Hospital Mergers and the Threat to Women’s Reproductive Health Services

Using the Establishment Clause of the Constitution to Fight Back

NATIONAL WOMEN’S LAW CENTER
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The National Women's Law Center is a nonprofit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families, including health and reproductive rights, employment, education, and family economic security. Dina Mossow is Senior Counsel at the National Women's Law Center.
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by Dina R. Lassow
Acknowledgments

Valuable assistance in the preparation of this report was provided by Beth Burkstrand-Reid, formerly with Crowell & Moring, Carrie F. Fletcher, Crowell & Moring, Washington, D.C., and Allison Sloater, formerly an attorney at the National Women’s Law Center.

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Introduction

Throughout the nation, women’s reproductive health services face serious threats as secular health care providers that offer a full range of care are sold to, merge, or otherwise affiliate with providers who adhere to religious restrictions on the services they provide. A religious nonprofit system may appear to be an attractive option for a public or community hospital looking for a new owner or partner to alleviate financial difficulties. However, that option may involve the curtailment of a wide range of basic health care services.

While many different religions provide health care services, the largest systems—and those with the most restrictions on services—are Catholic owned and affiliated. Catholic hospitals are subject to religious “Directives” that bar the delivery of vital reproductive health care, such as contraceptive services (including emergency contraception), sterilization, infertility treatment, abortion, HIV risk reduction counseling, and certain end-of-life care. When a secular hospital is sold to or becomes affiliated with a religious hospital, the religious hospital may impose its restrictions on both entities, leaving patients with reduced access to comprehensive reproductive and other health care.

If the Directives are imposed, rape survivors may be denied emergency contraception when brought into the emergency room, leaving them at risk of pregnancy. Women may be denied the option of having a tubal ligation because the only nearby hospital refuses to provide it, increasing the chance of an unwanted pregnancy. Patients may be denied end-of-life care that they request if the care does not comply with Catholic teachings. Patients who seek the services that are no longer available at their local hospital may be forced to bear the burden of additional costs, delays and health risks incurred by going elsewhere.

These burdens fall most heavily on poor women and those living in rural areas, but the reduction in available health services adversely affects everyone in need of reproductive and other types of restricted health care. Catholic facilities operate in every state in the nation, and according to the most recent data available, 15 percent of all hospital beds are in Catholic hospitals.

If a hospital sale, merger or other arrangement imposes religiously-based restrictions at a facility that is or was owned, leased or operated by the federal government or a state or local government, the Establishment Clause of the First Amendment to the United States Constitution, and similar provisions in state constitutions that require the separation of church and state, can provide grounds for challenging the restrictions. Other tools may also be available.

This report explains how constitutional provisions requiring the separation of church and state may be used to protect access to reproductive health services. Part I begins by discussing the legal standards for determining whether the Establishment Clause has been violated. Next, it describes the “state action” that must be present in order for the Establishment Clause (or state constitutional provisions) to be used to defeat the imposition of religious restrictions. In other words, a government entity must be shown to be so involved that the imposition of the restrictions can be viewed as government conduct that must be kept separate from religion. Part II provides three instructive examples of how community activists, in concert with the National Women’s Law Center and other attorneys, successfully challenged arrangements between religious providers and government-owned providers that threatened to restrict access to full reproductive health services and end-of-life care.
Using the Establishment Clause to Challenge Religious Restrictions on Services

A. What Kind of Conduct Violates the Establishment Clause?

The First Amendment to the U.S. Constitution provides that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.” The initial part of this provision, the Establishment Clause, has been interpreted to mean that governmental entities shall not “aid one religion, aid all religions, or prefer one religion over another.” Rather, there should be a “wall” between church and state, with governments remaining “neutral” towards religion.

The Directives under which Catholic hospitals operate are religious doctrine, which emphasize that the care provided under their guidance is an inherently religious act. They provide that “[e]mployees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to the Directives.” The Directives prohibit contraception and sterilization, and state that “[a]bortion . . . is never permitted.” They also govern end-of-life care. Therefore, when a governmental entity is involved in the imposition of the Directives on the provision of health care, the government may be aiding religion in violation of the Establishment Clause.

There are numerous Supreme Court cases that seek to define the conduct that is permissible under the Establishment Clause. In general, under what is referred to as the “Lemon test,” valid governmental action: (1) must have a secular purpose; (2) “its principal or primary effect must be one that neither advances nor inhibits religion”; and (3) it “must not foster ‘an excessive government-
ment endorsement of religion and prayer.21

As discussed above, the language of the Directives shows that they have a religious, not a secular, purpose. Therefore, advocates could claim that a governmental entity’s agreement to the use of religious doctrine to govern care at a hospital, like authorizing prayer at football games, has the “purpose and perception” of government endorsement of religion. To show that the other prongs of the Lemon test are also violated, it can be argued that the primary effect of the implementation of the Directives is to advance religion, not to improve health care. Moreover, the government is, or is at a minimum giving the perception of, endorsing the doctrine of a particular religion, and “[t]he clearest command of the Establishment Clause is that one religious denomination cannot be officially preferred over another.”22 Finally, the government’s involvement with the implementation of the Directives could be said to foster excessive entanglement with religion, violating the third prong of the test.

However, the health care providers involved are likely to defend themselves by arguing that the entire arrangement between the public and the religious entities must be considered, not just the imposition of the Directives. They could claim that the arrangement with a religious provider has the secular purpose of improving the hospital’s financial condition in order to preserve or increase services for the community. With regard to the second and third prongs, they would likely argue that the services offered by the Directives are a small part of the many services provided by the hospital, and that any advancement of religion is therefore incidental, not primary to the operation of the hospital. For the same reason, they could contend that there is no excessive entanglement with religion.

Keeping the focus of a case on the Directives themselves can be important, but advocates should be prepared to show that even if the entire arrangement and all hospital services are considered, the Establishment Clause has still been violated. With regard to the “purpose” prong of the Lemon test, the history of the public entity’s arrangement with a religious provider should be examined, to determine whether it can be shown that the arrangement was entered into for the purpose of imposing religious restrictions on reproductive and other health care services. To demonstrate that the second and/or third prongs of the Lemon test have not been met, the most helpful Supreme Court case on which to rely is Larkin v. Grendel’s Den.23 In that case, the Court held that a state statute that granted governing bodies of churches and schools the authority to veto the issuance of liquor licenses to any premises located within 500 feet of the church or school violated the Establishment Clause.


In Larkin, the Court found that the first prong of the Lemon test was satisfied because there was “little doubt” that protecting a church from the “hurdy-gurdy” associated with liquor outlets served “valid secular legislative purposes.”24 Nevertheless, the statute at issue did not satisfy the Lemon test’s second and third prongs. The Court found that far from having a “remote and incidental effect on the advancement of religion,” the statute gave churches “the right to determine whether a particular applicant will be granted a liquor license....”25 Moreover, “the mere appearance of a joint exercise of legislative authority by Church and State provides a significant symbolic benefit to religion in the minds of some by reason of the power conferred.” Therefore, the Court concluded that the statute had “a ‘primary’ and ‘principal’ effect of advancing religion.”26
In addition, because the statute delegated to and shared “important, discretionary governmental powers” with religious institutions, it impermissibly entangled government and religion, in violation of the third prong of the Lemon test.27

A helpful lower court case for advocates is Spacco v. Bridgewater School Department, which relies on Larkin to find that plaintiffs were likely to prevail on their claim that a town’s leasing of space in a Catholic church to be used for public school facilities violated the Establishment Clause, even though the leasing of the church had a secular purpose.28 The lease provided that the public school’s use of the rented space had to be consistent with the teachings of the Catholic Church, and that the parties to the lease were to “defer to the teaching authority of the Roman Catholic Archbishop of Boston.”29 The Spacco court stated that this lease provision constituted an endorsement of religion—and even more significantly, endorsement of a particular religion—that was invalid under the second prong of the Lemon test. The Spacco court was also concerned that the students attending classes in the church would see a large cross when they entered the building, as well as notices of religious events and other religious symbols. Accordingly, the town’s conduct was found to be unconstitutional because it had the primary effect of advancing religion.30

Similarly, when a government entity allows the Directives to be imposed, it is giving the church the right to determine whether particular health care services will be provided. The public entity is sharing with one religious denomination, the Roman Catholic Church, the power to determine aspects of the provision of medical care. As in Larkin, “the mere appearance of a joint exercise of authority by Church and State provides a significant symbolic benefit to religion” and is therefore unconstitutional. In addition, the government can be said to be endorsing or approving of the Directives, and this endorsement constitutes the advancement of religion. As in Spacco, further evidence of the impermissible endorsement of religion could be the placement of religious symbols, such as a cross, on a public hospital and on its publications.31 Other indications of government endorsement would be prayers broadcast over the hospital’s loudspeakers or recited at the beginning of meetings where hospital business is conducted.

With regard to entanglement, the court in Spacco found that “the lease in this case is the functional equivalent of sharing with the Roman Catholic Church the power to determine aspects of the public school curriculum.”32 Similarly, the lease between a public entity and a Catholic health care provider may be the “functional equivalent of sharing with the Roman Catholic Church the power to determine aspects” of what health care services will be provided. Under Larkin, the sharing of power between church and state constitutes unconstitutional entanglement: “it is impermissible for the government to delegate or share its discretionary functions with religious institutions.”33 A public entity that includes the Directives in a contract with a religious health care provider becomes further entangled with the church because the Directives are interpreted and can be modified by religious authorities, requiring the public entity to study and implement changing church policy.

There is one state court case, Wisconsin v. Lindner,34 on which a Catholic health care provider is likely to rely in arguing that the second and third prongs of the Lemon test are not violated by its arrangement with a public entity, even though only financial assistance, not a delegation of the state’s authority, was involved in that case. In Lindner, the Wisconsin Health Facilities Authority filed an original action in the Supreme Court.
of Wisconsin seeking a declaration that the state law authorizing the sale of tax-exempt bonds to finance improvements in health care facilities, including religious facilities, did not violate the Establishment Clause. The court examined the terms of the statute and a representative Catholic hospital that could receive tax-exempt financing, and found that the statute passed the Lemon test.

It was undisputed that the Act at issue in Linderer "carries a ‘wholesome secular purpose’ to improve health care delivery by lowering health care costs."

In determining that the second and third prongs were also satisfied, the court looked to a series of Supreme Court cases upholding government programs that provided financial benefits to private institutions of higher learning, including religious colleges and universities. Based on these cases, it focused on the nature of the institution receiving the funding and whether it was "so pervasively religious that a substantial portion of its functions are subsumed in the religious mission," and on whether specifically religious activities would be funded. The Linderer court recognized that the Catholic hospital being examined followed the Directives, but determined that "the procedures prohibited by the ‘Directives’ are not so great a part of fundamental health care that their prohibition marks the institution as distinctively religious." It further concluded that the statute "had sufficient safeguards to prevent the funding of religious activities." Accordingly, it concluded that the authorizing statute "does not have the primary effect of advancing religion."

The Linderer court then stated that whether there was excessive entanglement presented a more difficult issue. Nevertheless, for essentially the same reasons as it discussed in its primary effect analysis, it found that there was no entanglement problem.

However, with regard to an arrangement involving a public entity in the imposition of the Directives, the issue is not whether the government’s provision of a financial benefit to private religious institutions along with other non-profit institutions—whether health or educational—is constitutional. Rather, it is whether a governmental entity can delegate some of its authority in performing one of its functions—e.g., operating a public hospital—to a religious group. It is the "symbolic benefit to religion" and the perception of government endorsement of religion when certain services are restricted that is significant, not whether the public hospital has become a "pervasively religious institution." Therefore, the Supreme Court case that governs is Larkin, not the financial benefit cases.

Even under Larkin’s analysis, the religious provider may still rely on Linderer’s minimization of the significance of the Directives. To rebut this claim, the religious nature of the Directives and the pervasive effect of their imposition should be detailed. Advocates might demonstrate that many services other than abortion and sterilization, the only services mentioned in Linderer, are prohibited by the Directives, and that the Linderer court did not fully understand that the services prohibited by the Directives are a fundamental part of women’s health care. While a public hospital may not always be required to provide abortions, that does not mean that a governmental entity can participate in refusing to provide abortions on religious grounds, or in denying other aspects of care.

To show the entanglement of church and state under Larkin, any public role in the implementation of the Directives, including all aspects of government oversight of the hospital, any role of public officials in managing the hospital and setting policy (as members of the board of directors or otherwise), and any link between financial assistance and religious activities, such as the use of public
funds for hospital training sessions that include the Directives, should be described. The perception of government endorsement of religion, through this public role and through any religious symbols that are or will be displayed, should also be stressed.

In other words, based on a detailed analysis of the merger, lease or other arrangement being challenged, the argument to be made is that the delegation of authority to a religious group and the involvement of a public entity in health care that is governed by the Directives or other doctrine impermissibly advances religion—both in perception and actuality—and entangles church and state in violation of the Establishment Clause. The issue is whether the public entity is adopting and endorsing religious doctrine—such as the Directives—that will be interpreted by and can be changed by church authorities. If it is, the public entity can be said to be singling out and implicitly aiding and endorsing a particular religion, contrary to one of the basic tenets of the Establishment Clause.

B. What Kind of Conduct Violates State Constitutions?

Like the U.S. Constitution, most state constitutions mandate a separation of church and state, and many have stricter prohibitions on the establishment of religion than the U.S. Constitution. Therefore, it is important that advocates consider their state constitution as a basis for potential challenges to mergers and other affiliations between religious entities and secular hospitals that threaten reproductive health services.

State constitutional provisions may mirror the First Amendment, and may also provide additional protections forbidding (1) compulsory attendance at or preferential support of any religious activity; (2) state preference of one religion; or (3) state contributions to religious institutions, whether direct or indirect. Litigants have used these clauses to “extend the reach of the state constitution beyond the First Amendment.”

In addition, some state constitutions provide greater protection of the right to privacy than the U.S. Constitution, and, hence, greater protection of the right to choose abortion and receive other services. These provisions, as well as state pro-choice statutes, may be used to support the importance of a hospital’s or the government’s provision of full reproductive health care.

Thus, advocates working to defeat a hospital merger or other arrangement that threatens to restrict the availability of reproductive health care should look at the provisions in their state constitutions that are intended to separate church and state, as well as how those provisions have been interpreted in the state courts. For example, in Feminist Women’s Health Center v. Philibosian, 157 Cal. App. 3d 1076, 1090-93 (1984), a California state court of appeal held that the district attorney’s decision to give aborted fetuses to a Catholic group for burial violated several provisions of the California constitution, including its establishment clause, its “no preference of religion” clause, and its ban on “official aid to any ‘religious sect, church, creed, or sectarian purpose.’” It found that the burial had no secular purpose, “would give symbolic support to the religious views of the Catholic League,” and expressed “an unconstitutional preference for the views of the Catholic League,” and impermissibly enlisted “the prestige and power of the state” in the burial.

As with federal law, advocates relying on state law should use a careful analysis of the facts to demonstrate all the ways in which a public entity is involved in restriction of services caused by the imposition of the Directives or other religious restrictions on previously secular hospitals.
C. When is a Hospital a “State Actor” to Whom the Establishment Clause is Applicable?

The Establishment Clause can only be used as a tool to oppose the imposition of religious restrictions when government, or “state action,” is present, since the First Amendment does not apply to private conduct. In some instances, as when a public hospital or a local hospital authority itself imposes the restrictions, state action is easily shown. However, if a public hospital is being operated by a private entity—whether via a lease, operating agreement, or other arrangement—and the private entity imposes the restrictions, state action may be more difficult to demonstrate.

Under Supreme Court precedents, the conduct of the private entity must be shown to be so interrelated with a public entity or activity that the private entity can be considered to be a state actor. There must be such a “close nexus” between the government and the private actors that even if religious restrictions are technically imposed by the private entity, that entity’s behavior “may be fairly treated as that of the State itself,” so that state and federal constitutional provisions requiring separation of church and state continue to be applicable to the hospital.

Federal cases involving hospitals and state action show that the factors most relevant to determining whether state action is present when a public hospital is run by a private entity include:

- the involvement of the state in the conduct being challenged,
- the general involvement of the state in the operation of the hospital, including policy-making and financial support,
- the benefit derived by the state from its relationship with the private entity; and
- the injury to the plaintiff.

A helpful precedent is *Jatol v. Hurst-Euless-Bedford Hospital Authority*, in which the court held that a hospital owned by a municipal hospital authority but operated by a private non-profit corporation under a lease agreement was a state actor for the purposes of an employee’s racial discrimination claim. The factors considered by the court were that the hospital was publicly owned and had been constructed with public funds; the hospital had initially been operated by the hospital authority, which received a direct financial benefit from the private operation of the hospital; the authority continued to finance the hospital; and that, even though it had no direct input into personnel decisions, the municipal hospital authority was informed of the hospital board’s decisions concerning personnel. Because the authority, an arm of the local government, “monitored the activity of its lessee and retained the ability to prevent or control racial discrimination by its private manager,” any discrimination at the hospital was deemed to be state action:

The authority cannot benefit from private management of the hospital and at the same time insulate itself from liability for racial discrimination by that manager. The private defendants cannot receive public funds, utilize public facilities, and serve a public purpose, yet insist that their private status forecloses any correction of a violation of the constitutional rights of their medical staff.

An earlier case, *Greco v. Orange Memorial Hospital*, will have to be distinguished. In that case, no state action was found when a physician who worked in a hospital leased from a county government challenged a hospital policy prohibiting abortions. The court distinguished the case from *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961), and other cases in which...
state action was found primarily because, unlike Burton, no accusation of racial discrimination was involved. It asserted that the “doctrine of state action developed primarily in the area of racial discrimination,” and that in other areas the applicability of the doctrine should be defined “more precisely.” It minimized the harm alleged, stating that the refusal to perform non-therapeutic abortions “does not impinge upon the rights of a racial group seeking admittance and treatment, but rather affects primarily only the internal affairs of the facility.” The court also discussed the absence of a “symbiotic relationship” between the county and the hospital, and the fact that the record showed that county officials had not participated either directly or indirectly in the formulation of the abortion policy. In a concurring decision, one judge thought there was a “symbiotic relationship,” but agreed that the case should be dismissed because the hospital could not “be compelled to allow its facilities to be used for elective abortions.”

Greco was specifically distinguished a few years after it was decided in Downs v. Sawtelle. In Downs, the court found state action was present in a case challenging an involuntary sterilization performed in a private hospital as unconstitutional. The “most compelling factor” in this decision was that the entire board of directors of the hospital was appointed by the town’s Board of Selectmen. In addition, the hospital received thirty percent of its operating budget from Medicare, and was required to turn any profits over to the local government. In the event of its dissolution, all hospital assets after payment of debts were to revert to the town. Downs distinguished Greco because of the public control of the board, the town’s right to receive profits, and the “benefit” to the town of the sterilization of indigents. The court in Downs also noted that racial discrimination could be “equated with deprivation of a fundamental right for the purposes of state action analysis.”

While more cases follow Greco than Jafoti and Downs, and find no state action by hospitals, advocates should be able to distinguish Greco and its progeny if they can demonstrate that the government is involved in the action being challenged—the imposition of religious restrictions on health services—and not solely in the general administration of the hospital. In addition, it is important to demonstrate that the harm from the religious restrictions—namely, the denial of basic health care—is not merely an internal administrative matter, and warrants the same intervention as race-based discrimination claims. To make this showing, advocates should provide evidence of the importance of comprehensive reproductive health care to women.

Demonstrating state action may be considerably easier in some state courts. For example, the Alaska Supreme Court found that a private hospital was “quasi-public” and therefore subject to constitutional requirements because it was the only hospital serving the community, the construction of the hospital was funded by government grants, and about a quarter of the money received by the hospital for services came from government sources. Valley Hospital Ass’n v. Mat-Su Coalition for Choice, 948 P.2d 963, 968, 970-71 (Alaska 1997). It then held that the hospital’s refusal to provide abortions on “moral,” not religious, grounds, violated the Alaska constitution’s provision that “[t]he right of the people to privacy is recognized and shall not be infringed.” Similarly, the Supreme Court of New Jersey determined that three private hospitals were “quasi-public institutions” because they received substantial public funds, they benefited from tax exemptions, their facilities were available to the public, and they were subject to “control for the common good.” Doe v. Bridgeton
Hospital Ass’n, 366 A.2d 641, 645-47 (N.J. 1976). It found that the hospitals’ refusal to provide abortions on “moral” grounds was contrary to their obligation to serve the public and to the federal right to an abortion.

In addition, regardless of the court in which a case is brought, just as advocates may rely on strong state constitutional and statutory protections for privacy and reproductive rights to support arguments that the Establishment Clause has been violated, advocates may also rely on those provisions to show state action. The protections demonstrate the importance the state has put on protecting family planning and the right to choose abortion, and the accompanying need for the court to safeguard those rights.

## Case Studies

In 1997, the Establishment Clause was invoked by the Attorney General of Connecticut who argued that it would be unconstitutional for a proposed health care center sponsored by four hospitals, including a state hospital, a Catholic hospital, and two secular hospitals, to be subject to the Directives. However, the center was denied a Certificate of Need on other grounds by the state’s Office of Health Care Access, and the Establishment Clause argument was not addressed. The argument was raised a few years later in court cases that challenged the imposition of the Directives in Florida and Oregon, in which the National Women’s Law Center was involved. Once again, the Establishment Clause argument was not tested, because both cases were resolved before the courts made their decisions. Nevertheless, it proved to be a helpful tool. The arrangements that caused the imposition of the Directives were voluntarily ended, and full reproductive services were restored or continued.

### A. Religious Restrictions at a Proposed Ambulatory Surgical Center in Avon, Connecticut

In early 1997, four hospitals—St. Francis Hospital and Medical Center, the University of Connecticut’s John Dempsey Hospital, Hartford Hospital, and New Britain General Hospital—requested a Certificate of Need for a freestanding, ambulatory surgery center in Avon, Connecticut. Procedures that were not in accord with the Directives, such as sterilizations and abortions, would not be performed at the Avon Center. Women’s groups in Connecticut quickly organized a coalition to oppose the restrictions.

The Attorney General of Connecticut wrote to each of the hospitals, expressing his “concern about the importance of providing certain reproductive health care services for women at the proposed Avon Surgical Center.” He asked them to “reach an accommodation between the religious beliefs of the members of the consortium and the principle of equal access by women to reproductive health services.” But, no such accommodation was reached.

The grant of a Certificate of Need to the Avon Center was opposed by numerous parties. The Attorney General argued that the University of Connecticut’s participation would violate the constitutionally required separation of church and state. The City of Hartford protested that the Avon Center would drain resources from the health care providers in the city. In support of the application, it was argued “that rejection of this proposal would deal a serious if not fatal blow to the ability of Catholic hospitals in Connecticut to be competitive and maintain their status as...
principal providers of health care in Connecticut.**71**

The Office of Health Care Access did not rule on the constitutional issue or the Catholic provider’s plea. It denied the Certificate of Need because the Avon Center would have an “adverse impact on existing providers;”**72** no showing had been made that it would improve services, and the new center would “add unnecessary and duplicative costs to the health care delivery system.”**73** No further action was taken.

**B. Religious Restrictions at the Bayfront Medical Center, St. Petersburg, Florida**

In 1968, the City of St. Petersburg, Florida, leased a hospital it owned to a non-profit corporation, Bayfront Medical Center, for $10.00 per year. With the city’s consent, in 1997, Bayfront joined BayCare Health System as a cost-saving measure. One of the conditions of the confidential Joint Operating Agreement (“JOA”) governing BayCare (which included two Catholic hospitals) was that Bayfront would be subject to the Directives. When Bayfront’s refusal to provide abortions became a matter of public controversy two years later, the city claimed that it had not known about the religious restrictions when it consented to the hospital’s joining BayCare. In March 2000, the city filed suit against Bayfront and BayCare in federal court, alleging that the terms of the lease had not been followed and that the restrictions violated the Establishment Clause.**74**

Meanwhile, local groups mobilized to restore full reproductive services at Bayfront, including abortions. In August 2000, a pro-choice coalition filed its own federal court action against the city, Bayfront and BayCare.**75** In addition to claiming an Establishment Clause violation, the coalition alleged that the secret negotiation of the JOA violated Florida’s open meetings law and that Bayfront’s records concerning the JOA had to be disclosed under the state’s Public Records Act.**77**

The theory of the Establishment Clause violation was that requiring compliance with the Directives at Bayfront meant that the city was impermissibly imposing certain religious beliefs on the staff and patients of the hospital. Bayfront could be considered to be a “state actor” because its actions were entwined with those of the city: the hospital operated by Bayfront was owned by the city and leased for only a nominal sum, the lease required Bayfront to provide services for the poor, the city continued to oversee Bayfront’s operations, and the city had approved Bayfront’s entry into the JOA.

Bayfront and BayCare filed a motion to dismiss the coalition’s case against them, arguing that there was no state action. In other words, they argued that they could not violate the Establishment Clause because neither was a governmental entity that was subject to the terms of the First Amendment—or to the state disclosure laws. However, all proceedings in the litigation were stayed, as was the city’s case against Bayfront, and the court never had to decide the motion.**77**

While the litigation was on “hold,” several attempts to settle the dispute with Bayfront were made, including amendments to the JOA and an offer by Bayfront to buy the hospital from the city. After this offer was rejected, BayCare voted in October 2000 to oust Bayfront. A key factor in this ouster was BayCare’s concern that its records might become public. On December 31, 2000, Bayfront was officially “divorced” from BayCare, with all religious restrictions lifted.

The city settled its lawsuit in April 2001, with a detailed court order stating that the Directives did not apply to Bayfront as of January 1, 2001 and would not be applied in the future, and that as long as the lease between Bayfront and the city remains in effect, Bayfront will be operat-
ed as a non-sectarian hospital.

The coalition also entered into settle-
ment negotiations with Bayfront and
BayCare shortly after the “divorce,” which
were finalized in December 2001. Under
the Settlement Agreement, which is sub-
ject to enforcement by the court,
Bayfront may not rejoin BayCare if the
Directives will be imposed, and it may not
prohibit or restrict the provision of any
reproductive health services to its
patients. In addition, Bayfront paid
$50,000 to the coalition for attorneys’
fees and costs.

The multifaceted strategy of the
Establishment Clause argument, the
“open meetings/public records” claim,
and effective community activism all
contributed to the successful outcome of
restored reproductive health services.
Moreover, contrary to predictions of finan-
cial problems when Bayfront was ousted
from BayCare, the hospital appears to be
doing well.

C. Religious Restrictions in the
Pacific Communities Health
District, Newport, Oregon.

In 1999, the Pacific Communities
Health District, a municipal corporation
of the State of Oregon, began negotiating
an Operating Agreement ("OA") with
Providence Health System, a Catholic
non-profit organization. Under the OA, the
Health District was to lease its facilities—
which included the only hospital in
Newport, Oregon, a rural area—to
Providence, which would operate the
hospital in accord with the Directives. The
hospital would continue to receive sub-
stantial public funding, and the public
health district would oversee the oper-
ation of, and capital improvements to, the
hospital.

Faced with community opposition to
the plan, in March 2000 the health district
asked a state circuit court to determine
the validity of the OA prior to its imple-
mentation.73 Providence participated in
the proceedings as an Intervenor to
defend the arrangement. Residents of
the area, who were concerned about the
curtailment of reproductive health servic-
es and end-of-life care that would result
from the imposition of the Directives, par-
ticipated as Respondents in order to
oppose the OA.74 Along with due process
and other arguments that were rejected,
they contended that the OA violated the
Establishment Clause and the analogous
provision of the Oregon constitution.75
State action was not an issue here, as it
was in Bayfront, because the Oregon
public health district—a governmental
entity—was itself imposing the Directives
by entering into the OA that allowed
them to be implemented at the hospi-
tal.76

Providence filed a motion asking the
court to find that the OA was constitu-
tional. In a decision issued in November
2000, the court applied the Lemon test
to the OA, and found that it satisfied the
first prong of the test because it had a
secular purpose.77 It stated that the sec-
ond prong of the Lemon test was satisfied
because the OA’s “principal or primary
effect is one that neither advances, nor
inhibits religion.” However, it called for test-
imony on two questions related to the
third prong:

(1) Whether the Operating Agreement,
in operation, avoids excessive gov-
ernment entanglement with religion;
and

(2) Whether the hospital, post Operating
Agreement, is going to be operated as a “pervasively religious institu-
tion.”78

With regard to the Oregon Constitution,
the court found that while Providence
would be receiving money and it was
“admittedly a religious institution,” under
decisions of the Oregon Supreme Court,
the aid would not be prohibited if it were
going to the institution “as a hospital” as
opposed to going to a “religious
function.”79 Thus, in addition to asking the
same question about entanglement as it asked with regard to the United States Constitution, the court wanted to know “[w]hether the funding which is directed by the OA to Providence from the District ‘benefits’ Providence as a religious institution.”

At the trial, which lasted for a week and a half, Providence tried to show that it was receiving money from the district as a hospital, not as a religious institution. Father Tuoney, a Catholic priest employed by Providence as an ethicist, downplayed the religious aspects of the Directives, testifying that “more than 90 percent” of what is in them “would be found in your standard ethics textbook.”

Father Tuoney described a “rural” exception to the Directives that allowed a balance between “your own teachings as well as actually being able to serve the people where you are....” When asked about the prescribing of contraceptives, Father Tuoney said that no one would be listening in on the private conversations between physicians and their patients, or monitoring prescriptions that were written. He did acknowledge that abortions were prohibited, that tubal ligations would only be performed if they were medically indicated, and that emergency contraceptives would not be available if the OA were implemented.

The administrator of the health care district testified that the Directives would apply to all physicians who had staff privileges at the hospital or who rented space in a new medical office building that would be constructed by Providence. He also testified that the Catholic cross would be affixed to the hospital and would be on its stationery.

An expert for the area residents, Dr. John Golinski, a health care and bioethics consultant who was familiar with other Providence hospitals, testified about the importance of compliance with the Directives to the Catholic Bishops Conference. While Catholic hospitals are not directly under the control of the bishop, Dr. Golinski testified about instances of bishops intervening in a hospital’s operations. He also testified about the Directives’ categorical prohibition of any form of contraception, and that the physician-assisted suicide allowed under Oregon law was contrary to the Directives.

In a surprise move, in January 2001, before the court had made its decision, Providence informed the court that it had withdrawn from the OA, stating that it did not wish to spend the next several years tied up in appeals. It also announced that it was reimbursing the District for its attorneys’ fees and costs. The District then moved to dismiss its validation proceeding as moot.

The area residents opposed the dismissal because they were concerned that the District would enter into another similar OA. They went ahead and filed their brief on the merits of the case. In this brief, they discussed how the language of the Directives shows that they are religious, not secular, principles. While Father Tuoney had testified about a “rural exception” to the Directives, there was no evidence that the doctors knew of, or would be informed about, this exception. Instead, physicians called by the respondents had discussed the conflict between their current practices, the advice they would give their patients, particularly in the area of reproductive health care, and the strictures of the Directives. The residents argued that the hospital’s new name—the Providence Pacific Communities Hospital—and its new logo with a cross would join church and state.

Relying on Larkin and the other cases discussed above, the residents claimed that under the proposed OA, the Health District would unconstitutionally delegate its authority to Providence. They also cited the substantial financial and management ties between the public health district and the Catholic health system that would exist after Providence took over the
day-to-day operations of the hospital.98 However, the court granted the District’s motion to dismiss the proceedings, thus agreeing that there was no longer any need for the case to be decided, and the brief filed by the residents was never considered by the court.99

Newport currently has a lease agreement with another religious provider, Samaritan Health Services. However, the Directives are not involved, and no other restrictions have been imposed on the services provided. Thus, raising the Establishment Clause argument forced the Catholic health care system to withdraw its offer to run the public hospital, and full reproductive health and end-of-life services were preserved.

Conclusion

Governmental action that results in the application of the Directives or other religious restrictions at previously secular hospitals leaves patients without comprehensive reproductive and other health care. The argument that the imposition of these restrictions violates the separation of church and state required under the Establishment Clause of the U.S. Constitution and similar state constitutional provisions can be a powerful tool in an effort to restore or prevent the loss of the services. To make the argument effectively, advocates must learn all they can about the terms of a merger, lease or other arrangement that has resulted or will result in the imposition of the restrictions, in order to show how it advances a particular religion and how it entangles the government with religion. While there are no legal precedents directly on point, the assertion of the Establishment Clause argument has played a role in ending arrangements under which reproductive health and end-of-life services were or would have been restricted because of the Directives.
References

1 Driven by escalating costs and dwindling profit margins, providers are turning to mergers and affiliations with other providers to preserve their bottom line, a trend that is expected to continue. See, e.g., Hospital Mergers and Acquisitions Pick Up; Report, MOD. HEALTHCARE (Daily Dose web newsletter, posted July 13, 2005); Reed Abelson, After a Pause In Merger Activity, Hospitals are Again Joining Forces, N.Y. TIMES, Sept. 15, 2004, at 4 (citing 106 hospitals involved in mergers in 2004 and predicting that there will be “more pressure to consolidate”); Vince Galloro, An Offer They Can’t Refuse, As Mergers and Acquisitions Make a Comeback, Hospitals Large and Small are Choosing Consolidation Over Competition, MOD. HEALTHCARE, July 12, 2004, at 6 (predicting “more deals” as a result of an improved economy, cash from the Medicare Modernization Act, and consolidation among health plans).

2 Religious hospitals constitute seven of the ten largest nonprofit health care systems, based on number of acute care beds. Five of the ten largest health systems, as measured by patient revenue, are Catholic affiliated. Modern Healthcare’s Annual Hospital Systems Survey, MOD. HEALTHCARE, June 6, 2005, at 32.


5 CATHOLIC HEALTH ASS’N, CATHOLIC HEALTH CARE IN THE UNITED STATES (Jan. 2005), at http://www.chausa.org/NR/rdonlyres/6687C0E5-F0AA-4106-B182-7DF0C301CA0/FACTSHEET.pdf (last visited May 9, 2006).


7 U.S. Const., amend. I. The religious freedom protections in the First Amendment were made applicable to the states and their political subdivisions through the Fourteenth Amendment. See Everson v. Bd. of Educ., 330 U.S. 1 (1947); Santa Fe Indep. Sch. Dist. v. Doe, 530 U.S. 290, 301 (2000) (hereinafter Santa Fe).

8 Everson, 330 U.S. at 15.


11 For example, Directive 1 states “A Catholic Institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.” See Directives, supra note 8.

12 Directives, supra note 3, at Directive 9. In addition, the mission statement of Catholic health care systems often describes in detail their unique purposes in furthering the teachings of the church.

13 Directives, supra note 3, at Directive 52.

14 Directives, supra note 3, at Directive 53.

15 Directives, supra note 3, at Directive 45.

16 Directives, supra note 3, at Directives 55-56. For a summary of restrictions that may be imposed, see https://www.nwcic.org/pdf/ASK_End-of-life_August2005.pdf (last visited May 9, 2006).

17 Lemon v. Kurtzman, 403 U.S. 602, 612-13 (1971) (citation omitted). This test has frequently been criticized, but it remains the law. See, e.g., McCreary County v. Am. Civil Liberties Union, 125 S.Ct. 2722, 2732-33 (2005).

18 175 U.S. 291 (1899) (public funds could be used to build a ward for the treatment of contagious diseases that would be turned over to a Catholic hospital in the District of Columbia). In Bradfield, the Court stressed the fact that the articles of incorporation of the hospital did not mention religious purposes. Accordingly, Catholic hospitals have structured themselves as nonprofit
charitable corporations that are separate from the church in order to avoid problems with receiving government funding. See William W. Barrett, Private Religious Hospitals: Limitations Upon Autonomous Moral Choices In Reproductive Medicine, 17 J. Contemp. Health L. & Pol'y 455 (2001).

19 In her concurring opinion in Zeigler v. Simmons-Harris, 536 U.S. 639 (2002), which upholds Cleveland, Ohio’s school voucher program, Justice O’Connor cited a study by MergerWatch showing that religious hospitals received nearly $45 billion from Medicare and Medicaid in 1998, to make the point that “the support that the Cleveland voucher program provides religious institutions is neither substantial nor typical of existing government programs.” 536 U.S. at 666. See also Bowen v. Kendrick, 487 U.S. 589, 613-14 (1988) (rejecting the argument that government aid to a religious organization creates an “impermissible symbolic link” because such a concept “would jeopardize government aid to religiously affiliated hospitals.”)


21 Id. at 314, 316.


24 Id. at 123.

25 Id. at 125.

26 Id. at 125-26.

27 Id. at 126-27.


30 Other cases that may be helpful are Bd. of Educ. v. Grumet, 512 U.S. 687 (1994) (Court relied on Larkin to hold that a state statute carving out a school district that exclusively served a religious sect was an improper delegation of the state’s authority over public schools) and Commack Self-Service Kosher Meats, Inc. v. Rubin, 294 F.3d 415, 425 (2nd Cir. 2002), cert. denied, Weiss v. Commack Self-Service Kosher Meats, 537 U.S. 1187 (2003) (state laws making the state responsible for preventing fraud in the sale of kosher meat are an impermissible entanglement of government and religion because, among other concerns, they involve the state in the determination of how to define “kosher.”).

31 “When prominently displayed on a public building that is clearly marked and known to be such, the cross dramatically conveys a message of government support for Christianity…” Am. Civil Liberties Union v. City of St. Charles, 794 F.2d 265, 271 (7th Cir. 1986).


33 Id. at 844.

34 280 N.W.2d 773 (1979).

35 Id. at 777-78.


37 Linzer, 280 N.W.2d at 777.

38 Id. at 780. The only prohibitions mentioned by the court were abortion and sterilization. In determining that those prohibitions did not make a hospital a “distinctively religious” institution, the court found it significant that public hospitals are not required to provide abortion services under Poelker v. Doe, 432 U.S. 519 (1977), and that a federal program providing construction funds included the provision that health care providers did not have to make their facilities available for the performance of sterilizations or abortions. 42 U.S.C. § 300a-7(b)(2)(A) (2006) (the Church Amendment to the Hill-Burton program); In Poelker, the Court held that “the Constitution does not forbid a State or city, pursuant to democratic processes, from expressing a preference for normal childbirth as St. Louis has done.” 432 U.S. at 521. However, the Constitution does forbid a State or city from imposing religious doctrines on its citizens. Thus, in relying on Poelker, the Linzer court erred in failing to recognize the significance of the religious basis for the government’s action.

39 The authorizing statute requires the Authority to issue rules ensuring that a facility benefiting from the tax-exempt bonds “may not be used primarily for sectarian instruction or study or as a place for devotional activities or religious worship.” Wis. Stat. §
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231.03(6). After the bonds have been paid-off and title is reconveyed to the facility, the conveyance must have this same condition. Wis. Stats. § 231.07(2)(b).

40 Linnder, 280 N.W.2d at 781. The court also stated that its decision was “consistent with” Broadfield, id.

41 Id.,

42 For information on the importance of comprehensive reproductive health care see Nat’l Women’s Law Ctr., Healthy Women, Healthy Babies: Restrictions on Family Planning Services Can Harm Women, Children and Families (2003); Dept. of Health and Human Servs., Ctrs. for Disease Control and Prevention, Safe Motherhood: Promoting Health for Women Before, During and After Pregnancy (2003) (serious health conditions can be exacerbated by pregnancy, including diabetes, asthma, depression and high blood pressure, and therefore require close monitoring from conception, which is facilitated by family planning and prenatal care; perinatal transmission of HIV can be prevented with pregnancy planning); Brenda A. Buijoli, Postpartum Tubal Ligation: Timing and Other Anesthetic Considerations, 46 CUNY L. Rev. 657 (2003) (performing a tubal ligation immediately after delivery is generally safer and less expensive than waiting until after recovery from childbirth, and reduces the time a mother has to spend apart from her newborn); Gordon Smith et al., Interpregnancy Interval and the Risk of Preterm Birth and Neonatal Death: Retrospective Cohort Study, 327 Brit. Med. J. 313 (2003) (pregnancy spacing is an important risk factor in low birth weight and infant mortality).


45 Id. at 632 (citing Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Utah, Virginia, Washington, West Virginia and Wisconsin).

46 Id. at 633 (citing Florida, Missouri, Montana, and Oklahoma).

47 Id. at 634. Most of the cases where the state constitution was found to bar conduct permitted under the First Amendment involve state aid to parochial schools. Id. at 653.

48 For example, courts in Alaska, Arizona, California, Connecticut, Indiana, Illinois, Florida, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Oregon, Tennessee, Vermont and West Virginia have determined that their state constitutions protect reproductive freedom, including the right to obtain an abortion, more strongly than the U.S. Constitution. Protection for the right to choose has been found not only under explicit privacy protections, but also under equal rights amendments, and equal protection, due process, and privilege and immunities clauses. See Nat’l Abortion Rights Action League v. Choate, 925 A.2d 839 (Conn. 2007) (quoting the Connecticut constitution).

49 See id. for a list of pro-choice and anti-choice laws in each state.

50 In the Linnder case discussed above, the issuance of the bonds was also challenged under the Wisconsin Constitution, which provides in Article I, Section 18 that “no preference be given by law to any religious establishments or modes of worship; nor shall any money be drawn from the treasury for the benefit of religious societies, or religious or theological seminaries.” While this clause was stated to be “more prohibitive than the First Amendment,” it was still found to encompass the federal “primary effect” test. 260 N.W.2d at 782-83. This test was held to be satisfied because the financial aid “does not advance religion; instead it flows to the predominantly secular aspects of health care” and does not violate the state constitution. Id. at 783.

51 The seminal Supreme Court case on state action is Burton v. Wilmington Parking Auth., 365 U.S. 715 (1961). In Burton, a coffee shop that leased its space from a city parking authority was found to be a state actor when it refused to serve African Americans.

52 Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass’n, 531 U.S. 286, 295 (2001), quoting Jackson v. Metro. Edison Co., 419 U.S. 345, 349 (1974). Brentwood, the Supreme Court’s most recent case defining state action, lists a “host of facts” that the Court has relied upon to determine when a challenged activity constitutes state action: when “it results from the State’s exercise of ‘coercive power’... when the State provides significant encouragement, either overt or covert;” when the government actor and non-government actor operate jointly, when the non-government actor is controlled by an “agency of the State;” when the non-government actor “has been delegated a public function by the State;” or when the policies of the government and the non-government actors are “entwined.” Id. at 296 (citations omitted).

53 While it may be a factor, a hospital’s receipt of government funds is not itself sufficient to make the hospital a state actor.
Such funds are routinely provided to virtually every hospital through Medicaid and Medicare. Similarly, the benefits received through tax exemptions and tax-exempt bonds do not turn a private hospital into a state actor. See, e.g., Wolotsky v. Huhn, 960 F.2d 1331, 1336 (6th Cir. 1992); Modaber v. Culpepper Mem'l Hosp., 674 F.2d 1023, 1026-27 (4th Cir. 1982); Downs v. Sawtelle, 574 F.2d 1, 7 (1st Cir. 1978); Greco v. Orange Mem'l Hosp., 513 F.2d 873, 876 (5th Cir. 1975).

54 607 F.2d 1214 (5th Cir. 1987).

55 Jatoli, 807 F.2d at 1221-22. See also Milo v. Cushing Mun. Hosp., 861 F.2d 1194, 1197 (10th Cir. 1988) (following Jatoli where physicians challenged their suspension allegedly for reporting misconduct by another physician, and holding that a hospital authority's contracting with a private entity for day-to-day management of a city-owned hospital does not insulate the hospital from being a state actor) and Doe v. Charleston Area Med. Ctr., Inc., 529 F.2d 636, 643-44 (4th Cir. 1976) (private nonprofit hospital's anti-abortion policy based on the state's criminal abortion statute (which was held to be unconstitutional) is state action).

56 Greco, 513 F.2d at 873 (5th Cir. 1975). In Jatoli, the court stated that Greco was distinguishable, but did not actually give the grounds for the distinction. It simply found that the Supreme Court's decision in Burton (see note 51, supra), not Greco, was controlling. 807 F.2d at 1220-21.

57 Greco, 513 F.2d at 879.

58 Id. at 880.

59 Id. at 880-81.

60 Id. at 883.

61 Downs, 574 F.2d at 6-8.

62 Id. at 7.

63 In Greco, four members of the nine-member board were elected by the property owners of the county, and it is not specified how the others were chosen. Greco, 513 F.2d at 877.

64 Downs, 574 F.2d at 7 n. 7.

65 See, e.g., Willis v. Univ. Health Servs., Inc., 993 F.2d 837, 840 (11th Cir. 1993) (no state action in filing of a nurse who publicly criticized the obstetrics practices of a hospital operated by a private, nonprofit corporation under a lease agreement with a publicly held hospital authority that gave the corporation "sole discretion to hire and fire employees"); Wolotsky v. Huhn, 960 F.2d 1331, 1336 (6th Cir. 1992) (no state action in termination of an employee for alleged homosexual activity by a community mental health center that operated under a county contract because the county was not involved in personnel decisions); Albright v. Longview Police Dept., 864 F.2d 835, 840-41 (5th Cir. 1989) (no state action in case concerning an employee who protested hospital policies, distinguishing Jatoli because Jatoli involved a hospital authority that, unlike the more removed county government in Albright, oversaw hospital activities and was informed about personnel actions); Lubin v. Crittenton Hosp., 691 F.2d 414, 416 (9th Cir. 1983) (no state action in disciplining of a physician by a publicly owned hospital because the lease agreement gave a private nonprofit corporation "full and complete charge of the management and operation" of the hospital); Taylor v. St. Vincent's Hosp., 523 F.2d 75, 77-78 (9th Cir. 1975) (no state action in denial of tubal litigation by a Catholic hospital even though the hospital had the only maternity department in the city, because the state was not involved in the denial of services).

66 As stated by one court: "the symbiotic relationship between the public and private entities must involve the alleged constitutional violation." Patrick v. Floyd Med. Ctr., 201 F.3d 1313, 1316 (11th Cir. 2000) (no state action found in denial of hospital privileges to a physician).

67 See note 42, supra.

68 See notes 46 and 49, supra.


70 Letter of July 8, 1997 (on file with the National Women's Law Center).

71 OHCA Decision, supra note 69, at 11-12. (The submissions of the concerned parties are not available.)

72 Id. at 6.

73 Id. at 11.


75 Ndfl Org. for Women v. City of St. Petersburg, No. 8:00-CV-1698-3-26C (M.D. Fla. 2000).
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77 The proceedings were stayed before the Coalition filed its response to the motion to dismiss; so its legal theories were never developed in any court filings.

78 In re Hoagland, No. 00-1227 (Or. Ct. Cl. 2000) (unpublished, on file with the National Women’s Law Center). The case, brought pursuant to an Oregon statute entitled “Determination of Legality of Municipal Corporation Organization and Actions,” Or. Rev. Stat. §§ 33.710, was called a “validation proceeding.”


80 Article 1, § 5 of the Oregon Constitution provides that “No money shall be drawn from the Treasury for the benefit of any religious, or theological institution, nor shall any money be appropriated for the payment of any religious services in either house of the Legislative Assembly.”

81 In Bayfront, it was the private corporation that leased the city-owned hospital that agreed to follow the Directives.

82 In re Hoagland, supra note 78, at 20. This decision is not published, but it can be obtained from the National Women’s Law Center.

83 Id. at 25. The Court recognized that the evidence presented on these questions could also be relevant to the second prong.

84 Id. at 17 (emphasis in original);

85 Id. at 24 (emphasis in original).

86 Transcript of the testimony of Father John Tuohy, In re Hoagland, No. 00-1227, Nov. 29, 2000, at 19. This transcript and the other transcripts referenced may be obtained from the National Women’s Law Center.

87 Id. at 69.

88 Id. at 72-76.

89 Id. at 84, 97.

90 Transcript of the testimony of Michael Fraser, In re Hoagland, No. 00-1227, Nov. 27, 2000, at 71-73, 76-77.

91 Transcript of the testimony of Dr. John Golinski, In re Hoagland, No. 00-1227, Nov. 27, 2000, at 18-24.

92 Id. at 34-36.

93 Transcript of proceedings, In re Hoagland, No. 00-1227, Jan. 17, 2001, at 8-6.

94 Id. at 7-8.

95 Id. at 10-12. Respondents’ Closing Brief was filed on January 31, 2001 by attorneys Jane Paulson and Maureen Leonard, who practice in Portland, Oregon (on file with the National Women’s Law Center). See LaFrance, supra note 79, at 284 (discussing a brief prepared by Arthur LaFrance, but not filed).

96 Id. at 9-16.

97 Closing Brief for Respondents, at 16, In re Hoagland, No. 00-1227 (Or. Ct. Cl. 2000).

98 The health district and Providence relied heavily on Linzer (discussed on pp. 8-9, 12, and n. 50, supra) in their summary judgment and post-trial briefs, and it was quoted by the court in the decision on the motion for summary judgment. The residents sought to distinguish Linzer on the grounds that it involved financing only, an earlier version of the Directives, no development of the importance of the services prohibited under the Directives, and was decided on a limited record, with no discussion of religious activities related to the enforcement of the Directives, such as staff training. Closing Brief for Respondents, supra note 97, at 29-31.

99 The residents, who forced the termination of the OA, were not awarded their attorneys’ fees because of a Supreme Court decision that requires a court decision or court-approved settlement for such an award. See Buckhannon Bd. & Care Home v. W.V. Dept. of Health & Human Res., 531 U.S. 1004 (2001); LaFrance, supra note 79, at 266.
For more information on using legal theories to combat religious restrictions on reproductive and other health care, please see the National Women’s Law Center’s other publications in this series, all available for purchase or download from www.nwlc.org.

- Hospital Mergers and the Threat to Women’s Reproductive Health Services: Using Charitable Asset5s Laws to Fight Back (2001)