients who came to them facing dire situations after having been denied necessary care.



Dr. David Eisenberg. Image courtesy of Washington University School of Medicine.

Dr. David Eisenberg recalled that “the sickest patient I ever cared for during my residency” was a young woman denied care at a Catholic hospital outside of Chicago, Illinois. Her water had broken well before the fetus was viable, but the hospital refused to take steps to hasten delivery even though everyone knew the fetus could never survive. By the time she was transferred to Dr. Eisenberg’s hospital 10 days later, she had a fever of 106 degrees and was dying of sepsis. She survived, but she suffered an acute kidney injury requiring dialysis and a cognitive injury due to the severity of her sepsis. She spent nearly two weeks in the hospital before being transferred to a long-term care facility.

“I clearly remember sitting in her ICU room after her [uterine] evacuation, wondering if she would make it through the night,” Dr. Eisenberg recalled. “To this day, I have never seen someone so sick—because we would never wait that long before evacuating the uterus. Expediting the delivery is the right thing to do in such situations, *always*, regardless of the religious affiliation of the hospital.”

Another OB-GYN told the ACLU about a patient she treated at a secular hospital in New England. The patient had previously been evaluated at a local Catholic hospital after she started bleeding around 12 weeks into her pregnancy. The Catholic hospital performed an ultrasound and found that the patient had an abnormal pregnancy “with placenta coming out of her cervix,” but because there was a fetal heartbeat, they

“To this day, I have never seen someone so sick—because we would never wait that long before evacuating the uterus.”

Because there was still a fetal heartbeat, they told her she would have to wait.

patient had to stay in the intensive care unit and needed transfusion of seven units of blood during her hospital stay. None of this would have been necessary had the Catholic hospital provided appropriate care when the patient first presented.

told her she would have to wait. When the patient presented at this doctor's hospital a week later, she was hemorrhaging and severely anemic from her blood loss over the past week. The medical team at the secular hospital performed emergency surgery and was just barely able to avoid the need for a hysterectomy—but the

Many of these doctors spoke not only of the physical harm to pregnant women denied medically indicated care, but also of the emotional trauma that these religiously motivated denials inject into an already fraught situation.

Dr. Colleen Krajewski, an OB-GYN in Pennsylvania, recalled a patient whose water had broken at the very beginning of her second trimester. She went to the hospital closest to her, which happened to be Catholic. Although it was apparent to all that the (much desired) pregnancy had no chance of survival, the patient was left in a hospital bed for two days to passively wait for a spontaneous miscarriage. The patient was devastated that she was losing the pregnancy, and her trauma was compounded each time the hospital staff came to check if there was still a fetal heartbeat. The treating physicians petitioned the hospital's ethics committee to intervene, but the request was denied. The patient was eventually transferred to Dr. Krajewski's hospital, which provided the appropriate care. Dr. Krajewski observed, "the hours-long, middle-of-the-night transfer added to the patient's experience of fear and abandonment."

The Myth: “Abortion is never necessary to save a woman’s life.”



As recently as 2015, the USCCB claimed that there was no such thing as a life-saving abortion. It said that “there is significant credible evidence that the universe of abortions ‘necessary’ to save a woman’s life comprises an empty set.”¹⁰

But medical consensus says otherwise. According to the American College of Obstetricians and Gynecologists, the nation’s leading group of women’s health care physicians, “more than 600 women die each year from pregnancy and childbirth-related reasons right here in the United States. In fact, many more women would die each year if they did not have access to abortion to protect their health or to save their lives.”¹¹ There are a number of conditions that can arise during or be exacerbated by pregnancy that may require a life-saving abortion, such as the following:

“Direct abortion is never morally permissible . . . no matter what the reason.”

— U.S. Conference of Catholic Bishops

- **Hypertensive disorders**, such as preeclampsia and eclampsia, affect 5 to 10 percent of all pregnancies in the United States¹² and are responsible for nearly 10 percent of maternal deaths in this country.¹³ Preeclampsia is a pregnancy-related disorder characterized by extremely high blood pressure.¹⁴ Eclampsia is the onset of seizures that can result.¹⁵ While mild preeclampsia can in certain cases be managed through careful monitoring, the only definitive cure for either condition is delivery of the fetus and placenta¹⁶—which, before the pregnancy is viable, requires an abortion to be performed.¹⁷
- **Premature rupture of membranes (PROM)** complicates approximately three percent of all pregnancies in the United States.¹⁸ Preterm PROM occurs when the amniotic membranes surrounding a pregnancy rupture before the onset of labor and before the pregnancy has reached full term (approximately 37 weeks).¹⁹ Previabile PROM occurs when the membranes rupture before the pregnancy has reached viability (generally around 24 weeks).²⁰ PROM is commonly associated with intra-amniotic infection and placental abruption, especially when the rupture happens

earlier in pregnancy.²¹ These complications can be life-threatening. For instance, left untreated, an intra-amniotic infection can lead to sepsis, a serious systemic illness caused by bacteria and bacterial toxins circulating in the bloodstream, which can cause death.²² Although the management of PROM requires an individualized assessment, in cases of previable PROM, “[i]mmediate delivery should be offered,” and an intra-amniotic infection is a “clear indication[] for delivery.”²³

The fact is this: Without the option of a life-saving abortion, some women will die. This tragic reality was broadcast around the world in 2012 with the death of 31-year-old **Savita Halappanavar**, who sought emergency care at a hospital in Ireland when she was miscarrying at 17 weeks. Savita repeatedly requested that the doctors complete the miscarriage by providing an abortion, but they refused; while she was undeniably very sick, they did not at that time consider her life to be at risk, as is necessary for an abortion to be legal in Ireland.²⁴ Savita passed away from a fatal infection. Reportedly, at least one health care professional informed Savita and her husband that she could not have an abortion because “[Ireland] is a Catholic country.”²⁵

The Myth: *“In an emergency, even a Catholic hospital will provide abortion services.”*



This misconception exists for a reason: Both medical ethics *and* federal law prohibit hospitals from denying emergency care. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that all hospitals that receive Medicare funds (which includes virtually all hospitals) and operate emergency departments provide stabilizing treatment to patients experiencing emergency medical conditions.²⁶ EMTALA prohibits such hospitals from transferring or discharging patients who are unstable, except in extremely narrow circumstances.²⁷ The Medicare and Medicaid Conditions of Participation similarly require hospitals to meet their patients’ emergency needs.²⁸

But the ACLU has collected numerous stories of women being denied emergency care at Catholic hospitals, with more emerging all the time. Taken together, these cases should raise serious concerns about systemic denials of emergency care at Catholic hospitals. For instance:

In 2010, **St. Joseph’s Hospital and Medical Center** in Phoenix, Arizona, provided a life-saving abortion to a young mother of four. That hospital did the right thing—but the USCCB did not agree, and it stripped the hospital of its official Catholic status. Following that incident, the Roman Catholic Diocese of Phoenix (which oversees St. Joseph’s) and the USCCB itself issued statements clarifying that “[d]irect abortion is never morally permissible . . . no matter what the reason.”²⁹ Moreover, Sister Margaret Mary McBride, a nurse with 30 years of experience who had served as the liaison between the hospital’s ethics committee and the physicians treating the woman, was excommunicated and demoted by the local bishop.³⁰ The backlash against St. Joseph’s thus put Catholic hospitals on notice that there may be penalties for violating the Directives, even where doing so saves a patient’s life.

In 2012, the Centers for Medicare & Medicaid Services (CMS), a federal agency with authority to hold hospitals accountable for EMTALA violations,³¹ penalized **St. John Hospital and Medical Center** in Michigan for denying a woman miscarriage treatment because of the Directives. The woman had to be driven by a family member to another hospital, where she needed emergency

surgery and seven pints of blood.³²

In addition, the ACLU recently brought a lawsuit against **Trinity Health Corporation**, one of the largest Catholic health systems in the country, for its repeated and systematic failure to provide women suffering pregnancy complications with medically indicated emergency abortions as required by federal law.³³ Indeed, **Faith Groesbeck**,

a public health researcher in Michigan, has reported that at one of Trinity's hospitals alone, at least five women who were suffering from miscarriages and needed urgent care were denied that care because of the Directives.³⁴ One of those women became septic—but, because of the Directives, the doctors still did not induce labor. Instead, they watched her temperature climb for eight hours before she began to deliver. Her baby died an hour later.³⁵

Doctors watched her temperature climb for eight hours before she began to deliver. Her baby died an hour later.

UNNECESSARY RISK

Women Denied Tubal Ligations After Pregnancy

While **Jessica Mann** was pregnant with her third child in 2015, her doctors explained to her that because she had pre-existing brain tumors, another pregnancy could kill her. They highly recommended that she get a tubal ligation—a safe, effective, and extremely common form of contraception³⁶—to prevent another pregnancy. They also recommended that she have the tubal ligation at the same time as she delivered her baby to avoid the serious risk to her health that would be caused by having to undergo a second procedure after recovering from childbirth.

Similarly, for **Shauna Sharpe**, pre-existing brain angiomas made pregnancy risky, and with two children already, she and her husband knew that their family was complete. She, too, requested a tubal ligation at the time of her delivery.

And even when health concerns aren't a factor, as was the case for **Rachel Miller** and **Rebecca Chamorro**, the safest and best time for a woman to have a tubal ligation is at the time of her delivery.

But the hospitals where Jessica, Shauna, Rachel, and Rebecca planned to deliver their babies forbade their OB-GYNs from providing this safe and effective care.



Jessica Mann, March 2016. Credit: Danna Singe/ACLU

Although each of these women had an OB-GYN trained and willing to perform the sterilization, the Catholic hospitals in Michigan and California where they planned to deliver prohibited their doctors from performing the procedure. Jessica's brain tumors and Shauna's brain angiomas did not change the outcome because the Directives apply even when a subsequent pregnancy would put a woman's health at risk. In Rachel's case, in the face of a threatened ACLU lawsuit, the hospital eventually capitulated, allowing the surgery to go forward notwithstanding the Directives.

The safest time for a woman to have a tubal ligation is at the time of her delivery.³⁷ Nevertheless, because of Directive 53, a woman who desires a tubal ligation, but who is unable to get one at the time she delivers, will have to wait several weeks for her uterus to return to its normal size before having the procedure performed. At that point, surgical tubal ligation will typically involve multiple incisions under general anesthesia.³⁸ Moreover, she will have to overcome the logistical hurdles of obtaining another significant surgery weeks or months after discharge while caring for a newborn baby and often other children as well. For some women, these obstacles will be insurmountable.

“Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution.”

— Directive 53

Jennafer and Jason Norris were shocked to learn in 2014 that Jennafer was pregnant after a rare birth control failure. They had recently moved to Rogers, Arkansas, for Jason’s work, and Jennafer had happily returned to the workforce now that her two children were in school. Jennafer did not realize that her contraception had failed and that she was pregnant until she was eight weeks along and experiencing symptoms of preeclampsia, which she recognized from her first two pregnancies. It was mixed news: Jennafer and Jason were excited to

expand their family, but very worried about her health.



Jennafer Norris and family, March 2016. Credit: Danna Singe/ACLU

The pregnancy was difficult from the start. Jennafer spent six weeks on bedrest, making it impossible for her to continue to work. Then, at 30 weeks, her health took a severe downturn. She was admitted to Mercy Hospital Northwest Arkansas and diagnosed with fast onset of atypical preeclampsia,



Jennafer Norris and family, March 2016. Credit: Danna Singe/ACLU

Jennafer was in horrible pain and so dizzy that she could hardly see, and her medical team had warned her repeatedly that she could have a stroke or seizure at any moment. Jennafer and Jason decided that they could not risk it, and she went ahead with the delivery at the Catholic hospital.

“It’s shocking when a hospital that is open to the public . . . can cite their faith as a reason to deny you a necessary medical service.”

which caused symptoms ranging from blurred vision to excruciating headaches. Jennafer’s blood pressure was also extraordinarily high, putting her at great risk of a seizure or stroke. Her mother flew to Arkansas to help watch the kids while Jason sat vigil at Jennafer’s hospital bed. Everyone was terrified.

Jennafer was scheduled to deliver by C-section, and she requested a tubal ligation at the time of the delivery—for obvious reasons, she could not risk getting pregnant again. But the hospital refused. While Jennafer’s physician was sympathetic, she explained with regret that she was bound by the Catholic hospital’s policy prohibiting sterilization. The only alternative, the hospital staff informed Jennafer, was to be treated at another hospital. The Norrises were outraged: The nearest hospital was 30 minutes away,

The Norrises are horrified that the hospital could get away with this. As Jason observed, “[i]t’s shocking when a hospital that is open to the public, and takes government funding, can cite their faith as a reason to deny you a necessary medical service.” Jennafer summarized it simply: “They are jeopardizing my life.”



Dr. Rebecca Cohen. Image courtesy of the Children's Hospital Colorado.

In 2014, **Dr. Rebecca Cohen** provided an abortion to a woman who had also been shocked to discover that she was pregnant. She had decided during her previous pregnancy that she wanted a tubal ligation and had informed the secular hospital where she was then receiving prenatal care. She signed the necessary consent forms well in advance of her delivery.

When she went into labor, however, she had to rush to the nearest hospital—a Catholic hospital—because the fetus was in a breech position, her contractions were coming quickly, and she would not have been able to make it to the hospital where she had received her prenatal care. She presented the consent forms for the tubal ligation and had an emergency C-section. All went well, and she assumed that the tubal ligation had been completed as planned.

The hospital certainly never told her otherwise.

When she realized that she was pregnant again, she was devastated. Through her tears, she asked Dr. Cohen, “I’m not even Catholic—where are my rights?”

“I’m not even Catholic—where are my rights?”

The Catholic hospital’s failure to inform Dr. Cohen’s patient that its staff did not perform the tubal ligation she had requested was not dictated by the Directives. But Dr. Cohen’s patient would never have found herself in this position if the hospital nearest to her home did not put religion above medical standards and patient needs.

ONE IN SIX

The Prevalence of Catholic Hospitals

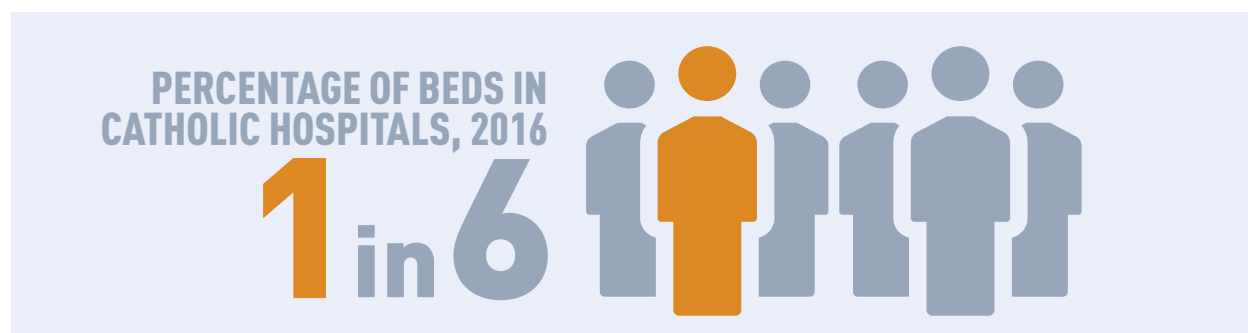
As of March 2016, there are 548 hospitals in the United States that adhere to the Directives—14.5 percent of all acute care hospitals in this country. That includes hospitals that are owned by a Catholic health system or diocese, hospitals affiliated with a Catholic hospital or system through a business 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.³⁹ This reflects a 22 percent increase in the number of Catholic hospitals since 2001.⁴⁰

Number and Percentage of Total Acute Care Hospitals by Hospital Type: 2001, 2016

(Showing Catholic Hospitals Within Each Category of Hospital Ownership)

Ownership	Religion	2001		2016		Growth of Catholic Hospitals 2001–16
		Number of Hospitals	Percentage of All Hospitals	Number of Hospitals	Percentage of All Hospitals	
Non-Profit Church	Catholic	329	8.2%	355	9.4%	7.9%
	All Other	248	6.2%	153	4.0%	
Non-Profit Other	Catholic	97	2.4%	148	3.9%	52.6%
	All Other	1,840	45.8%	1,575	41.7%	
Public	Catholic	19	0.5%	10	0.3%	-47.4%
	All Other	824	20.5%	546	14.4%	
For-Profit	Catholic	4	0.1%	35	0.9%	775.0%
	All Other	656	16.3%	957	25.3%	
Total Catholic		449	11.2%	548	14.5%	22.0%
Total Hospitals		4,017		3,779		

One in six hospital beds in this country is now in a facility that abides by Catholic restrictions on care.⁴¹



The Myth: *“If a patient does not want her care to be influenced by Catholic beliefs, she can choose to go to another hospital.”*

DEBUNKED

Ideally, all women in this country *would* have their pick of hospitals. But the reality is far more complicated.

- First, a woman’s provider might perform deliveries only at a Catholic hospital—leaving her with the choice between receiving care from a provider with whom she has a relationship or finding a new provider who delivers at a secular facility.
- Second, insurance can be a barrier. Some women may have health insurance that includes only one local hospital. If that hospital is Catholic, the woman then has a difficult choice between accepting the hospital’s religious restrictions or facing thousands of dollars in out-of-network costs. For many women, this is no choice at all.

- Third, a patient cannot choose to go to another hospital if she is not aware that her Catholic hospital allows religion to trump medical standards of care—and some patients may not be informed of these religious restrictions until it is too late. **Angela Valavanis**, for example, did not learn that her OB-GYN was prohibited from performing a tubal ligation at Presence Saint Francis Hospital in Evanston, Illinois, until she had already been in labor for three days and was being wheeled in for her C-section. While this is an extreme example, even several weeks (or months) of notice will not always be enough time for a woman to find a new hospital covered by her insurance and develop a relationship with a provider who performs deliveries there.

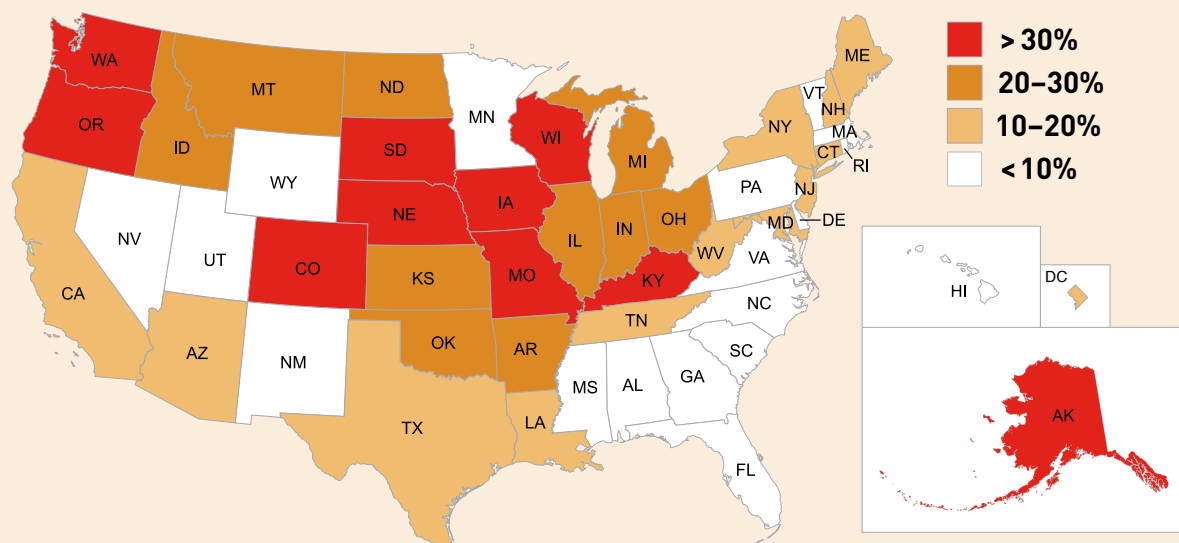


Angela Valavanis, March 2016. Credit: Danna Singe/ACLU

- Fourth, any choice will be illusory for most women living in a region where the only hospital abides by the Directives. This is no mere hypothetical: As of March 2016, there are 46 Catholic hospitals designated by the federal government as the “sole community hospitals” for their geographic region,⁴² and that definition does not even capture every facility that, in practice, is the only source of pregnancy-related care in a particular area.

Women living in these communities may have no other option but to accept substandard care. For instance, when **Tamesha Means** was in the midst of a miscarriage, bleeding and developing an infection, she turned to Mercy Health Partners in Muskegon, Michigan—the only hospital in Muskegon County. Similarly, for **Rebecca Chamorro**, the nearest non-Catholic hospital that provides maternity services is 70 miles away from her home in Redding, California. When her local Catholic hospital refused to let her doctor perform a tubal ligation, Rebecca was left with the “choice” between uprooting her life in the final weeks of pregnancy to move to a town nearer to that hospital, away from her husband and children; attempting to travel 70 miles while in labor; or accepting the local hospital’s religious restrictions. Rebecca ultimately delivered at the Catholic hospital and did not receive the tubal ligation she desired.

Percentage of Hospital Beds in Catholic Hospitals, 2016



CONCLUSION AND RECOMMENDATIONS

Protecting Patients' Health and Rights

When it comes to the provision of health care in hospitals, medical standards and patient needs, not religion, should be the guide. In the short term, there are immediate steps that lawmakers, patients, providers, and advocates can take to improve access to reproductive health care, many of which are outlined in *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, which MergerWatch and the ACLU released in 2013.⁴³ These include closely scrutinizing proposed hospital mergers, affiliations, and acquisitions, and identifying, publicizing, and, where possible, preventing any loss of vital health care services that will result.

In particular, CMS should issue a statement clarifying that all hospitals, regardless of religious affiliation, must provide the critical care that EMTALA and the Conditions of Participation demand, and emphasizing that denying emergency reproductive health care violates federal law. The agency should also undertake a systematic investigation into violations by Catholic hospitals and take all necessary corrective action where violations are found.

More broadly, we need to reform public policy so that it protects women in need of reproductive health services, as well as the practitioners who are prohibited from providing this essential care.

Catholic hospitals point to federal and state protections for religious objections to argue that they should be allowed to turn away a woman seeking reproductive health care on the basis of religion, even when her life or health is at risk. While such laws do not cover many of the situations described in this report, they nevertheless send a harmful message that hospitals should be allowed to deny basic health care, and dignity, to women.

Those policies will not change without a public outcry. We must demand more protection for patients' rights and access to reproductive health care. The power of the public purse should be leveraged to ensure that facilities no longer withhold essential health care from patients.

We cannot stay silent and let hospitals use their religious identity to discriminate against, and harm, women.

APPENDIX A

2016 Short-Term Acute Care Hospitals by State

State	Catholic Hospitals	Percentage of All Hospitals	Beds in Catholic Hospitals	Percentage of All Hospital Beds
AK	1	16.7%	391	49.2%
AL	4	4.5%	1,144	8.6%
AR	7	14.6%	1,589	22.6%
AS	0	0.0%	-	0.0%
AZ	9	14.8%	1,912	15.5%
CA	46	14.2%	10,275	15.9%
CO	17	33.3%	2,536	33.9%
CT	5	13.9%	1,090	17.7%
DC	1	14.3%	272	11.9%
DE	1	14.3%	180	8.9%
FL	14	6.7%	3,285	6.6%
GA	4	3.8%	663	3.7%
GU	0	0.0%	-	0.0%
HI	0	0.0%	-	0.0%
IA	13	35.1%	2,420	42.1%
ID	3	18.8%	598	26.4%
IL	40	29.2%	7,990	29.5%
IN	22	22.9%	3,571	24.4%
KS	13	23.6%	1,627	27.2%
KY	19	26.4%	3,459	30.3%
LA	12	11.3%	2,052	16.3%
MA	6	8.3%	1,166	8.6%
MD	5	10.2%	1,194	10.8%
ME	4	19.0%	363	14.6%
MI	21	19.8%	5,057	24.4%
MN	4	7.7%	624	7.2%
MO	20	24.1%	5,205	33.8%
MP	0	0.0%	-	0.0%
MS	0	0.0%	-	0.0%
MT	3	23.1%	458	25.8%
NC	0	0.0%	-	0.0%
ND	2	22.2%	295	22.7%
NE	9	36.0%	1,492	39.7%
NH	2	14.3%	388	19.6%
NJ	11	14.7%	2,158	11.8%
NM	2	6.9%	168	4.8%
NV	3	13.0%	449	9.6%
NY	26	13.8%	5,365	12.5%
OH	37	25.5%	7,266	29.2%
OK	15	16.3%	2,639	27.4%
OR	10	28.6%	1,783	31.1%
PA	7	4.0%	1,571	5.0%
PR	1	1.9%	167	2.1%
RI	1	9.1%	180	7.8%
SC	5	8.2%	725	7.0%
SD	6	30.0%	781	40.5%
TN	12	10.7%	2,332	13.7%
TX	42	11.4%	6,541	12.1%
UT	0	0.0%	-	0.0%
VA	8	9.3%	1,341	8.8%
VI	0	0.0%	-	0.0%
VT	0	0.0%	-	0.0%
WA	19	33.9%	3,929	40.9%
WI	33	45.2%	4,099	40.7%
WV	3	9.4%	621	12.2%
WY	0	0.0%	-	0.0%

APPENDIX B

Sampling of the Ethical and Religious Directives for Catholic Health Care Services

5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. 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.⁴⁴

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.
40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.
41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).
44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.
45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.
47. 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.⁴⁵
48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.
50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.

52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.
53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.

APPENDIX C

Sampling of State Laws Protecting Hospitals that Refuse to Provide Certain Health Care Services

This appendix provides a sampling of the laws in more than 40 states that insulate hospitals from liability if they refuse to provide certain health care services.⁴⁶ These laws send a harmful message that hospitals should be allowed to deny critical health care, and dignity, to women. However, these state laws may be limited by other state laws, and they cannot override federal law, including EMTALA.

California

“Nothing in this article shall require a nonprofit hospital or other facility or clinic that is organized or operated by a religious corporation or other religious organization . . . to perform or to permit the performance of an abortion in the facility or clinic or to provide abortion services. No such nonprofit facility or clinic organized or operated by a religious corporation or other religious organization, nor its administrative officers, employees, agents, or members of its governing board shall be liable, individually or collectively, for failure or refusal to participate in any such act. The failure or refusal of any such corporation, unincorporated association or individual person to perform or to permit the performance of such medical procedures shall not be the basis for any disciplinary or other recriminatory action against such corporations, unincorporated associations, or individuals. Any such facility or clinic that does not permit the performance of abortions on its premises shall post notice of that proscription in an area of the facility or clinic that is open to patients and prospective admittees This section shall not apply to medical emergency situations and spontaneous abortions.” Cal. Health & Safety § 123420(c)–(d).

Delaware

“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.” Del. Code Ann. tit. 24, § 1791(b).

Hawaii

“Nothing in this section shall require any hospital or any person to participate in an abortion nor shall any hospital or any person be liable for a refusal.” Haw. Rev. Stat. Ann. § 453-16(e).

Idaho

“No hospital shall be required to furnish facilities or admit any patient for sterilization procedures if, upon determination by its governing board, it elects not to do so No refusal to accept a patient for sterilization procedures shall form the basis for any claim for damages or for recriminatory action against the declining person or hospital.” Idaho Code Ann. § 39-3915.

Illinois

“No person, association, or corporation, which owns, operates, supervises, or manages a health care facility shall be civilly or criminally liable to any person, estate, or public or private entity by reason of refusal of the health care facility to permit or provide any particular form of health care service which violates the facility’s conscience as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. 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.” 745 Ill. Comp. Stat. Ann. 70/9.

Kansas

“No medical care facility, medical care facility administrator or governing board of any medical care facility shall be required to permit the performance, referral for, or participation in medical procedures or in the prescription or administration of any device or drug which result in the termination of human pregnancies of an effect of which the medical care facility, administrator or board reasonably believes may result in the termination of human pregnancies within its facility and the refusal to permit such procedures, prescription or administration shall not be grounds for civil liability to any person.” Kan. Stat. Ann. § 65-444.

Louisiana

“No hospital, clinic or other facility or institution of any kind shall be held civilly or criminally liable, discriminated against, or in any way prejudiced or damaged because of any refusal to permit or accommodate the performance of any abortion in said facility or under its auspices.” La. Stat. Ann. § 40:1061.3.

Missouri

“No physician or surgeon, registered nurse, practical nurse, midwife or hospital, public or private, shall be required to treat or admit for treatment any woman for the purpose of abortion if such treatment or admission for treatment is contrary to the established policy of, or the moral, ethical or religious beliefs of, such physician, surgeon, registered nurse, midwife, practical nurse or hospital. No cause of action shall accrue against any such physician, surgeon, registered nurse, midwife, practical nurse or hospital on account of such refusal to treat or admit for treatment any woman for abortion purposes.” Mo. Ann. Stat. § 197.032.

New Mexico

“This article does not require a hospital to admit any patient for the purposes of performing an abortion, nor is any hospital required to create a special hospital board.” N.M. Stat. Ann. § 30-5-2.

New York

“No hospital shall be required to admit any patient for the purpose of performing an induced termination of pregnancy, nor shall any hospital be liable for its failure or refusal to participate in any such act, provided that the hospital shall inform the patient of its decision not to participate in such an act or acts. The hospital in such event shall inform the patient of appropriate resources for services or information.” N.Y. Comp. Codes R. & Regs. tit. 10, § 405.9(b)(10).

Washington

“No person or private medical facility may be required by law or contract in any circumstances to participate in the performance of an abortion if such person or private medical facility objects to so doing.” Wash. Rev. Code Ann. § 9.02.150.

APPENDIX D

Relevant Portions of the Emergency Medical Treatment and Active Labor Act (EMTALA)

42 U.S.C.A. § 1395dd

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

- (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
- (B) for transfer of the individual to another medical facility in accordance with subsection
- (C) of this section.

....

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

- (A)(i) the individual (or a legally responsible person acting on the individual’s behalf) after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,
 - (ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
 - (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
- (B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

....

(e) Definitions

In this section:

(1) The term “emergency medical condition” means—

- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part; or
 - (B) with respect to a pregnant woman who is having contractions—
 - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
- (2) The term “participating hospital” means a hospital that has entered into a provider agreement under section 1395cc of this title.
- (3) (A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).
- (B) The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
- (4) The term “transfer” means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.
- (5) The term “hospital” includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

ENDNOTES

1. The phrase “Catholic hospitals” is used in this report to refer to short-term acute care hospitals that comply with some or all of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the United States Conference of Catholic Bishops. 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.
2. Some of these stories come from cases the ACLU is litigating; others were shared with us by women and doctors. In the latter case, we take the patients and physicians at their word and have not further investigated those stories.
3. “Cisgender” refers to a person whose self-identity conforms with the gender they were assigned at birth (i.e., a non-transgender person).
4. MERGERWATCH & AM. CIVIL LIBERTIES UNION, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 13–14 (Dec. 2013), *available at* <https://www.aclu.org/report/miscarriage-medicine>.
5. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), *available at* <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 *Directive* or *Directives*].
6. *Directive 45*, *supra* note 5, at 26. The Directives do allow for an “indirect abortion,” which is defined as treatment that has as its “direct purpose the cure of a proportionately serious pathological condition of a pregnant woman . . . even if [it] will result in the death of the unborn child.” *Directive 47*, at 26. However, the USCCB clarified in a 2010 document that *Directive 47* does *not* encompass circumstances in which an abortion—that is, the “directly intended termination of pregnancy”—is necessary to save a woman’s life. *Directive 47* instead applies to scenarios in which, for instance, a pregnant woman develops uterine cancer and requires a hysterectomy. U.S. CONFERENCE OF CATHOLIC BISHOPS, THE DISTINCTION BETWEEN DIRECT ABORTION AND LEGITIMATE MEDICAL PROCEDURES 1–2 (2010), *available at* <http://www.usccb.org/about/doctrine/publications/upload/direct-abortion-statement2010-06-23.pdf> [hereinafter *THE DISTINCTION*].
7. *Directive 53*, *supra* note 5, at 27.
8. *Directive 28*, *supra* note 5, at 20.
9. Although Mindy’s local hospital is a secular facility, when it purchased the hospital from a Catholic entity, it agreed to adhere to the Directives.
10. U.S. Conference of Catholic Bishops, Comments on Proposed OFCCP Regulations on Sex Discrimination, 80 Fed. Reg. 5246, at 4 (Mar. 30, 2015), <http://www.usccb.org/about/general-counsel/rulemaking/upload/Comments-Discrimination-Basis-of-Sex-March-2015.pdf>.
11. Am. Coll. of Obstet. & Gynecol., Response to Politician’s Inaccurate Abortion Comments (Oct. 19, 2012), <http://www.acog.org/About-ACOG/News-Room/News-Releases/2012/Response-to-Politicians-Inaccurate-Abortion-Comments>.

12. Elena V. Kuklina, Carma Ayala & William M. Callaghan, *Hypertensive Disorders and Severe Obstetric Morbidity in the United States*, 113 *OBSTET. & GYNECOL.* 1299, 1299 (2009).
13. Andreea A. Creanga et al., *Pregnancy-Related Mortality in the United States, 2006–2010*, 125 *OBSTET. & GYNECOL.* 5, 9–10 (2015).
14. Am. Coll. of Obstet. & Gynecol., *Practice Bulletin No. 33: Diagnosis and Management of Preeclampsia and Eclampsia*, 99 *OBSTET. & GYNECOL.* 159, 159 (2002).
15. *Id.* at 160.
16. WORLD HEALTH ORG., WHO RECOMMENDATIONS FOR PREVENTION AND TREATMENT OF PRE-ECLAMPSIA AND ECLAMPSIA 2, 4 (2011), *available at* http://apps.who.int/iris/bitstream/10665/44703/1/9789241548335_eng.pdf [hereinafter WHO RECOMMENDATIONS].
17. AM. COLL. OF OBSTET. & GYNECOL., HYPERTENSION IN PREGNANCY 6 (2013), *available at* <http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Hypertension-in-Pregnancy>; WHO RECOMMENDATIONS, *supra* note 16, at 2; Am. Coll. of Obstet. & Gynecol., *Practice Bulletin No. 135: Second-Trimester Abortion*, 121 *OBSTET. & GYNECOL.* 1394, 1394 (reaffirmed 2015) [hereinafter *Practice Bulletin No. 135*].
18. Roger E. Packard & Awathif D. Mackeen, *Labor Induction in the Patient with Preterm Premature Rupture of Membranes*, 39 *SEMIN. PERINATOL.* 495, 495 (2015).
19. *See id.*
20. *See* Am. Coll. of Obstet. & Gynecol., *Practice Bulletin No. 160: Premature Rupture of Membranes*, 127 *OBSTET. & GYNECOL.* e39, e40 (2016) [hereinafter *Practice Bulletin No. 160*].
21. *Id.* at e39–e40; Packard & Mackeen, *supra* note 18, at 495.
22. *Practice Bulletin No. 160*, *supra* note 20, at e40; Anne Elixhauser, Bernard Friedman & Elizabeth Stranges, Agency for Healthcare Research & Quality, *Statistical Brief No. 122: Septicemia in U.S. Hospitals, 2009*, at 1 (Oct. 2011), *available at* <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb122.pdf>.
23. *Practice Bulletin No. 160*, *supra* note 20, at e42, e45; *see also Practice Bulletin No. 135*, *supra* note 17, at 1394; Aaron B. Caughey, Julian N. Robinson & Errol R. Norwitz, *Contemporary Diagnosis and Management of Preterm Premature Rupture of Membranes*, 1 *REV. OBSTET. & GYNECOL.* 11, 16–17 (2008).
24. Health Service Executive, Investigation of Incident 50278 From Time of Patient’s Self Referral to Hospital on the 21st of October 2012 to the Patient’s Death on the 28th of October, 2012, at 33 (June 2013), *available at* <http://www.lenus.ie/hse/bitstream/10147/293964/1/nimreport50278.pdf>.
25. Paul Cullen & Kitty Holland, *Midwife Manager ‘Regrets’ Using ‘Catholic Country’ Remark to Savita Halappanavar*, *THE IRISH TIMES* (Apr. 10, 2013), <http://www.irishtimes.com/news/health/midwife-manager-regrets-using-catholic-country-remark-to-savita-halappanavar-1.1355895>.
26. 42 U.S.C.A. § 1395dd(b) (West 2016).
27. 42 U.S.C.A. § 1395dd(c) (West 2016).
28. 42 C.F.R. § 482.55 (2016).

29. THE DISTINCTION, *supra* note 6, at 1–2; The Roman Catholic Diocese of Phoenix, St. Joseph’s Hospital No Longer Catholic: Statement of Bishop Thomas J. Olmsted 2 (Dec. 21, 2010), <http://www.washingtonpost.com/wp-srv/health/documents/abortion/Bishop-Statement.pdf> [hereinafter Statement of Bishop Olmsted].
30. Statement of Bishop Olmsted, *supra* note 29, at 2.
31. U.S. GEN. ACCOUNTING OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 1 (June 2001), *available at* <http://www.emtala.com/062001.pdf>.
32. Ctrs. for Medicare & Medicaid Servs., Dep’t of Health & Human Servs., St. John Hospital and Medical Center Emergency Medical Treatment and Labor Act (EMTALA) Survey (Dec. 11, 2012) (on file with MergerWatch).
33. Complaint, Am. Civil Liberties Union of Mich. v. Trinity Health Corp., No. 15-cv-12611 (E.D. Mich. July 23, 2015).
34. Molly Redden, *Abortion Ban Linked to Dangerous Miscarriages at Catholic Hospital, Report Claims*, THE GUARDIAN (Feb. 18, 2016), <http://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners>.
35. *Id.*
36. In 2012, tubal ligation was the contraceptive method of choice for 15.5 percent of women ages 15–44. GUTTMACHER INSTITUTE, FACT SHEET: CONTRACEPTIVE USE IN THE UNITED STATES 1 (Oct. 2015), *available at* http://www.guttmacher.org/pubs/fb_contr_use.pdf.
37. This is so for several reasons: First, immediately postpartum, a woman’s uterus is enlarged and located just under the abdominal wall, which makes it easier for her doctor to access her fallopian tubes. Am. Coll. of Obstet. & Gynec., FAQ052: Postpartum Sterilization (2013), <http://www.acog.org/Patients/FAQs/Postpartum-Sterilization>. Second, if the patient is having a C-section, she already has an incision in her abdomen through which her doctor can access the fallopian tubes, or if she is having a vaginal delivery, her doctor can make a small incision below her navel. *Id.* Third, during a C-section, a woman is already receiving anesthesia, and for vaginal delivery, an epidural catheter placed during labor can in most cases be left in for the anesthesia for the tubal ligation. *See* Am. Coll. of Obstet. & Gynec., *Practice Bulletin No. 133: Benefits and Risks of Sterilization*, 121 OBSTET. & GYNECOL. 392, 392 (2013) [hereinafter *Practice Bulletin No. 133*]. The tubal ligation does not add to the patient’s hospital stay or recovery period. *See id.*
38. *Practice Bulletin No. 133*, *supra* note 37, at 394 (describing laparoscopy procedures used for “interval” procedures, i.e., procedures that are separate from pregnancy).
39. The methodology used in this report differs from the methodology used in 2011 in MISCARRIAGE OF MEDICINE, *supra* note 4. MergerWatch and the ACLU reported then that there were 381 Catholic-sponsored or -affiliated acute care hospitals in the United States—10 percent of the market—and that nearly one in nine hospital beds in this country was in a Catholic-sponsored or -affiliated hospital. *Id.* at 7–8. But those figures reflected only “non-profit, church-owned” hospitals, and, as a result, significantly underrepresented the number of hospitals in this country that operate under Catholic restrictions. The data in this report, by contrast, encompass *all* hospitals in the United States that adhere to the Directives—even those that do not classify themselves as non-profit, church-owned

hospitals in their annual filings to the Centers for Medicare & Medicaid Services. Thus, this revised methodology more accurately reflects the vast number of hospitals in this country operating under Catholic restrictions. For a more detailed discussion of the methodology, see LOIS UTTLEY & CHRISTINE KHAIKIN, MERGERWATCH, GROWTH OF CATHOLIC HOSPITALS AND HEALTH SYSTEMS: 2016 UPDATE OF THE MISCARRIAGE OF MEDICINE REPORT (May 2016), *available at* www.mergerwatch.org.

Notably, these numbers and percentages differ from those published by the Catholic Health Association of the United States (CHA). See Catholic Health Assoc. of the U.S., Catholic Health Care in the United States (Jan. 2016), https://www.chausa.org/docs/default-source/general-files/cha_mini_profile2016.pdf?sfvrsn=2. That is because this report focuses solely on short-term acute care hospitals. CHA's stated membership of 639 facilities includes rehabilitation hospitals and other types of facilities that generally do not provide emergency or pregnancy-related care. See *id.*

40. In order to determine this figure, the 2001 data were reanalyzed using the new methodology discussed in *supra* note 39. This statistic thus reflects the growth since 2001 in the *total* number of hospitals adhering to the Directives, not only those hospitals that are classified as “non-profit and church-owned.”
41. While the number of Catholic hospitals is current as of 2016, the bed count within those hospitals is based on the hospitals' most recently filed Medicare cost reports, which generally reflect data from 2014 or 2015.
42. See 42 C.F.R. § 412.92 (2016) (defining criteria for sole community hospitals, largely based on distance from other like facilities).
43. See *supra* note 4, at 21–23.
44. *Directive 36* further specifies in an endnote: “It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures.” See *supra* note 5, at 40 n.19.
45. The USCCB has clarified that *Directive 47* does *not* allow for an abortion, even where a woman's life or health is endangered. See *supra* note 6.
46. GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES 2 (Mar. 1, 2016), *available at* http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.

