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practice—What are the plans if a lifesaving abortion is needed? Who will provide it?

Indeed, the stronger moral, and even legal, case for responsibility—criminal or otherwise—lies with hospital administrators and hospitals. Health care organizations are moral communities. The persons who comprise them are moral agents who share common causes and complementary roles. Their collective mission is informed by a unique construction of moral professionalism (Austin 2007; Mickelsen 2013). The core aims of that moral professionalism are promoting health, preventing disease, relieving pain and suffering, forestalling death, curing disease when possible, and caring for those who cannot be cured (Cassell 1991). Administrators and organizational leaders are co-fiduciaries with physicians and other clinicians for promoting these aims and providing quality care. They share the “ethical weight” of morally vexing cases, as well as the responsibility to balance organizational values, professional norms, the integrity of clinicians, and duties to patients in developing and executing strategies to resolve them (Mickelsen 2013). However they are worded, health care organizational mission statements generally embrace the clinical norm of acting in patients’ best interests or “putting the patient first.” The failure to do so occasions moral distress in clinicians, undermines institutional integrity, and, most importantly, harms patients (Mickelsen 2013).

Blanket policies that impose a complete ban on therapeutic abortions no matter how early the pregnancy or how imperiled the woman’s life do just this. Indeed, a health care institution whose policies force clinicians to disregard the particular circumstances of individual cases, including the risk of maternal morbidity and mortality in the setting of therapeutic abortion, fits exactly the idea of showing “extreme indifference” to the value of a pregnant woman’s life. It also forces clinicians to violate accepted standards of practice.

Health care institutions have at least a moral duty to effect plans to handle emergency cases whether by referrals or the use of other physicians (i.e., outside the

institution), or, if those would not be sufficiently timely, then by having a willing physician in the institution carry out the therapeutic abortion. This could entail an institutional willingness to employ a physician (or physicians) who would be willing to perform an abortion in emergency circumstances.

While we are wary of escalating the use of the criminal law surrounding pregnant women and fetuses, we agree with Nelson that, in the absence of prospective policies to accommodate therapeutic abortion in lifesaving emergencies, neither individual nor collective institutional conscience absolves clinicians or health care institutions of a criminal act that warrants prosecution. ■

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Pregnant Women and Equitable Access to Emergency Medical Care

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A diabetic patient suffering from ketoacidosis was taken from his hospital bed, removed from the hospital, and left in the parking lot without shoes or a shirt because the patient did not have health insurance and had not paid for prior services (Fedas, Alexander, and Chase-

Lubitz 1991). The patient died at home the following day. A man with a steak knife in his back, wedged against his spine, was transferred from an emergency room because he was uninsured and could not pay \$1,000 cash in advance to remove the knife (Annas 1986).

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A woman who was mistakenly identified as uninsured was turned away by two hospitals during the early stages of birth despite indications of fetal distress, and once she reached a hospital that would provide the necessary care the fetus had died (Gionis, Camargo, and Zito 2002). After a pregnant woman's water broke at 14 weeks, she was denied services at a hospital and sent on an 80-mile cab ride to receive the procedure her physician declared medically necessary (Clark 2003). A woman whose water broke at 18 weeks was sent home twice from a hospital without receiving treatment or accurate information on the status of her fetus, denying her the medical services that would most ensure her safety (NeJaime and Siegel 2015). The first three cases represent examples that led to the passing of the Emergency Medical Treatment and Active Labor Act (EMTALA), which sought to end patient dumping, where hospitals would deny service or transfer patients, typically poor individuals, whom they did not want to care for. The last two cases were enabled by the government through the passage of the conscientious objection statutes that Nelson (2018) references, which allow providers, including large for-profit hospital systems, to deny medically necessary, potentially lifesaving care due to religious or moral beliefs.

While Nelson (2018) focused on the potential criminal liability of providers who deny abortions when they are the standard of care in a lifesaving emergency, this commentary focuses on the role of the government in enabling these actions. With high rates of maternal mortality that continue to rise (Carroll 2017), it is troubling that the government is creating a dichotomy that attempts to minimize the practice of hospitals denying emergency services to low socioeconomic status patients while deliberately encouraging the denial of emergency services to pregnant women. In doing so, the government goes beyond the constitutional requirements of free exercise of religion, instead raising questions of equal protection by doing little to minimize the risk to pregnant women.

Though the First Amendment generally protects the free exercise of religion, this right, as with all constitutional rights, is a negative right. It prohibits the government from interfering with the practice of one's religious beliefs, but does not obligate the government to take positive actions to ensure that one is able to freely practice one's religious beliefs at all times. This concept of negative rights has already played a significant part in abortion jurisprudence, when the Supreme Court declared that while the right to have an abortion is constitutionally protected, the government need not take positive action to ensure that all women have access (Harris v. McRae 1980). Yet in this circumstance, the government is taking legislative action to actively reduce access to potentially lifesaving medical procedures.

These actions contradict the state obligation to protect individuals equally. This obligation does not cease due to the beliefs or morals of individuals. Proponents of the COTA laws that Nelson (2018) references argue that they

do just that. They protect the religious beliefs of providers while those seeking treatment can access the services elsewhere. As the preceding examples show, in an emergency where a woman's life is on the line, this is hardly the case. In fact, the government rarely requires providers to take steps to minimize the risks of harm to these women. In contrast, the laws go out of their way to increase the risk. These accommodation laws often provide expansive exemptions for any religion or, with the inclusion of moral objections, no religion at all. Accommodation laws often go beyond allowing mere refusals, authorizing providers to withhold information that would enable women to find needed care, under the argument that this would make religious providers complicit in the abortion that may eventually occur (NeJaime and Siegel 2015).

The Religious Freedom Restoration Act (RFRA) prevents the government from substantially burdening a person's exercise of religion unless the government has a compelling interest and is using the least restrictive means to further that interest (*Burwell v. Hobby Lobby* 2013). Yet the U.S. Supreme Court has stated that "in applying RFRA 'courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries'" (*Burwell v. Hobby Lobby* 2013). Instead, states have created a two-tier system, where some providers are obligated to ensure lifesaving, emergency services and other providers are enabled to deny services to pregnant women who may not share their beliefs. For those women who have access only to religious or religiously affiliated providers, these separate systems can hardly be considered equal.

Though some may feel this is a relatively minor reduction in access to ensure protection of religious beliefs, the continuing trend of health care provider mergers make this a growing threat to any woman unfortunate enough to find herself in need of a potentially lifesaving abortion. Nearly 20% of hospitals, and 8 of the 25 largest health care systems, are religiously owned, with one in six patients treated by a Catholic hospital (NeJaime and Siegel 2015). And they can dominate in specific local markets. For example, in Lane County, Oregon, the Catholic health care system provided approximately 70% of the hospital services (NeJaime and Siegel 2015).

While Catholic hospitals are required to follow the Ethical and Religious Directives for Catholic Health Care Services, the increase in mergers means restrictions have expanded to providers that do not necessarily share those beliefs. For example, the 80-mile cab ride referenced earlier was at a secular hospital that had recently merged with a Catholic hospital and as part of the contract agreed to adopt the same restrictions in care (Clark 2003). Though the physician stated that an abortion was medically necessary, the head of the hospital refused to approve the procedure (Clark 2003).

With the reality of expanding religious affiliations and the frequent requirement that secular providers adhere to their belief system, this raises the question of

why states are not moving to reduce the potential harm to those in the community, including pregnant women in emergency circumstances. Moreover, policymakers should consider the message sent when the state provides these exemptions with little concern for the impact on pregnant women. If neither the government nor those seeking accommodations are interested in minimizing harms to pregnant women, or third parties in general, it seems the concern is not with protecting the health and interests of all parties but instead with enforcing religious norms on those who do not share those beliefs, which itself could violate constitutional protections of religious freedom.

As seen in the opening paragraph's last two examples where the women's water broke extremely early, a medically necessary abortion in a potentially lifesaving emergency is rarely, if ever, the outcome the woman sought. If we as a society believe no state should require a physician to perform an abortion against his or her will, we should also ensure mechanisms to prevent pregnant women from being forced to bear the burden of others' religious convictions. If states insist on protecting providers' religious objection to abortion, they should also insist on providing equal protection to the constitutional rights of pregnant women. Providers should be required to make known to the public the services they will not offer, even in lifesaving emergencies. Health care providers open to the public mislead the community into believing they would receive emergency care if needed, and to then deny these services when they are most in need should be considered immoral and unacceptable in a civilized society. Providers seeking accommodation should be required to assist patients in a medical emergency to find a provider that will perform the necessary procedure, including within their own facility if time or the woman's condition will not allow for a transfer. Finally, acquisitions and mergers that expand provider exemptions to reduce access to constitutionally protected rights and place pregnant women at risk should be prevented.

While the government may not have a positive duty to ensure that pregnant women can access their constitutional right to abortion, active steps should not be taken to eliminate access. EMTALA was passed to

counter the rise of for-profit hospitals refusing to serve poor patients. Today, religious and moral accommodations institutionalize efforts of the expanding religiously affiliated hospital system to deny certain medically necessary lifesaving procedures to pregnant women, which likely has a disparate impact on the same low socioeconomic patients EMTALA sought to help. If morality is truly the value these laws promote, accommodation laws must follow EMTALA in seeking to provide care to pregnant women in their hour of need, rather than relegating their status to that of second-class citizens (Ulrich 2012). ■

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