

ETHICS & MEDICS

A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

PLAN B AND THE ROUT OF RELIGIOUS LIBERTY

On October 1, 2007, new legislation went into effect in Connecticut mandating that licensed health care facilities treating victims of sexual assault also provide them with medically, factually accurate, and objective information relating to emergency contraception (EC),¹ inform them of its availability, use and efficacy, and dispense it to them on request.

The legislation was strenuously opposed by the Catholic bishops of Connecticut because it would compel Catholic hospitals to provide EC to rape victims even if noninvasive testing suggested an increased possibility that its use would impede implantation of a fertilized ovum in the endometrium.² On September 27, 2007, just days before the effective date of the law, the bishops announced that they would reluctantly comply with the legislative mandate and forgo such testing.

The history of the Plan B³ law in Connecticut is one of episcopal courage in the face of general dissent, and outright hostility, apathy, or tepidness on the part of the Connecticut Catholic community at large, and its medical professionals in particular. Not one Catholic medical professional personally appeared to testify at the legislative hearing on the bill.⁴ Proponents of the bill produced a stream of medical professionals, political activists, pro-choice group advocacy representatives, rape victims, social workers, and sexual assault counselors pressing for passage and decrying what they labeled misrepresentation of EC as a potential abortifacient.⁵ In the face of that challenge, opposition to the bill amounted to a handful of pro-life activists, two rape victims, a lawyer, and a deacon. No qualified medical expert appeared in person to oppose the bill.

In announcing the decision to accept the legislative mandate, one Connecticut bishop disclosed that legal advice indicated a court challenge “would most likely not succeed.”⁶ While a challenge on constitutional grounds would probably fail, unique provisions in Connecticut’s Religious Liberties Act (chapter 925, general statute §52-571b) provide protections for free exercise of religion greater than those provided by the constitution. What I propose is an examination of legal sources, brief as permitted by space, yet sufficient to demonstrate that there exist serious grounds for a legal challenge to the law.

History of the Act

Prior to 1990, and at least since 1963 when the U.S. Supreme Court decided *Sherbert v. Verner*,⁷ constitutional jurisprudence subjected government action that burdened the free exercise of religion to a strict scrutiny test. Such action had to advance a compelling government interest by the least restrictive means. In practical terms, if the government interest was not “compelling,” or if that interest could be vindicated by other means less destructive of our first freedom, the action would be declared unconstitutional. In 1990, the Court changed course. In *Employment Division v. Smith*,⁸ the court held that religiously inspired use of peyote was not protected by the free exercise clause of the first amendment, and that employees discharged for violation of the state’s criminal ban on use of the drug were properly denied unemployment compensation benefits. The Court held that neutral legislation of general applicability passed muster under constitutional analysis even where it resulted in an incidental burden on the free exercise of religion.

The response to the court’s decision was seismic. Dozens of states and Congress passed legislation aimed at restoring the “compelling interest/least restrictive means” test.⁹ In 1993, Connecticut adopted general statute §52-571b, which provides that the “state . . . may burden a person’s exercise of religion only if it demonstrates that application of the burden to the person (1) is in furtherance of a compelling government interest, and (2) is the least restrictive means of furthering that compelling government interest.” The act was aimed directly at the Supreme Court’s decision in *Smith* and effectively restored the pre-existing strict scrutiny test.

In *Rweyemamu v. Commission on Human Rights and Opportunities*,¹⁰ the Connecticut Appellate Court recognized that

the overarching purpose of §52-571b was to provide more protection for religious freedom under Connecticut law than the *Smith* decision would provide under federal law. . . . The legislature illustrated its intent to reverse the effects of the *Smith* case by considering a

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REFLECTIONS ON THE STATUS OF THE LAW
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number of specific situations in which its application would lead to the decreased protection of religious freedoms.¹¹

The Court held that §52-571b protected the free exercise of religion “with the strict scrutiny test” and that the legislature intended greater protection for religious practices “such as the ritualistic use of peyote at issue in *Smith*. . . . The legislative history is replete with examples of religious practices that the legislature intended to protect under §52-571b’s strict scrutiny test.”¹²

In a footnote to that statement, the Court cited examples that demonstrate the application of the Connecticut statute to the Plan B bill: “lighting of candles in church, the receiving of wine at holy communion, and wearing a yarmulke in court.” These were drawn from comments of state representatives during the legislative hearing on the bill. Those references were in response to concerns that neutral laws of general applicability (i.e., fire codes and minimum drinking age laws) could prevent lighted candles in buildings or provision of communion under the form of wine to children, and thus not be protected by the constitutional analysis adopted in *Smith*. The other examples cited by the Appellate Court are critical. They were drawn from the testimony of Robert Leikind, Director of the Connecticut Office of the Anti-Defamation League. Mr. Leikind noted that since the decision in *Smith*, the Amish community in Minnesota was compelled to place reflectors on their horse drawn buggies, something that violated their religious practice of shunning forms of adornment. He also noted that in Michigan the body of a Jewish man killed in an automobile accident was subjected to an autopsy despite the fact that his religion barred the procedure and his family objected.¹³

These examples, specifically chosen for citation by the Appellate Court, point out that government regulation of licensed activities affecting public health, safety, and welfare, such as requiring reflectors on horse drawn buggies (which are generally subject to a rational basis test), will be subjected to greater scrutiny of §52-571b when they implicate religious free exercise.

The Religious Liberties Act and Plan B

The Roman Catholic bishops of Connecticut opposed the Plan B law because it imposed a mandate to dispense EC in circumstances where it *may* prevent a fertilized ovum from implanting in the endometrium. In the case of rape, health care directives adopted by the U.S. Conference of Catholic Bishops (USCCB) permit treatment with medications that would prevent ovulation, sperm capacitation, or fertilization. However, they expressly prohibit either the provision or recommendation of treatments that have as their purpose or direct effect the interference with implantation of a fertilized ovum.¹⁴ There is no question that current medical and scientific research has not resolved whether Plan B has such a post-fertilization effect. The manufacturer of Plan B and some medical literature support the view that Plan B may have such an action. Other literature challenges that claim but without definitive findings. The most notable medical literature disputing

an abortifacient modality for Plan B nonetheless concludes that “in the absence of absolute proof about Plan B’s mechanisms of action . . . women should continue to be informed, as they are now in the Plan B labeling, that its use may affect postfertilization events.”¹⁵ It is in that context of serious doubt and competing scientific claims that the Connecticut bishops favor LH surge testing in order to enhance the quantity and quality of information regarding the likelihood that Plan B may operate in a manner prohibited by Catholic doctrine.

Given the overwhelming legislative history of §52-571b and the Appellate Court’s decision in *Rweyemamu*, litigation challenging the mandatory EC rape treatment bill must be judged as having a reasonable chance of success. The elements of a successful action are present. Catholic hospitals in Connecticut are religion-based institutions. The mission of St. Vincent Medical Center in Bridgeport is rooted in the healing ministry of Jesus Christ and is specifically Catholic.¹⁶ St. Francis Hospital in Hartford describes itself as “a health ministry of the Catholic Archdiocese of Hartford.”¹⁷ The USCCB’s *Ethical and Religious Directives for Health Care Services*, replete with references to Jesus’s healing ministry, plainly state that health care and healing are a core element of Christianity.¹⁸ The provision of medication that is primarily anovulant but which *may* impede implantation of fertilized ova clearly implicates questions of faith and morals in Catholic teaching. While the Church has not issued a definitive teaching, the bishops of Connecticut have repeatedly voiced their objection to compulsory EC distribution in rape cases without LH surge testing¹⁹ and have only agreed to “reluctant compliance.”

For the Plan B bill to survive a challenge under the strict scrutiny test, the state would have to establish a compelling government interest that could not be achieved by other means. Assuming that the offer of EC to rape victims implicates a compelling government interest (which is by no means certain), there is ample evidence that alternative means exist to advance that interest. Every Catholic hospital in Connecticut is located within ten minutes of a secular hospital.²⁰ In the rare event that a positive LH test precluded provision of EC,²¹ the patient could be promptly transferred between facilities. Other alternatives include state maintenance of mobile teams that could respond to Catholic hospital emergency rooms and transport patients off premises for administration of EC.²²

Existing legislation already allows a health care provider unwilling to comply with a patient’s advance medical directive to transfer the patient to a health care provider willing to comply with the patient’s wishes.²³ Potential cases subject to that law would include someone diagnosed in persistent vegetative state whose advance directive mandates the withdrawal of nutrition and hydration. Catholic hospitals simply cannot comply with that request in light of the recent response of the Congregation for the Doctrine of the Faith asserting that such intervention is ordinary care and must be provided, even by artificial means.²⁴ Yet Connecticut legislation clearly provides for the right of a health care provider to

transfer the patient rather than comply with a religiously objectionable advance directive. Similarly, transfer of rape victims to secular hospitals or to mobile response teams is an alternative sufficient to accommodate the government interest behind the rape treatment bill. A mobile response team may require additional personnel and expense, but that merely indicates that the State of Connecticut would prefer a different alternative, not that it is unavailable. Since either alternative could secure the governmental interest, the "least restrictive means" element of §52-571b would create a substantial barrier to application of the legislation to Catholic hospitals.

What Is at Stake?

On the surface, the current dilemma in Connecticut appears to be limited to EC treatment in rape cases. It will undoubtedly be used as a sword in state legislative battles across the nation and may well become a national campaign issue in the upcoming presidential election. But much more is at stake. Religious liberty has suffered a terrible defeat. If provision of medication that may prevent implantation of fertilized ova can be thrust upon Catholic hospitals in Connecticut, why not require that rape victims be provided with RU-486 at discharge in case EC fails and the patient subsequently discovers that she is pregnant? What about direct abortions? The list of potential state interventions into Catholic health care services is lengthy. How about tubal ligation or provision of oral contraceptives following childbirth if requested by the patient? Or compelled participation in the death penalty by injection at any licensed health care facility? Or mandated in vitro fertilization procedures at all licensed health care facilities providing obstetric care? Or perhaps a repeal of the conscience clause applicable to advance medical directives that currently permit patient transfer as set forth in §19a-580a, such that Catholic health care facilities would be obliged to withdraw nutrition and hydration from patients to whom they are doctrinally obliged to provide such care. EC for rape victims without prudential testing as judged appropriate on religious and moral grounds is just the beginning. The stakes could not be higher or the implications more ominous.

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¹Emergency contraception (EC) is defined in the Connecticut bill (Public Act No. 07-24, effective October 1, 2007) as "one or more prescription drugs used separately or in combination ... to prevent pregnancy." This article assumes familiarity with the evolving and at times misleading definitions of "conception," "pregnancy," "contraceptive," and "abortion" that have marked the cultural, medical, and ethical debate associated with the scientific manipulation of reproduction and fertility. For more on that topic and its relationship to the debate over EC in rape treatment protocols, see my article in *The Catholic Transcript*, April 27, 2007, http://www.catholictranscript.org/index.php?option=com_content&task=view&id=268&Itemid=34.

²LH (luteinizing hormone) surge testing is frequently, if inaccurately, referred to as an "ovulation test." In fact, a positive LH surge means that a woman may have or will ovulate in the near future. The test consists of a urine dip, which, if positive, discloses the presence of LH at surge levels. LH surge levels usually appear sixteen to thirty-two hours prior to the release of an ovum and rapidly decline thereafter. Thus, LH at surge levels provides a time range extending from approximately thirty-two hours before ovulatory release of an ovum to a similar duration following such release.

³Plan B is a trade name for the most commonly used and best known emergency contraceptive, levonorgestrel.

⁴The emergency department chairman of one Catholic hospital submitted written comments in opposition to the bill, noting that EC is administered if testing determines that the victim "is not pregnant or not ovulating." (Written submission of Ronald Thomas, M.D., to Connecticut Human Services Committee, Bill No. SB-1343, Public Hearing March 13, 2007; summarized in HS Committee Joint Favorable Report, <http://www.cga.ct.gov/2007/jfr/s/2007SB-01343-R00HS-JFR.htm>.) Disturbingly, Amy Breakstone, M.D., Chair of the Division of Obstetrics and Gynecology in the Department of Surgical Services at Bristol Hospital, testified in 2006 and submitted written testimony in 2007 to the effect that "it has been the unspoken habit of emergency department physicians and [physician assistants] to provide emergency contraception, even in those hospitals where policy dictates otherwise." (Testimony before the Connecticut Public Health Committee, March 6, 2006, transcript, <http://www.cga.ct.gov/2006/PHdata/chr/2006PH-00306-R001000-CHR.htm>.) Dr. Breakstone's testimony was essentially that the staff of a Catholic hospital emergency room were providing Plan B to rape victims in violation of their own hospital rules, thereby placing their jobs in jeopardy, and that the mandatory legislation was needed to protect their employment.

⁵Strikingly, one proponent, Matthew Saidel, M.D., an obstetrician-gynecologist and medical director of Women's Health Connecticut and Physicians for Women's Health, submitted written testimony that directly supports the claim that EC operates to prevent implantation of fertilized ova. "On the rare occasion that it does not prevent the egg from being released, emergency contraception simply makes it much more likely that it will not find a place to land." (Testimony summarized in HS Committee Joint Favorable Report, Public Hearing March 13, 2007, <http://www.cga.ct.gov/2007/jfr/s/2007SB-01343-R00HS-JFR.htm>.)

⁶Bishop William E. Lori Blog, September 29, 2007, www.bishoploriblog.org/.

⁷374 U.S. 398 (1963).

⁸494 U.S. 872 (1990).

⁹The federal Religious Freedom Restoration Act (RFRA), 42 U.S.C. §2000bb, was declared unconstitutional as applied to the states in *City of Boerne v. Flores*, 521 U.S. 507 (1997). However, in *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418 (2006), the Supreme Court upheld the act as applied to federal action. The decision effectively reversed the result of *Smith* (as applied to federal action), holding that seizure of sacramental tea containing a schedule 1 banned substance, while clearly permissible pursuant to rational relationship test applied in *Smith*, could not survive the "compelling government interest/least restrictive means" test legislated through RFRA.

¹⁰98 Conn. App. 646 (2006).

¹¹*Ibid.*, 660-61.

¹²*Ibid.*, 664.

¹³Testimony of Robert Leikind before Connecticut Judiciary Committee, Bill No. SB-1343, Public Hearing March 1, 1993, transcript 1993JUD00301-R001500-CHR.HTM available at <http://www.cga.ct.gov/>. Ironies abound in legislative histories no less than in life. Of note is the odd fact that the principal religious opposition to the Connecticut Religious Freedom Act came from the Catholic Church. At the same public hearing, John King, a spokesman representing the Connecticut Catholic Conference, specifically objected to the bill because it "would in effect be overturning the recent decisions of the United States Supreme Court in this



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area" with respect to free exercise of religion, a clear reference to the *Smith* decision, as made abundantly clear by ten pages of transcript in which the Catholic Conference's witness was questioned by at times surprised legislators, who were puzzled that the Catholic Church would oppose legislation designed to limit government intrusion into free exercise.

¹⁴U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: USCCB, 2001), directive 36.

¹⁵F. Davidoff and J. Trussell, "Plan B and the Politics of Doubt," *Journal of the American Medical Association* 296.14 (October 11, 2006): 1775-1778. That recognition by ardent proponents of Plan B is particularly significant in light of the legislative mandate that rape victims be provided with "medically and factually accurate and objective information" regarding EC. Accordingly, rape victims should be advised, as part of standard protocol, that EC may prevent implantation of fertilized ova. Failure to make such disclosure would constitute a material omission in violation of the statute and of the health care provider's duty to obtain "informed consent." Such disclosure will raise critical issues at Catholic facilities offering "reluctant compliance" with the statute. While moral issues of cooperation, proximate or remote, conditional or otherwise, are beyond the scope of this article, the need for disclosure of a potential abortifacient effect points out the substantial impact of the law on the free exercise of religion.

¹⁶St. Vincent's Medical Center's mission statement provides, "The Mission of St. Vincent's Medical Center is rooted in the healing and loving ministry of Jesus Christ. . . . Our health ministry is spiritually centered. . . . St. Vincent's Medical Center is a local Catholic health ministry" (<http://www.stvincents.org/aboutus/mission.cfm>).

¹⁷St. Francis Care, "Our Mission and Core Values," <http://www.stfrancis.org/default.cfm?id=1676> (original emphasis).

¹⁸The following excerpt from the general introduction to the *Ethical and Religious Directives* demonstrates the religious nature of Catholic health care ministry and its relationship to episcopal authority charged with the duty to preserve its moral and religious identity: "The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing. . . . Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9: 35). . . . The mystery of Christ casts light on every facet of Catholic

health care; to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ. . . . Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop . . . ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese."

¹⁹Bishop William E. Lori, "Religious Freedom in the Constitution State," *Fairfield County Catholic*, April 28, 2007, <http://www.bridgeportdiocese.com/column4.28.07.shtml>; and Archbishop Henry J. Mansell, "Plan B," *Catholic Transcript*, May 2007, http://www.archdioceseofhartford.org/writings2/archbmanzell_column_07-05-01.htm.

²⁰St. Francis Hospital and Hartford Hospital in Hartford; St. Raphael Hospital and Yale-New Haven Hospital in New Haven; St. Mary Hospital and Waterbury Hospital in Waterbury; and St. Vincent's Medical Center and Bridgeport Hospital in Bridgeport.

²¹From the inception of the LH protocol at Connecticut's Catholic hospitals, no rape victim has been denied EC on that basis. See Bishop Lori, "Religious Freedom" (fn. 19 above), and the Connecticut Catholic Conference, "Survey of Connecticut Catholic Hospitals Concerning Emergency Room Distribution of Plan B to Rape Victims," 2006, http://www.connecticut.nasccd.org/bins/connecticut/templates/default.asp?_resolutionfile=templatespath/default.asp&area_2=Catholic%20Hospital%20Survey%20Plan%20B.

²²Attorney Barry Feldman, testifying on behalf of the Connecticut Catholic Hospitals Council, noted the proximity of the secular hospitals and the cooperation Catholic hospitals were prepared to offer in order to facilitate transfers. This author noted that FDA approval of over-the-counter Plan B in 2006 obviated the need for a prescription and effectively allows the state to maintain supplies that can be provided by public authorities in many ways that would not compel a Catholic hospital to violate its principles. (Testimonies summarized in HS Committee Joint Favorable Report, Public Hearing March 13, 2007, <http://www.cga.ct.gov/2007/jfr/s/2007SB-01343-R00HS-JFR.htm>.)

²³Conn. Gen. Stat. §19a-580a.

²⁴See Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the USCCB Concerning Artificial Nutrition and Hydration," *Ethics & Medics* 32.11 (November 2007): 1-3.

