

Federal Refusal Clause

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To conserve space, the history of hospitals and healthcare outside the United States or prior to the Declaration of Independence, will be glossed over. (See [Raffel 1980] for greater detail.) Suffice it to say that public healthcare consisted primarily of segregation from the general population either by distance (outside the town limits or on islands) or incarceration (for the violently insane). Most facilities were founded primarily to help those who could not afford to pay for the services of a private physician, surgeon or nurse. Those who could afford private healthcare received it at home.

Pennsylvania Hospital, the first “voluntary hospital” (as opposed to a charity or alms hospital), was founded in Philadelphia in 1751 with the connivance of Benjamin Franklin at the instigation of Thomas Bond in order to provide a facility for Bond to practice surgery and midwifery.

Other hospitals in North America were either founded outside the geographic bounds of the eventual United States (such as the Hôpital Dieu in Montreal) or were not “voluntary” (such as the healthcare facilities provided by the Franciscans in conjunction with the mission system they built in the southwest).

Historical Background of Hospitals in the United States

After the break from England, other voluntary hospitals followed slowly, in New York, Boston, and New Haven. Further facilities followed the population's migration westward. Some municipalities, such as Mobile, Alabama, invited Catholic medical orders to manage their hospitals.

The only church hospitals (all Catholic) founded prior to 1840 were De Paul Hospital in St. Louis, St. Joseph Infirmery in Louisville, and Mt. Hope Retreat in Baltimore.

Churches grew impressively in the last half of the 19th Century, fueling a parallel growth in the number of church-founded hospitals. Catholic Sisterhoods, such as the American branch of St. Vincent de Paul's Sisters of Charity, established hospitals in Detroit, Philadelphia, Buffalo, Milwaukee, New York City, Norfolk, Mobile, Rochester, Troy, Cincinnati, New Orleans, St. Louis, and Los Angeles (and more).

The Protestant Deaconess movement, started in Germany in 1833, came to the United States by 1849 and resulted in the founding of hospitals in Pittsburgh, Milwaukee, Chicago, Jacksonville, Illinois, and points west, including

the Hospital of the Good Samaritan in Los Angeles.

(Jewish healthcare facilities are also prominent, but I have little information on them. One of the motivations in founding Jewish hospitals was to provide healthcare that allowed Jewish doctors to practice medicine freely, and patients to follow Jewish religious practice. For example, Montefiore Hospital was founded in 1905 by the Jewish community of western Pennsylvania and continues now as the Jewish Healthcare Foundation (see [JHF 2004]).)

Conditions and practices in hospitals subsequent to 1840 were greatly influenced by advances in science, which influence has only accelerated with the passage of time and the increase in scientific knowledge.

Today, hospitals are divided by their type of service into two main types: general and specialty (such as maternity, children's and psychiatric facilities). Hospitals may also be divided according to whether they are non-profit or for-profit, government-owned or privately-owned, secular or church-affiliated.

Funding for all these hospitals comes from donor bequests, charitable contributions from secular and religious individuals and organizations, private health insurance, direct payment by patients, and from the federal and state programs such as Medicare, Medicaid and Title X of the Public Health Service Act.

According to [Rothstein 1995]:

All voluntary and for-profit hospitals are really quasi-public hospitals in that they receive tax benefits, government payments for Medicare and Medicaid patients, government reimbursement for charity patients, and often direct government appropriations. The differences among them are primarily matters of ownership and administration.

Urban public hospitals have become more like voluntary hospitals in recent decades. Forty years ago, patients in urban public hospitals had a much longer average length of stay than those in voluntary hospitals. Today the length of stay is very similar in the two types of hospitals. Forty years ago, also, urban public hospitals had few or no paying patients, while voluntary hospitals had mostly paying patients. Today Medicare, Medicaid, and employer health insurance plans provide coverage for many patients in urban public hospitals.

A summary from page 202 of [Raffel 1980]:

The hospital has become an essential public service agency. It is as necessary to man's physical well-being as the church is to his spiritual welfare and as the school is to his intellectual development. No other agency that serves the public has had to make greater efforts in overcoming popular prejudices, in adjusting its organization and functions to changing conditions, and in establishing its value to society in so short a period of time. Courts of justice depend upon centuries-old codes of law to control human behavior. Education is based on the transmission of ideas and knowledge from one culture to another through spoken, written, and printed language. Hospitals deal with life itself. They reflect the rapid strides in the biological sciences in the last hundred years. They are created and maintained through the power of humanitarian and religious forces. Herein lies the secret of progress in the development of hospitals.

The reader must understand that this brief overview leaves much out, such as the effect of federal funding in the building of local clinics in small towns and rural areas.

For the purposes of my discussion, I will focus on that portion of the healthcare industry affiliated with the Catholic Church. I exclude other church-affiliated healthcare facilities only due to my own ignorance as to the religious strictures placed on the facilities by the sponsoring church.

According to [NCRONLINE 2003], 11 percent of the community hospitals in the United States are Catholic, and 16 percent of all admissions to community hospitals are to Catholic facilities. Three of the ten largest healthcare systems are Catholic, and seven of the ten largest non-profit systems.

The Catholic facilities, while they may not be unique, have the highest-profile in looking for relief under the Weldon Amendment to allow them to continue their ministry while obeying the dictates of their members' faith.

The United States Conference of Catholic Bishops' directives pertinent to the Weldon Amendment [USCCB 2001] are:

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.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.

Background of the Federal Refusal Clause ("Weldon Amendment")

According to [NFPRHA 2004], the model **A** for the Federal Refusal Clause is the Abortion Non-Discrimination Act (ANDA), brought to a vote on the floor of the House of Representatives by Rep. Dick Armey (R-TX) on September 25, 2002 and approved by a vote of 229-189. The Senate did not consider ANDA, so the bill died without enactment.

The Weldon Amendment was added to the Omnibus Appropriations bill by voice vote of the House Appropriations Committee on July 14, 2004. Subsequent negotiations to reconcile Senate and House versions of the Appropriations bill left the Weldon Amendment intact over the protests of Senator Feinstein and others.

(See the Appendix for the full text of the Weldon Federal Refusal Clause.)

ANDA and the Weldon Federal Refusal Clause are an expansion of the concept of a "conscious clause" such as the Coats Amendment that was added to a similar appropriations bill in 1996. The Coats Amendment pertained only to post-graduate training programs in abortion, contraceptive and sterilization procedures, and allowed training facilities to continue receiving federal support if they did not offer these programs.

Senator Feinstein's Position

On her official website, Senator Feinstein has posted a press release with a copy of a letter to Senator Ted Stevens (R-Alaska), Chairman of the Senate Committee on Appropriations, in which she and her co-signers request that the Federal Refusal Clause be dropped from the Fiscal Year 2005 Omnibus Appropriations bill. [Feinstein 2004] The reasons (summarized below) listed in the letter are:

- The Weldon Amendment allows just about any type of healthcare company to opt out of providing abortion services.
- The Weldon Amendment prevents governments at all levels from requiring healthcare companies to provide either abortion services, or referrals to abortion service providers.
- The Weldon Amendment makes it more likely that healthcare companies that do provide abortion services will become targets of demonstrations and intimidation,

and allows them to be forbidden from providing abortion services or referrals.

- The Weldon Amendment makes it more difficult for Attorneys General to interfere (by approving or imposing terms) with the sale of non-profit healthcare companies.

Senate leadership has promised an opportunity to repeal the Federal Refusal Clause between now and April 30, 2005.

In the meantime, the NFPRHA has filed a suit for an injunction against enforcing the law. [NFPRHA 2004]

Reasons to Oppose Senator Feinstein's Position

Before stating my own reasons for opposition to Senator Feinstein's position, I wish to make clear that I am no legal professional, neither lawyer nor judge nor law professor. I would enjoy reading comments on the Weldon Amendment from Eugene Volokh or Professor Bainbridge, or any number of other law-bloggers.

My analysis and opinions come from my own reading, pondering, and working out of my reasons for opposition. If writing this down helps someone else to work it out for themselves, that's good. The effort has already been valuable to me.

The analysis is in three parts. First, I look at why, as a Catholic Christian, I oppose her effort to repeal the Weldon Amendment. Second, I look at why, as an American citizen, I oppose

her effort to repeal. Third, I respond specifically to each of the bulleted items summarized from her letter.

First. As a Catholic

As a Catholic, I am astonished at the contortions that Catholic-affiliated healthcare providers are required to perform to pursue their mission, and grateful that the Weldon Amendment was passed to ease their plight.

I suspect that Senator Feinstein and her co-signers are unwilling to admit targeting church-affiliated healthcare providers in their attempt to repeal the Amendment. However, it would seem unlikely that secular operations would be affected unless providing abortion services cannot be made profitable, or at least break even.

I would also suspect that someone at some point will try to say that the Amendment is an attempt to impose a specific religious belief on the general population without consent. I reject that interpretation, as the Amendment does not require that healthcare providers stop offering abortion services. It merely allows a healthcare provider to avoid offering these services without penalty.

Second. As an American Citizen

As an American citizen, I oppose government coercion of citizens to break with their conscious or religious faith. I see it as a violation of the First Amendment's guarantee of religious freedom (see Appendix 2).

Senator Feinstein and other supporters of abortion rights would say that denying a woman her “right to choose” is a similar abridgement of Constitutional rights, and that the Weldon Amendment provides a loophole for any health-care company to shrug its corporate shoulders while making this denial, without even providing a referral.

I disagree.

However, if I grant for the sake of discussion that a “right to choose” lurks in the Constitution, how does that Constitutional right trump another Constitutional right? The two directly conflict, even allowing the stipulation that the child has no rights until granted them either by birth, or by the mother declaring her desire to carry the child to term and give birth.

As to the rights of the child, I do not stipulate that the child’s right for protection under the Constitution is less than the mother’s right.

The value of a person may not be assigned to that person by another, rather than being intrinsic to the person. The moment that the child exists as a separate person, that child has merit and standing in the eyes of God and man. The moment of separate existence is conception, and conception occurs when the father’s sperm fertilizes the mother’s egg. Any other position leads to incoherent logical induction on the worth of all people; as I would not be declared valueless, so I would not declare even the most vulnerable valueless.

Third, Specific Response

Now, to respond specifically to the individual bulleted items from Senator Feinstein’s letter:

- I firmly believe that the government should *not* be in the business of dictating the services that private healthcare companies provide. If Senator Feinstein wishes to dictate to government-run healthcare facilities, I will not object.
- I firmly believe that the government should not require private healthcare companies to provide abortion services, or referrals. Referrals qualify as “material cooperation” in the directives of the USCCB. Any healthcare facility affiliated with the Catholic Church is required *not* to provide referrals. There is no way out of this bind: either the church-affiliated facility follows the legal requirement, and apostasizes its members’ faith; or the religious directive, and places its members in legal jeopardy. If Senator Feinstein wishes to dictate to government-run healthcare facilities, I will not object.
- “Demonstrations and intimidation” is victimology and hyperbole. A handful of peaceful demonstrators praying the rosary and offering sidewalk counseling is hardly threatening. Even at the height of anti-abortion activism, violence was rare. I do not support violence against property or persons engaged in abortion services; but I find it

ludicrous that those who are pro-choice put on sack cloth and ashes over their own victimization.

The second part of this seems to be speaking to affiliated churches forbidding abortion services and/or referrals, and I would think that it should be within their prerogative as a sponsoring organization to do so.

- That Attorneys General can now interfere in the sale or transfer of assets of non-profit healthcare facilities is astonishing news to me, and I am repelled to think that such is the case.

Conclusion

If governance and funding of healthcare facilities had remained local, as it had been historically before the enactment of Medicare, Medicaid and the Public Health Service Act, church-affiliated facilities would not be in their current bind between meeting their mission and meeting the ever-increasing expenses associated with modern medicine. The enormous involvement of the federal government in the healthcare area, in the form of public health insurance and Title X funds, distorts the ability of church-affiliated healthcare facilities to follow the directives of their governing bodies while remaining within legal bounds. Without some kind of escape clause, such as the Weldon Amendment, church-affiliated healthcare facilities would be forced either into legal persecution, apostasy or aban-

donment of their historic mission. Legal persecution would likely take the form of fines or loss of federal funds. (If someone knows the prescribed legal penalty for non-compliance, I would like to know.) Apostasy would take the form of material cooperation in providing abortion services, or referral for abortion services, against the directives of the USCCB. Even the decision to abandon their mission and sell their assets is limited by the ability of Attorneys General to set terms and conditions on the sale of these assets.

Appendix 1 Text of the Federal Refusal Clause

From [NFPRHA 2004], the text of the Federal Refusal Clause appears below. It was appended to the end of Section 509 of Title X of the Public Health Service Act.

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization or plan.

Appendix 2

Text of the 1st Amendment

From [US Constitution 1787], the text of the First Amendment, part of the Bill of Rights, appears below.

Amendment I - Freedom of Religion, Press, Expression. Ratified 12/15/1791.

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

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