Disestablishing Hospitals

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Abstract: We argue that concentration of power in religious hospitals threatens disestablishment values. When hospitals deny care for religious reasons, they dominate patients' bodies and convictions. Health law should — and to some extent already does — constrain such religious domination.

Even as the rest of the hospital market has contracted, Catholic health systems have grown rapidly since the 1990s through acquisitions, affiliations, and joint ventures.[1] The 688 officially designated Catholic hospitals now vastly outnumber all other religious hospitals combined.[2] In the past year, more than 1 in 7 patients received care and half a million babies were delivered in a Catholic hospital.[3]

With size comes economic — and religious — power. Like other major players in the healthcare market, Catholic systems enjoy significant market clout. They experience the concomitant advantages in administration, contract negotiations, physician recruitment, and patient services.

But, unlike other players, they combine their economic power with religious stringency. They require healthcare providers and partner entities to deliver care consistent with rules based on religious doctrine. As a consequence, patients — and entire communities — are denied access to an array of health services, from abortion to IVF to end-of-life care to gender-affirming treatment. They find themselves subjected to religious convictions that they do not share.

To date, the problem of religious hospital concentration has been analyzed through the lens of healthcare access, antitrust law, and informed consent.[4] In this Essay, we instead argue that the increasing size, scope, and power of religious hospitals threatens disestablishment values. We show that market power combined with control over critical resources can translate into the imposition of religion on patients, contrary to the disestablishment value of non-domination. Under such circumstances, we argue, the non-domination principle should — and to some extent already does — constrain institutions from deploying their authority

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outside its legitimate scope. Hospitals may deny care and exercise power legitimately where they act with the goal of delivering medically indicated care and serving the community. But when they deploy authority in a manner unconnected to this goal in order to serve institutional religion, they dominate patients' bodies and beliefs and threaten the normative core of religious disestablishment.

To be clear, ours is not a claim that the Establishment Clause applies directly to privately owned hospitals. But Establishment Clause values have some application where religious actors hold economic power and play a vital social role. Indeed, although health law may not have been designed with disestablishment in mind, we show that it nevertheless reflects concerns about religious domination and contains some tools to deter it.

Our focus on disestablishment values also illuminates the constitutional significance of critical markets dominated by religion. Framing the problem in terms of disestablishment values, in turn, may help reorient reform efforts toward structural solutions to a concentrated religious healthcare market that go beyond individual patient access.

Concentration of Religious Hospitals

Many Americans live in areas where a religious hospital predominates. For most of them, that hospital will be Catholic. In the last two decades, the number of Catholic acute-care hospitals has grown a substantial 28%.[5] At the same time, the rest of the market has shrunk almost 14%.[6] Hospitals with Catholic affiliation now occupy 15.8% of the national market but hold considerably larger market shares in the range of 30% and 40% in many states.[7]

With market concentration comes organizational power. Catholic hospitals are increasingly organized into mega-systems. Four of the ten largest systems in the United States are Catholic, garnering billions of dollars in revenue.[8] System-wide consolidation provides advantages ranging from economies of scale to network effects. It also delivers the well-known efficiency benefits of centralized management.

Catholic systems leverage their control over assets to dictate what services doctors provide to patients. Providers must commit by contract to comply with the Ethical and Religious Directives for Catholic Health Care Services (the "ERDs") in their care of patients.[9] These directives prohibit a wide range of common reproductive health services, including contraception, sterilization, abortion, some miscarriage management techniques, the least invasive treatments for ectopic pregnancies, and assisted reproductive technologies. Treatments derived from fetal tissue or embryonic stem cells are not permitted. Under the ERDs, patients may only be informed of "morally legitimate alternatives."[10] And patients' wishes about the use or withdrawal of artificial life support will not be honored if they run counter to Catholic teaching.[11] Some hospitals also refuse to provide gender-affirming care for transgender patients, although the ERDs do not contain any explicit prohibition.

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Through the legal institutions of private law — primarily property and contract — Catholic hospitals have expanded the scope and scale of their religious restrictions. As one of us has explained, Catholic healthcare systems have used leases and contracts to require other institutions to comply with Catholic doctrine.[12] As a result, hospitals that are nonsectarian, affiliated with other faiths, or even public follow the ERDs as part of joint ventures, management agreements, mergers, or even loose collaborations with Catholic healthcare. This trend likely will intensify, because the latest version of the ERDs now requires that all entities "be operated in full accord with the moral teaching of the Catholic Church" regardless of whether the collaboration takes the form of "acquisition, governance, or management."[13]

Commentators have observed the obstacles that religious hospitals pose for patient access to repro-

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ductive and end-of-life care. We aim to widen the lens and explore the denial of care as a form of religious domination, which both raises distinct concerns and suggests the constitutional valence of critical markets governed by religion.[14]

The Constitutional Value of Religious Non-Domination

Religious domination is a familiar concern from foundational discussions of Establishment Clause doctrine and theory.[15] In the *Memorial and Remonstrance Against Religious Assessments*, James Madison put the problem in sharp relief. Madison was particularly worried about the state's arbitrary use of power: "the same authority which can force a citizen to contribute three pence only of his property for the support of any one establishment, may force him to conform to any other establishment in all cases whatsoever[.]"[16] Madison continued, "Who does not see that the same authority which can establish Christianity, in exclusion of all other Religions, may establish with the same ease any particular sect of Christians, in exclusion of all other Sects?"[17] The tendency of unchecked authority to creep beyond its bounds, as Madison explained, risked domination. The value of non-domination would guard against such illegitimate uses of power.

In other writing, Madison expressed similar concerns about private power. In an essay entitled *Monopolies, Perpetuities, Corporations, Ecclesiastical Endowments*, he presaged, "[b]esides the danger of a direct mixture of Religion and civil government, there is an evil which ought to be guarded against in the indefinite accumulation of property from the capacity of holding it in perpetuity by ecclesiastical corporations."[18] Control over property could risk disestablishment values. And yet, Madison said, "[t]he danger of silent accumulations and encroachments by Ecclesiastical Bodies ha[s] not sufficiently engaged attention in the U.S."[19]

Madison's warnings about religious domination proved influential in the modern development of Establishment Clause doctrine. In *Engel v. Vitale*, an early school prayer case, the Supreme Court quoted the *Memorial* at length in support of a non-domination principle.[20] So too in *Abington School District v. Schempp*, a case challenging Bible reading in public school, Justice Clark echoed Madison's concern with unchecked religious power, noting that "today a trickling stream may all too soon become a raging torrent."[21]

The non-domination principle, to be sure, does not hold that power is always problematic or abusive. Indeed, it grants ample scope to the exercise of legitimate authority. But when that same authority extends beyond its legitimate scope — no longer controlled by the principle that justified its use in the first place — that use of power becomes arbitrary and works to dominate and subordinate those subject to its imposition.[22] Public schooling, for example, falls well within the state's legitimate authority to educate and form citizens. When state power is employed to impose religion on students, however, it falls outside its legitimate scope, and religious domination ensues.[23]

The Establishment Clause, of course, directly applies only to governmental actors. Nonetheless, it affects how the state may structure markets and subsidies to purportedly private actors. And it informs regulatory responses to those entities that otherwise might have power to subvert religious freedoms of weaker individuals and institutions.

Moreover, relationships between private parties may be regulated in ways that reflect the values enshrined in the Establishment Clause. For example, as one of us has argued, Title VII of the Civil Rights Act of 1964 safeguards employee religion and practice by applying disestablishment values to employers.[24] Analogous to the state, employers must respect employee conscience, show mutual respect toward workers, and refrain from using economic power to engage in religious domination of employees.[25]

So how does the non-domination value in particular apply to employment? To start, employment law recognizes a broad realm of legitimate uses of employer power over employees. Employers can set rules for employees and hire and fire them based on business reasons that underlie why we structure production through firms. They can fire an inefficient employee, require workers to greet customers with the company motto, and sell goods that may offend particular employees' religious convictions.

Employment law, however, bars employers from engaging in acts of religious domination, which necessarily exceed the economic rationales for organizing production through firms in the first place.[26] Given employer authority over the corporate workplace, Title VII both mandates reasonable accommodation of employees' religious exercise and forbids companies from imposing religion on them. So, for example, while an employer may require employees to wear nametags — "a practice with a clear and close nexus to business objectives" — it may not demand that employees display religious messages on their nametags.[27] In this vein, courts have "rejected the notion that an employer is entitled to religious subservience in return for paying an employee's salary."[28]

The exercise of corporate authority thus requires an economic justification, consistent with the social purpose of firms. Companies may deploy their power to control employees in innumerable ways to bolster effi-

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cient production.[29] But use of corporate power beyond these ample parameters — for example, to dominate employees' deepest projects and commitments — lies beyond the pale.[30]

Does the same principle hold for hospitals as service providers? Are these institutions similarly constrained in using their economic power to impose religion on patients? The next Part argues that a similar logic should apply.

Power and the Principle of Non-Domination

Hospitals bear two central hallmarks of actors likely to dominate the vulnerable. Their markets manifest significant failings from concentration and information asymmetries. And they meet critical and time-sensitive needs.

First, ninety-five percent of hospital markets in America are highly consolidated — and becoming more consolidated.[31] In urban and rural areas, the overall supply of hospital care has declined.[32] As a result, in most areas, the prices that hospitals charge are not in any significant way determined by competitive forces.[33] This control over assets and other critical resources — as the law and economics literature teaches — can lead to control over people.[34] As in other concentrated markets, the consumers of healthcare services — that is, the patients — suffer disadvantages from lack of options.[35]

Second, not only are hospitals economically powerful, but they also provide critically important services. As Nicholas Bagley has argued, hospitals both serve important human needs and operate in a market that risks oppression of people.[36] Healthcare markets, Bagley explains, "suffer from well-understood failings associated with market concentration, informational asymmetries, and moral hazard"[37] — to the detriment of patients. People depend on hospitals for succor in urgent and emergent situations and for access to technological innovation. Patients typically must rely on providers for knowledge and expertise in health and medicine. And in exigent circumstances, they must place their bodies under the control of the nearest hospital and its staff. Though ostensibly in a contractual relationship, patients have no effective means by which to bargain with hospitals for better terms or otherwise to check hospital power.[38] These markets are necessarily local — patients typically seek care in a nearby hospital, rather than travel far from family and home. They also tend to be locked into a hospital based on where their physician practices or which doctors are part of their insurance network of providers.[39]

The urgency of care delivered in hospitals further undermines patients' ability to exert countervailing power. Unlike other healthcare institutions, hospitals deal with emergencies, which pair the acute interests of patients with the difficulty — if not impossibility — of seeking care elsewhere. Many patients would suffer severe hardships if hospitals denied them urgent care. And even where transfer to a different institution is possible, transfer in emergencies delays treatment and increases risks for patients.

When concentrated power combines with control over access to critical services, the need to impose limits on the use of such power becomes acute. Non-domination, in our view, is one such limit. Hospitals should not employ economic power to dominate their patients by imposing moral and religious restrictions on healthcare.

One might accept this argument as applied to nonsectarian hospitals, but object on legal grounds to wider applications. While disestablishment values may have a place in public or nonsectarian institutions, it might be thought counterintuitive — even a bit shocking — to suggest that disestablishment values ought to apply to religious hospitals. After all, these institutions generally are organized as religious corporations and dedicated to the mission and ministry of healing. Consistent with free exercise values, Title VII of the Civil Rights Act authorizes them to choose employees based on shared faith.[40] These hospitals often bear religious names — like St. James — and display religious symbols — like crucifixes. And while these names and symbols might make some uncomfortable, one would be hard-pressed to identify how they run afoul of legal norms.[41]

Nevertheless, we think that the non-domination principle should — and at least to some limited extent already does — apply to religious hospitals.[42] To begin with, religious hospitals have the same power and control over critical resources as their secular and public counterparts. Indeed, in many circumstances, religious hospitals hold monopolies. Due to geographic constraints and market concentration, Catholic hospitals are the only available provider for many populations.[43] Twenty-six percent of Catholic hospitals are rural.[44] Fifty-two Catholic hospitals are "sole community hospitals" — a federal designation that applies where the nearest alternative is at least 35 miles away or the hospital is rural and meets other qualifications.[45]

Like their secular and public peers, Catholic hospitals operate in markets driven by revenue, with healthcare providers and patients of many beliefs drawn from the local community. These modern hospitals compete on services, technology, and patient experience. They choose staff for their expertise, not their faith. The vast majority of patients who seek

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treatment in Catholic hospitals are not Catholic and/or do not subscribe to the doctrinal interpretations of the U.S. bishops.

Consistent with this functional similarity between secular and religious institutions, the public views religious hospitals as healthcare providers, not ministries to co-religionists. Indeed, in *Bradfield v. Roberts* — a case now over a century old — the Supreme Court upheld government financing for construction on a Catholic hospital on the theory that the institution was engaged in secular activities and provided its hospital services to the general public without sectarian discrimination.[46]

Catholic hospitals have long cultivated this public understanding. By the mid-1800s, Catholic hospitals already advertised themselves as being open to all, providing admission and treatment without discrimination, and ensuring all patients' "ability to avail themselves of their own spiritual advisers."[47] Along the same lines, The Metropolitan Catholic Almanac of 1859 explained that, within hospitals, "[t]he rights of conscience must be held paramount to all others."[48] And administrators made clear that institutional religion would not oppress patients. Today, this public understanding is entrenched. Patients consider Catholic hospitals a resource for services and treatments identical to other sophisticated healthcare providers.

Given this cultural understanding, patients are not well-positioned to guard against religious hospitals' exercise of religious domination. Just as patients lack the expertise in medicine to evaluate their own needs and treatment with precision, considerable empirical evidence now shows that most patients are not aware of religious restrictions that apply to their care.[49] Nor are they typically in a position to do extensive research on where such limitations are in place. Access can vary between and even within Catholic institutions, moreover, because the stringency of the directives depends on ad hoc decision-making by ethics committees, workarounds of providers, and interpretations of local bishops. Indeed, with the rapid spread of Catholic restrictions to institutions that are not identifiably Catholic — including hospitals affiliated with other religious traditions or associated with governmental bodies — it can be very difficult to determine where one will encounter religious limitations on care.[50]

One might object that competitive markets will prevent religious hospitals from wielding this sort of power over patients. But that is not the world in which we live. Hospital markets are far from competitive. And in emergencies, the power of choice that consumers enjoy in well-functioning markets is noticeably absent.

None of this analysis is meant to deny the scope and scale of necessary care delivered in Catholic and other religious hospitals. Decision makers in these hospitals can — and often do — use their institutional power for benevolent ends. But as Louis Brandeis once observed, organizations may "develop a benevolent absolutism, but it is an absolutism all the same."[51] It is that absolutism — that power *over* others to arbitrarily interfere with their life prospects — that motivates the principle of non-domination. The next Part considers where the line between domination and non-domination lies in hospital settings.

Locating the Line between Legitimate and Arbitrary Uses of Hospital Power

The idea of domination requires separating arbitrary from legitimate uses of hospital power. As with employment, we first need to identify the role that hospitals play in the basic structure of our social institutions. Once we've done that, we can distinguish between uses of power inside and outside the bounds of legitimacy. Our claim here is that while some denials of care prove legitimate, religious refusals contravene the social role of hospitals.

So, what role do hospitals play in our system of social cooperation among people who differ on fundamental questions? In short, the hospital's primary role today is to channel professional medical care to patients and to serve community health needs. Although it originated as a place to tend to the deserving, dying poor, the modern hospital is defined by the complexity and sophistication of its services and procedures.[52] It operates within a complex network of rules set by federal, state, and private regulators to ensure patient safety.[53] In many states, to enter a market or expand services or facilities, hospitals must secure a certificate of need from the state through a process that aims to expand access to healthcare and minimize unnecessary spending.[54] The very term "community hospital" reflects the ways hospitals straddle a fine line between private entity and public function — financed, regulated, and supported by the state and local community.[55]

The hospital's obligation to serve the community is also reflected in a variety of laws. Hospitals must periodically engage in community needs assessments to design their services for the public. Their boards must include members of the community, drawn from outside the institution. They may not discriminate against patients and must safeguard their privacy. These laws reflect widespread recognition that healthcare is a "critical good or service."[56]

Consistent with its social role of delivering professional medical care that meets community needs, Catholic hospitals — like their peers — exercise eco-

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nomic and healthcare power in many legitimate ways. Most often, they use control over facilities, equipment, and staff to deliver medically indicated care to patients. They leverage the scope and scale of their operations to deliver services more efficiently or at lower cost. In these respects, no issue of domination arises.

Many denials of care that patients desire also qualify as legitimate uses of hospital power. In order to serve their social role, hospitals must allocate treatments and resources efficiently and responsibly. Most obviously, hospitals may deny care that is futile or medically unnecessary. Staff availability and expertise may also structure the services provided. Health law recognizes the legitimacy of such decisions by, for example, allowing hospitals to transfer patients with emergency medical conditions to another facility when the medical benefits of transfer outweigh the risks to patients.[57]

Revenue generation may also provide the basis for legitimate hospital decisions. Economic concerns, for example, drive closures of particular departments (labor and delivery, for example) and credentialing of medical staff (requiring, for example, a minimum number of annual patient admissions). These denials of care may be inconvenient, frustrating, or even harmful, but they do not result in domination.

But hospitals also deny medically indicated services for religious reasons to patients who depend upon them for care. Women have found Catholic hospitals unwilling to authorize their ob-gyns to perform tubal ligations following labor and delivery — requiring them to undergo two surgeries or to travel to another hospital. Others have suffered injuries when hospitals denied them abortions and ectopic pregnancy treatment in urgent situations.[58]

Are these uses of power within the legitimating reasons for hospital authority? To see why they are not, let's consider a few examples removed from the context of Catholic healthcare. Imagine a hospital affiliated with Christian Science — a faith community that rejects most medical care. It seems quite clear that such an institution cannot plausibly fulfil the social role of a hospital while offering only care consistent with Christian Science. Or to move the hypothetical closer to reality, we might think of a Jehovah's Witness hospital that generally would offer care consistent with medical practice but might withhold blood transfusions. There is little doubt that no state or federal regulator would license or fund such an institution as a hospital. So why are these hypotheticals so clearly beyond the pale?

Our claim is that these religious restrictions on hospital care prove socially illegitimate because they cannot be justified by the reasons that support use of hospital authority in the first place. They fail to advance the goal of providing medically appropriate care to the public and, in doing so, they depart significantly from social expectations of the hospital's role. While hospitals vary in the specialized services they offer, patients and the public anticipate that they have equipment, expertise, and staff to deliver general medical services and meet acceptable standards of practice. In urgent and emergent situations, they expect to receive comprehensive care consistent with the emergency department function. In denying care for religious reasons, hospitals instead extend their institutional authority over patients' healthcare to require religious adherence. And their denial of necessary and expected care serves to dominate patients' bodies and convictions.

A reader might be persuaded by the normative argument against domination in Catholic hospitals, but nonetheless query whether the value of non-domination has any practical foothold in these settings. Scholars have explored nondomination in areas from employment law[59] to financial regulation,[60] but it has received less attention in health law. In this short Essay, we don't aim for a comprehensive review of health law's protections against domination, but we can nevertheless identify a few obvious examples that provide proof of concept.

For starters, laws related to pastoral care in hospitals draw lines that reflect concerns about domination. Under federal and state law, all hospitals must respect patients' rights to spiritual and pastoral care consistent with their own needs.[61] These requirements apply regardless of whether a hospital is secular or sectarian. Hospital chaplains must work not as proponents of their specific faith but as providers of non-directive pastoral care reflective of the needs and values of each patient.[62] Moreover, as Stacey Tovino explains, one of the functions of hospital chaplains is "protecting patients from unwelcome forms of spiritual intrusion."[63] Consistent with that goal, hospital admissions documents often ask for a patient's religious preferences, including whether they welcome a chaplain visit. The regulatory framework thus distinguishes between the legitimate — an offer of pastoral care — and the arbitrary — an imposition of pastoral care, in a way consistent with non-domination.

In a similar vein, Medicare's Conditions of Participation establish that it is for patients to determine their own family structures and select their visitors consistent with their own commitments. Promulgated in response to incidents of hospitals denying access to same-sex partners and spouses of patients,[64] the regulation distinguishes arbitrary denials of visitation from "clinically necessary" or otherwise reasonable limitations that the hospital "may need to place on such rights."[65] In effect, the regulation prohibits insti-

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tutional religious teachings about marriage and family to dominate patients. A hospital thus may not deny visitation because its affiliated church disapproves of divorce or same-sex marriage, but it may set conditions for reasons of efficiency and healthcare provision consistent with its social role.[66]

Duties of informed consent — contained in administrative regulations, state statutes, and common law precedent — also specifically seek to avoid domination of patient values.[67] Although these laws sometimes take the form of transparency and notice requirements, they nevertheless work to safeguard patients from the imposition of views about medical care that they do not share. The Patient Self Determination Act, for example, aims "to assure that individuals receiving services will be given an opportunity to participate in and direct health care decisions affecting themselves."[68] State statutes commonly require institutions to inform patients in advance of any religion-based objections to compliance with advance directives and then to "immediately make all reasonable efforts to assist in the transfer of the patient" to a willing provider or institution and to comply with the treatment request during the search.[69] Religious objections do not excuse institutions from duties to respect patients' rights to informed consent and decision making.

Ultimately, going forward, we need to consider how law and politics structure and shape the role of religion in healthcare. In doing so, we ought to be mindful of the growing power of religious hospitals in the healthcare system and the corresponding threat they pose to our deeply rooted disestablishment values.

Finally, the priority of emergency care duties over religious objection, reflected in Emergency Medical Treatment and Labor Act (EMTALA), further reflects a nondomination principle. Under normal circumstances, as we have noted, hospitals need not provide a particular specialized service or admit a patient who cannot pay. Conscientious refusal laws, moreover, explicitly grant them the authority to deny contested services, commonly abortion, often sterilization, and sometimes other procedures for reasons of religious objection. Where, however, a patient arrives at the hospital with an emergency medical condition — a narrow category of severe conditions, including labor — a hospital must provide care to stabilize the patient, regardless of whether she requires treatment that it otherwise might refuse on religious grounds. Conscientious refusal laws cede to the federal EMTALA.[70] At least in emergencies, the institution's interest in adherence to religious doctrine is outweighed by the patient's bodily and decisional integrity.

Once again, we make no claim to have provided an exhaustive catalogue of non-domination in health law. And, to be sure, some laws allow hospitals to thwart patient access and self-determination in various ways. Yet these examples should suffice to make our basic point that traces of the non-domination principle are already part of health law.

Conclusion

The chief aim of this Essay has been to re-frame religious refusals of hospital care in terms of domination and religious establishment. This frame offers a number of advantages. To begin with, it trains our sights on pervasive power relations between religious hospitals and their patients. Patients depend on local hospitals for the necessities of life and are therefore vulnerable to their arbitrary use of power.

The lens of non-domination can also help us see state action in what we thought were narrower conflicts between private parties. Recognizing that the state not only regulates, but also constitutes the healthcare markets may in turn illuminate a range of First Amendment values in healthcare.[71] We may even start to see the outlines of a healthcare constitution, akin to the "workplace constitution" that has gained momentum in employment law.[72]

By the same token, thinking in terms of disestablishment values might illuminate what's really wrong with religious restrictions on care and point toward a more appropriate vocabulary for the harms that patients suffer. To be sure, one problem with such restrictions on care is that they are often inadequately disclosed — and, for this problem, more transparency would be a welcome development.[73] But the problems with religious restrictions run deeper than insufficient transparency.

Faced with hospitals that provide urgently needed care and operate in concentrated markets, we have two pathways before us. First, we might attempt to foster competition. If we want to respect institutional freedom while at the same time mitigating religious domination, then we may need to think in terms of dispersing market power and preserving patient options. We might adopt more robust antitrust enforcement as generative of religious non-dominance as well as

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vibrant markets.[74] Given the control that religious institutions have over critical hospital resources, the public has a significant interest in curtailing their institutional power. The revival of a public option in the form of public hospitals may need to be considered.

Second, we might regulate so as to ensure non-domination. The proliferation of religious doctrine across distinctly Catholic hospitals, partner secular hospitals, and public hospitals speaks to weaknesses of the regulatory environment. We might consider limiting the spread of religious restrictions, consistent with goals of having religious and secular options in the marketplace. California law, for example, has moved in this direction, preventing hospitals from maintaining restrictions on treatments after a hospital is sold.[75] And in Oregon, the Equal Access to Care Act — passed in July 2021 — protects against the loss of reproductive and gender-affirming services when ownership is transferred to a religious institution.[76] More ambitiously, commentators for decades have suggested treating hospitals as public utilities. The basic argument is that "[b]ecause service, cost, utilization, and quality decisions affect not only providers and users but also the wider social environment, it is necessary to make society privy to those decisions" through public utility regulation.[77]

Ultimately, going forward, we need to consider how law and politics structure and shape the role of religion in healthcare. In doing so, we ought to be mindful of the growing power of religious hospitals in the healthcare system and the corresponding threat they pose to our deeply rooted disestablishment values.

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6. *Id.*
7. *Id.* See also C. Drake et al., "Market Share of US Catholic Hospitals and Associated Geographic Network Access to Reproductive Health Services," *JAMA* Network Open (Jan. 29, 2020) (reporting that 35.3% of US counties, where 38.7% of US women of reproductive age live, have a high or dominant Catholic hospital market share).
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26. See *id.* at 615-20.
27. See *id.* at 617.
28. See *id.* at 619.

The Journal of Law, Medicine & Ethics, 49 (2021): 542-551. © 2021 The Author(s)

29. See A.A. Berle, *Power without Property: A New Development in American Political Economy* (New York: Harcourt, 1959): at 98-110 (discussing the concept of "legitimacy").
30. See *id*.
31. J.S. King et al., *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States* 6 (June 2020), *available at* <https://2zele1bn0sl2i91io41niae1-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf> (last visited July 30, 2021).
32. See Community Catalyst, *supra* note 1, at 4.
33. N. Bagley, "Medicine as a Public Calling," *Michigan Law Review* 114, no. 1 (2015): 57-106, at 65.
34. See, e.g., O. Hart and J. Moore, "Property Rights and the Nature of the Firm," *Journal of Political Economy* 98, no. 6 (1990): 1119-1158; R.G. Rajan and L. Zingales, "Power in a Theory of the Firm," *Quarterly Journal of Economics* 113, no. 2 (1998): 387-432; Nelson, *supra* note 15, at 635-41.
35. See Bagley, *supra* note 33, at 84-87. On the harms of economic concentration more generally, see T. Wu, *The Curse of Bigness: Antitrust in the New Gilded Age* (New York: Columbia Global Reports, 2018); L. Khan, "The End of Antitrust History Revisited," *Harvard Law Review* 133, no. 5 (2020): 1655-1683 (reviewing Wu).
36. See Bagley, *supra* note 33, at 59.
37. *Id*. at 62.
38. See, e.g., *Tunkl v. Regents of the University of California*, 383 P.2d 441 (Ca. 1963) (establishing a highly influential test to determine when a waiver of liability relates to the "public interest" and concluding that hospital care meets each of the factors given the importance of the service that is a practical necessity, the hospital's decisive advantage in bargaining strength, and the state's extensive regulation).
39. See Sepper, *supra* note 12, at 977.
40. 42 U.S.C. § 2000e-1(a).
41. E.g., I.C. Lupu, "The Increasingly Anachronistic Case Against School Vouchers," *Notre Dame Journal of Law, Ethics & Public Policy* 13, no. 2 (1999): 375-396 (describing a Catholic hospital with religious symbols and name caring for his Jewish father at the end of his life and observing that "[n]o Religion Clause scholar or advocate of whom I am aware would argue that government payment to St. Peter's Hospital for the cost of medical service for my father's benefit violated the Establishment Clause.").
42. *See infra* Part IV.
43. See A. Littlefield, "Barrett's Confirmation Would Empower Catholic Hospitals to Deny Crucial Care: Catholic Hospitals Have Increasingly Become the Only Option for Many Communities," *Truthout*, October 15, 2020, *available at* <https://truthout.org/articles/barretts-confirmation-would-empower-catholic-hospitals-to-deny-crucial-care/>.
44. Catholic Health Association, *supra* note 2, at 1.
45. This number has increased from thirty in 2013.
46. *Bradfield v. Roberts*, 175 U.S. 291 (1899).
47. C.J. Kauffman, *Ministry and Meaning: A Religious History of Catholic Health Care in the United States* (New York: Crossroad, 1995): at 71 (noting such an advertisement in the 1850s); see *id*. at 104, 149, 151 (noting other nineteenth century examples of Catholic hospitals asserting nonsectarian character and management and nondiscrimination in admission and treatment of patients).
48. *Id*. at 76 (quoting the almanac).
49. D.B. Stulberg et al., "Women's Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals," *Perspectives on Sexual & Reproductive Health* 51, no. 3 (2019): 135-142; L.R. Freedman et al., "Religious Hospital Policies on Reproductive Care: What Do Patients Want to Know?" *American Journal of Obstetrics & Gynecology* 21, no. 2 (2018): 251.e1-251.e9; M. Guiahi et al., "What Are Women Told When Requesting Family Planning Services at Clinics Associated with Catholic Hospitals? A Mystery Caller Study," *Perspectives on Sexual & Reproductive Health* 49, no. 4 (2017): 207-212.
50. E.L. Hill, D.J.G. Slusky, and D.K. Ginther, "Reproductive Health Care in Catholic-Owned Hospitals," *Journal of Health Economics* 65 (2019): 48-62 (finding that hospital affiliation with a Catholic health care system reduced tubal ligation rates by over 30%).
51. L. Brandeis, *Industrial Relations: Final Report and Testimony* (Washington, DC: Government Printing Office, 1916): 7657-7681, at 7659.
52. Kauffman, *supra* note 47, at 73 (observing that all voluntary hospitals at mid nineteenth century admitted only the "worthy poor"); D.B. Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor: University of Michigan Press, 1999): at 13 (observing that whereas private hospitals limited care to the "deserving" poor, public hospitals served the remainder of the indigent); K.M. Bridges, "The Deserving Poor, the Undeserving Poor, and Class-Based Affirmative Action," *Emory Law Journal* 66, no. 5 (2017): 1049-1114 (discussing the ways social welfare programs in the United States, including Medicaid, were constructed around categories of morally deserving poor).
53. Governments have long engaged in such regulation. Kauffman, *supra* note 47, at 138 (observing that in the 1880s "provincial statutes codified the proper procedures from admitting to releasing patients" for secular and sectarian hospitals alike).
54. P.C. Smith and D.A. Forgione, "The Development of Certificate of Need Legislation," *Journal of Health Care Finance* 36, no. 2 (2009): 35-44, at 37.
55. Catholic hospitals alone took in $47.8 billion in federal funding in 2020. See Littlefield, *supra* note 43, at 6.
56. K.S. Rahman, "The New Utilities: Private Power, Social Infrastructure, and the Revival of the Public Utility Concept," *Cardozo Law Review* 39, no. 5 (2017): 1621-1692 (discussing control over critical services and its relation to public utility regulation).
57. Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd(c)(1)(A)(ii).
58. National Health Law Program, "Health Care Refusals: Undermining Quality Care for Women" (2010): 1-84, at 15, 40, 57, *available at* <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf> (last visited August 3, 2021); A.M. Foster et al., "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," *Women's Health Issues* 21, no. 2 (2011): 104-109, at 106.
59. See, e.g., S. Bagenstos, "Employment Law and Social Equality," *Michigan Law Review* 112, no. 2 (2013): 225-274.
60. See, e.g., Rahman, *supra* note 56.
61. The Joint Commission on Accreditation of Healthcare Organizations, the primary independent accreditor for hospital Medicare participation, sets standards that require hospitals to "accommodate the right to pastoral and other spiritual services for patients" and to end-of-life care that "addresses the patient's and his or her family's psychosocial and spiritual needs." Joint Commission on Accreditation of Healthcare Organizations, Hospital Accreditation Standards RI.2.10(2) & (4) (2021). State laws also often contain similar duties. S.A. Tovino, "Hospital Chaplaincy Under the HIPAA Privacy Rule: Health Care or 'Just Visiting the Sick?'" *Indiana Health Law Review* 2, no. 1 (2005): 51-92, at 83 (citing Texas law).
62. Tovino, *supra* note 61, at 81. See "Hospice Chaplain Reflects on Life, Death and the 'Strength of the Human Soul,'" National Public Radio, October 31, 2016, *available at* <https://www.npr.org/sections/health-shots/2016/10/31/499762656/hospice-chaplain-reflects-on-life-death-and-the-strength-of-the-human-soul> (last visited August 2, 2021) (discussing role and experiences of chaplaincy).
63. Tovino, *supra* note 61, at 69.
64. See, e.g., T. Parker-Pope, "Kept from a Dying Partner's Bedside," *New York Times*, May 19, 2009; M.D. Shear, "Obama Extends Hospital Visitation Rights to Same-Sex Partners of Gays," *Washington Post*, April 16, 2010.

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65. 42 C.F.R. § 482.13(h).
66. Under the Conditions of Participation, reasons must be given in written form to patients.
67. See, e.g., Medicare Conditions of Participation, Patient's Bill of Rights, 42 C.F.R. § 482.13 ("The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.").
68. Patient Self Determination Act of 1990, Pub. Law No. 101-508, Sec. 4206, Nov. 5, 1990.
69. B.R. Furrow, T.L. Greaney, S.H. Johnson, T.S. Jost, R.L. Schwartz, B.R. Clark, E.C. Fuse Brown, R. Gatter, J.S. King, and E. Pendo, *Health Law: Cases, Materials and Problems* (West Academic Publishing, 8th ed. 2018): at 1337. Under the Uniform Health Care Decisions Act for example, which has been adopted in some form in a number of states, an institution that declines to comply with a healthcare decision must promptly inform the patient, provide continuing care until a transfer can be effected, and "immediately make all reasonable efforts to assist in the transfer of the patient." Uniform Health Care Decisions Act Sec. 7 (g).
70. Some state laws make explicit that state refusal laws do not justify refusal of emergency medical care. See, e.g., Cal. Health & Safety Code § 123420(d) (West 2016) (containing an exception for emergency for abortion); Tex. Occ. Code Ann. § 103.004 (West 2016) ("A private hospital or private health care facility is not required to make its facilities available for the performance of an abortion unless a physician determines that the life of the mother is immediately endangered.").
71. Some scholars have begun to think about the ways in which delegation of power and discretion to private entities both conceals and implicates the state in denial of healthcare. Jessie Hill, for example, argues that looking to abortion restrictions as spatial regulation renders visible the action of the state in creating and reinforcing what otherwise appear to be private decisions. See B.J. Hill, "The Geography of Abortion Rights," *Georgetown Law Journal* 109, no. 5, (2021): 1081-1138.
72. For discussion of the "workplace constitution," see S.Z. Lee, *The Workplace Constitution from the New Deal to the New Right* (Cambridge: Cambridge University Press, 2014): at 1; see also C. Estlund, "Rethinking Autocracy at Work," *Harvard Law Review* 131, no. 3 (2018): 795-826 (discussing the "constitution of the workplace").
73. J. Takahashi et al., "Disclosure of Religious Identity and Health Care Practices on Catholic Hospital Websites," *Journal of the American Medical Association* 321, no. 11 (2019): 1103-04.
74. Some authors have proposed a role for antitrust law in preserving reproductive healthcare. Durand, *supra* note 4; J.C. Appelbaum and J.C. Morrison, "Hospital Mergers and the Threat to Women's Reproductive Health Services: Applying the Antitrust Laws," *New York University Review of Law & Social Change* 26, no. 1 (2001): 1-36. Because antitrust often falls short as an effective tool against extensive concentration in many healthcare markets, scholars have begun to develop other tools to confront institutional power. See T.L. Greaney, "Coping with Concentration," *Health Affairs* 36, no. 9 (2017): 1564–1571.
75. Cal. Corp. Code § 5917.5.
76. H.B. 2362, 81st Leg. Assemb., Reg. Sess. (Or. 2021). For analysis, see A. Littlefield, "Oregon Will Protect Reproductive Health Care When Hospitals Merge," *The Nation*, July 19, 2021.
77. W.E. Corley, "Hospitals as a Public Utility: or 'Work with Us Now or Work for Us Later,'" *Journal of Health Politics, Policy & Law* 2, no. 3 (1977): 304-309, at 304 (noting arguments from 1950s).

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