No. 19-1135

IN THE
Supreme Court of the United States

DIGNITY HEALTH D/B/A MERCY SAN JUAN MEDICAL CENTER,
Petitioners,

v.

EVAN MINTON,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT

BRIEF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AND THE ALLIANCE FOR CATHOLIC HEALTH CARE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI CURIAE[1]

The decision of the California Court of Appeal in the instant case portends ill for all religious organizations that serve the public following the precepts of religious teaching. It does not overtly bar a religious organization from following those teachings. It is more insidious: it allows the maintenance of a lawsuit seeking sweeping relief under California's Unruh (antidiscrimination) Act. It therefore penalizes the religious actor and, going forward, communicates to Petitioner and all similarly situated religious service providers that following your beliefs comes at a price. Given the size of the religious service sector, the adverse impacts of such a rule will be widespread and pernicious. These *amici* write to urge this Court to correct it now.

The Catholic Health Association of the United States ("CHA") is the national leadership organization for the Catholic health ministry, encompassing more than 600 hospitals and 1,600 long-term care and other health facilities across all

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[1] Counsel of record for all parties received timely notice at least ten days prior to the filing due date of CHA's intention to file this brief. All parties have consented to the filing of this brief. Pursuant to Rule 37.6 of the Rules of this Court, CHA and ACHC state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief *amicus curiae*. No other person other than CHA, ACHC or their counsel made a monetary contribution to its preparation or submission.

50 states and the District of Columbia. In this role, CHA provides a passionate voice for organizations carrying on Jesus' mission of love and healing in the Catholic tradition. Rooted in and inseparable from the teachings of the Catholic Church, these ministries embrace a holistic approach to health care that surpasses merely providing for the physical body, but also seeks to care for a person's mind and spirit, as well as the surrounding community. Catholic hospitals were created specifically for the purpose of providing this faith-based healing ministry and continue this mission today.

The Alliance of Catholic Health Care ("ACHC") represents Catholic health care providers in California committed to carrying out the ministry of health care by serving their patients and communities. ACHC provides advocacy, health ministry formation, and leadership to the 51 Catholic and community-based affiliated hospitals throughout the state of California. Its advocacy includes public policies and access to health care as a basic human right, the promotion of nonprofit health care, and the protection of religious freedom in the exercise of the healing ministry of the Church.

On behalf of their members, including Petitioner, CHA and ACHC highlight the broader impacts of this case and how it sows an intolerable level of inconsistency and confusion for faith-based health care. *Amici* urge this Court to grant review in Petitioner's case to make clear that organizations founded squarely within a religious tradition and actively carrying out their faith-based ministry

through practices aligned with church teachings cannot be forced to take actions prohibited by that religion or penalized (including by litigation) when they adhere to religious teaching. The alternative is unthinkable, to categorically deny Catholic health care entities, and all religious ministerial organizations, the right to carry out their ministry according to their religious beliefs. The instant case is emblematic of a broader, well-orchestrated national assault on religious ministries that seeks to compel them to conform to secular norms or cease serving their communities. Silence by the Court will incentivize continued litigation across the country designed to force religious organizations to separate their beliefs from their ministries—striking a blow at the heart of religious freedom.

SUMMARY OF ARGUMENT

The case at bar (hereinafter, "*Minton*") penalizes the direct expression of faith in a religious health care institution. Going forward in this case and in others like it around the country, it would chill protected religious expression in public ministry, creating a Hobson's choice for such institutions between exercising its religious identity or abandoning it to avoid liability.

Catholic health ministry has been practiced according to the principles of the faith community for hundreds of years, engaging in the constant call to discern holistic approaches to care that result from faithful reflections on the teachings of the Church. Since the first Christian disciples healed a paralyzed

man "in the name of Jesus Christ" (Acts 3:1-10), Christians have followed the model and call of Jesus to care for the sick, the poor, and the vulnerable. Throughout history, the call has remained the same, even as the methods and means of care have evolved in response to the needs and signs of the times. In the United States, the call has taken the form of a large institutional and ministerial presence in health care.

Contemporary Catholic health ministry extends well beyond the name on the hospital. It embodies a holistic approach to health, underpinned by social justice; a preferential option for the poor that hears the voices of the marginalized and assists the most vulnerable members of society; and employment practices that value and respect the contributions of all. It cares for people of all ages, races, faiths, sexual orientation and ethnic backgrounds, in keeping with the example of Jesus' own life and work.

The concrete expression of Catholic healthcare ministry is found in the Ethical and Religious Directives for Catholic Health Care Services ("ERDs"). These principles and directives guide the application of the Church's teaching on medical and moral matters to Catholic health care providers. The ERDs are developed and approved by the United States Conference of Catholic Bishops, in consultation with religious communities, theologians and ethicists, religious associations of ministries, medical experts, the offices of the Holy See in Rome,

and Catholic health ministries and *amicus* CHA.[2] The ERDs are a well-established standard of care applied uniformly to all patients and procedures, without reference to sex, gender, race, or other status. Treatment is individualized and directed at the situation of the person needing care. Transgender individuals routinely receive health care at Catholic hospitals on the same terms as any other individual and are not denied services that are not prohibited by the ERDs for cisgender men and women as well as transgender men and women.

However, the practical effect of *Minton* permits any person who is denied a procedure because of the application of the ERDs to his or her case to press a liability action against the ministry. The threat of such actions invites the religious organization to consider bending or abandoning its beliefs to avoid liability. Our Constitution protects religious health care providers from having to make such choices. This Court must act to avoid rendering religious ministry vulnerable to state-sanctioned remedies in instances where a person's requested procedures cannot be allowed without violating the tenets of the religion on which it is founded.

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[2] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Sixth Edition, June 2018) found at http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf

ARGUMENT IN SUPPORT OF GRANTING THE PETITION

To be "Catholic," hospitals must adopt and adhere to the ERDs, a requirement enforceable by the local Catholic Bishop, violation of which can jeopardize a hospital's standing within the Church, including the loss of inclusion within the Church's tax exemption group ruling and other sanctions. Yet, the *Minton* decision allows private litigants to penalize Catholic hospitals unless they eschew the ERDs in favor of a state's anti-discrimination act, because any refusal to honor a person's request for a service contrary to a uniform application of the ERDs, could constitute a violation of the law, subject to state sanction. The result leaves faith-based organizations unprotected from a government mandate that, if followed, places them at risk within their own Church. Such a result violates the most fundamental understanding of religious freedom.

A. The Ministry of Catholic Health Care Must Follow the Ethical and Religious Directives for Catholic Health Care Services

Historically, religious communities of diverse faith backgrounds have shared an expectation that members of the faith have a duty to care for anyone in need, as it had been commanded and recorded in

the very documents of faith.[3] The practical effect of this obligation was to provide ministries that addressed more than the parochial needs of members, but rather served the community around them, including providing care for the poor, orphaned, and sick, the proverbial "least of them" in the community. Schools, hospitals, and other forms of public-serving charities trace their roots to the community service of churches and religious communities. This is especially true of religious health care where, in almost every community, there are health care organizations with a religious tradition as part of their heritage.

In the Catholic faith tradition, health care ministry has deep roots. For nearly three hundred years, that ministry has consistently been "animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church."[4] Over that time, the health care industry has grown and changed. While advancing and adapting to changes in medicine and the market, the Catholic health ministry has preserved its enduring mission to do the work of Jesus. This provides the motivation, and even the

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[3] *See e.g.* Deuteronomy 15:11 ("Therefore I command you to be openhanded toward your brothers and toward the poor and needy in your land."); Proverbs 31:9 ("Speak up and judge fairly; defend the rights of the poor and needy."); Matthew 24:40 ("Truly I say to you, to the extent that you did it to one of these brothers of Mine, even the least of them, you did it to Me.").

[4] ERD Directive 1.

method, of their ministry even through challenges, both economic and non-economic, when it might seem easier to abandon the mission or surrender it to secularity. In the United States, the Church, through the women and men religious who founded Catholic health care and their successors, conducts its health care ministry according to the teaching and values of the Church, for patients, their families and their communities, reassured that its ability to serve according to Catholic teaching is constitutionally protected.

The Catholic health ministry is a values-based mission animated by faith over profit to provide quality health care with compassion and justice.[5] The work of the Catholic Church was always recognized to extend through the words and actions of its ministries, whether ministries were carried out by clergy and formal religious orders, or by lay people. This reality was spelled out explicitly by the Church's statement of the shifting weight of Christian ministry work to lay members following the Second Vatican Council.[6]

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[5] Mission, Vision, Values, DIGNITY HEALTH, https://www.dignityhealth.org/sacramento/about-us/mission-vision-and-values (last visited April 9, 2020).

[6] Karen Sue Smith, *A Summary: Caritas in Communion*, 94 HEALTH PROGRESS 80 at 81 (July—August 2013) (describing how the Second Vatican Council shifted the basis of Christian work to the work of the laity as ministry based on their sacramental baptism in the faith).

The Catholic institutional presence in health care, understood as a moral force, a standard-bearer for certain fundamental values, is indeed important, but its social posture and institutional values and priorities have also delivered empirical results. The results of this values-based approach to health care speak for themselves. For example, a 2010 independent study of 255 health systems found that "Catholic and other church-owned [health] systems are significantly more likely to provide higher quality performance and efficiency than investor-owned systems."[7] The same study found the Catholic systems provided higher quality performance than secular or investor-owned systems, including lower rates of mortality, fewer recurrent hospitalizations, and comparably shorter stays. These results are more than just brand recognition when a hospital or health care provider has the word "Catholic" in its name. They are the product of the core values that inform the actions taken, or not taken, as part of a holistic health care approach designed to encompass the body, mind, and spirit.

To guide this holistic health care approach, the Church set out its core values in the Ethical and Religious Directives for Catholic Health Care Services ("ERDs") as standards for how to apply the

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[7] Differences in Health System Quality Performance by Ownership, THOMSON REUTERS, Aug. 9, 2010.; David Foster et al., "Hospital Performances Differences by Ownership," *Truven Health Analytics* (June 11, 2013).

Church's teaching on medical and moral matters for Catholic providers of health care services.[8] The ERDs are developed and approved by the United States Conference of Catholic Bishops, in consultation as needed with religious communities, theologians and ethicists, ministry associations, medical experts and the offices of the Holy See in Rome. The purposes of the ERDs are two-fold, "first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today."[9] However, the guidance does "not attempt to cover in detail all of the complex issues" faced in health care, but requires attention to the subtleties in individual cases.[10] They are principles by which organizations provide health care that expresses Catholic identity. Beyond any rote checklist, the ERDs flexibly accommodate ever-advancing medical care and technology by engaging in an ongoing process of reconciling modern medical practices with long-standing beliefs rooted in faith. As such, the ERDs are a well-established standard for aligning Church teaching with health care practices as an expression

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[8] ERDs at p. 4.

[9] *Id.*

[10] *Id.*

of religious beliefs through a ministry of health care.[11]

For hospitals to be recognized as Catholic, they must adopt the ERDs into their operating and organic documents which make them binding on the ministry and enforceable by the local Catholic Bishop. Failure to follow the ERDs can result in the hospital losing its "Catholic" status within the Church, exclusion from the Catholic Church's group tax exemption ruling, and even religious sanctions for the sponsors of the hospital.[12] "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel." ERD Directive 5. The

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[11] Kevin O'Rourke, Thomas Kopfensteiner, Ron Hamel, *A Brief History: A Summary of the Development of the Ethical and Religious Directives for Health Care Services*, 82 HEALTH PROGRESS 6, Nov.-Dec. 2001.

[12] Each Bishop in his own diocese has the right to declare that an activity is "Catholic" or "not Catholic." For instance, the Bishop of Baker, Oregon withdrew the Catholic designation from a hospital in Bend, Oregon due to his conclusion that it no longer adhered to some Catholic teachings when it permitted elective sterilizations. See Ed Langlois, Bishop says Oregon hospital can no longer be called Catholic, CATHOLIC NEWS SERVICE (Feb. 16, 2010), available at http://www.catholicnews.com/services/englishnews/2010/bishop-says-oregon-hospital-can-no-longer-be-called-catholic.cfm (last visited April. 10, 2020).

medical privileges of physicians and other health professionals depend on adherence to the ERDs, with the health organization held responsible by the Church for providing instruction in and supervision of the standards.

The ERDs and fundamental values of Catholic health care as applied reflect the nuances of individual situations and evolving medical science measured against ethical and religious principles about the innate dignity of persons, the value of human life and needs of the human community. In all instances, Catholic values and moral reasoning inform the contours of Catholic health care ministry in practice.

Value-based practice and procedure is an exercise that every health care institution engages in daily. Standards may coalesce around some points across institutions, but also vary from each other to reflect institutional circumstances and decisions that reflect its own situation. Facilities and providers are bound by the standards that reflect the culture of the entity itself. The distinction here is that the ERDs distill those standards from a background that is informed by Catholic faith and therefore reflect the priorities of Church teaching applied to health care. Each individual case is assessed on its own facts and circumstances against these principles.

The fact that Dignity Health's Catholic hospitals are required to follow the ERDs was acknowledged by both parties in this case and was central to the initial decision to dismiss the case

based on this critical context of Petitioner's actions. It is undisputed that the hospital in this case was adhering to ERD No. 53, which provides that "[d]irect sterilization of either men or women, whether permanent or temporary, is not permitted . . .. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology *and* a simpler treatment is not available." ERDs, Directive 53 (*emphasis added*). Mercy San Juan Medical Center, a Catholic hospital listed in the Official Catholic Directory ("OCD"), determined that the procedure was not compatible with the ERDs, including ERD 53. Petitioner's cancellation of Mr. Minton's surgery arose from the hospital's interpretation of the ERDs and its obligation to follow them, an issue not in dispute. The procedure was subsequently performed at another Dignity hospital that is not Catholic and, therefore, not bound by the ERD directive related to sterilization.

Any Catholic hospital facing a surgical request for sterilization, whether the patient is male or female, cis- or transgender, must turn to the ERDs and related guidance. The exercise of Catholic values in health care are central to what makes it Catholic and ministry. Carrying out this mission is layered and individualized. To penalize use of the ERDs would forbid the hospital from expressing its religious identity and purpose.

What makes Catholic health care distinctive is that it follows centuries of Church teaching about the

dignity of the person, solidarity among all human persons, and respect for the needs of all. Following its tenets sometimes requires departing from the secular norm. Medical procedures require professional decision-making which necessarily implicates morality and ethics. In religious health care institutions, these decisions are guided by the religious mission animating the health care ministry. Where the exercise of Church teaching clashes with otherwise neutral state laws, the solution should favor a result that does not compel religious organizations to act in contravention to their beliefs or to forego their religious mission entirely.

B. State Regulation Should Not Penalize Religious Health Care.

By allowing litigation to proceed under the state's anti-discrimination statute for non-discriminatory religious practices, the *Minton* decision penalizes Petitioner's protected rights. Not only does it run afoul of foundational First Amendment principles, it assures the threat of endless litigation against religious organizations, pressuring them to either abandon their faith or exit the public square. This landscape disadvantages all those religious organizations who are carrying out their health care ministry *consistent* with all federal and state health regulatory oversight, but nonetheless are subject to targeted litigation if through application of religious principles they make a decision in an individual case that the person may protest through the courts.

This Court has made it clear that churches, and the organizations carrying out the missions of those churches, may not be automatically compelled to violate their fundamental tenets in order to satisfy anti-discrimination laws. *Hosanna-Tabor Evangelical Lutheran Church & School v. EEOC,* 565 U.S. 171 (2012). Even neutral and generally applicable employment discrimination laws prohibiting disparate treatment of women cannot constitutionally compel the ordination of women when that is prohibited under religious law. *Id.* at 189. This Court did not say the state's anti-discrimination interest was less compelling, but instead acknowledged the limits of applying that interest against constitutionally protected freedoms of religious ministries.

In the context of this case, it is within a patient's control to choose a health procedure that is not permitted under Catholic moral teaching, including those barred by the ERDs. However, this choice cannot compel faith-based hospitals to provide those procedures where there is a pre-existing religious prohibition on the desired treatment under the facts of the presenting case. Furthermore, as already discussed, physicians with admitting privileges at Catholic hospitals understand these limitations and accept them as a condition of their practice. Just as a doctor would not schedule a procedure at a hospital that lacked facilities for a particular procedure, a doctor would not choose to schedule a procedure at a Catholic hospital that violates the institution's religious standards as well

as the admitting agreement extended to the physician.

In contrast, the Catholic hospital, which could not allow the hysterectomy Mr. Minton wanted, is precisely the type of organization which possesses an institutional First Amendment right against state penalty for its religious practices. Its operation exists for the purpose of providing health care in a manner wholly consistent with the fundamental tenets of Catholic faith. As such, it is "well established, . . . courts should refrain from trolling through a person's or *institution's* religious beliefs." (emphasis added). *Mitchell v. Helms,* 530 U.S. 793, 828 (2000) (plurality).

The First Amendment unequivocally protects the right to the free exercise of religion. And this Court has long recognized the need to guarantee religious organizations "independence from secular control or manipulation" by refusing to intrude on matters of Church operations and governance. *Kedroff v. St. Nicholas Cathedral,* 344 U.S. 94, 116 (1952); *see New v. Kroeger,* 167 Cal.App.4th 800, 815 (Cal.App. 2008). Such intrusion second guesses the legitimacy and applicability of religious beliefs, which are beyond the purview of a State to weigh, regardless of whether those religious beliefs are "acceptable, logical, consistent, or comprehensible to others". *Thomas v. Review Bd. of Ind.,* 450 U.S. 707, 714, (1981); *Mitchell v. Helms*, *supra.* To find otherwise would impermissibly entangle courts in assessing how a religious organization should apply

its fundamental tenets to its actions, such as in the case of medical procedures provided or denied based on compliance with the ERDs. The "very process of inquiry leading to findings and conclusions" by this Court would interfere with the Catholic faith in a way that violates the First Amendment. *See N.L.R.B. v. Catholic Bishop of Chicago,* 440 U.S. 490, 502 (1979).

In the specific context of Catholic health care, it has long been recognized that hospitals operated by religious organizations acting within the bounds of their stated faith-based purpose have the right to follow religious teaching in the medical practices of the hospital and that this right must be strongly protected. *See Taylor v. St. Vincent's Hosp*. 523 F.2d 75, 77, (9th Cir. 1975) ("If the hospital's refusal to perform sterilization infringes upon any constitutionally cognizable right to privacy, such infringement is outweighed by the need to protect the freedom of religion of denominational hospitals 'with religious or moral scruples against sterilizations and abortions'") (citation omitted); *Watkins v. Mercy Med. Ctr.* 364 F. Supp. 799, 803, (D. Idaho 1973) ("Mercy Medical Center has the right to adhere to its own religious beliefs and not be forced to make its facilities available for services which it finds repugnant to those beliefs"), *aff'd* 520 F.2d 894 (9th Cir. 1975); *Allen v. Sisters of St. Joseph,* 361 F.Supp. 1212, 1213-14 (N.D. Tex. 1973) ("The interest that the public has in the establishment and operation of hospitals by religious organizations is paramount to any inconvenience that would result to the plaintiff

in requiring her to either be moved or await a later date for her sterilization"), *aff'd* (5th Cir. 1974) 490 F.2d 81. Policing the decision-making process of a Catholic hospital about matters expressive of religious teaching would necessitate analysis by the court to assess the weight and correctness of the standards, parsing the ERDs with reference to specific medical procedures, and balancing that judicial assessment against an alleged injury. Such actions are all beyond the constitutional authority of the courts. *See, e.g. Means v. United States Conference of Catholic Bishops*, 2015 WL 3970046 at *13 (W.D. Mich. 2015), *aff'd* (6th Cir. 2016) 836 F.3d 643. As such, no inquiry aimed at determining if the specific application of religious principles through the ERDs had discriminatory intent can withstand scrutiny under the First Amendment.

In cases such as this one, heightened protection of the organization's religious exercise is appropriate to prevent government from impeding religious expression. *See, e.g., Corporation of the Presiding Bishop v. Amos*, 483 U.S. 327, 344-45 (1987) (Brennan, J., concurring) (distinguishing nonprofit corporations based on their organization to provide community services and noting that, "Churches often regard the provision of such services as a means of fulfilling religious duty . . . ."); *Burwell v. Hobby Lobby Stores,* 134 S.Ct. 2751, 2794 (2014) (Ginsburg, J., dissenting). In *Hobby Lobby*, this Court protected the exercise of religion by secular for-profit corporations: "Any suggestion that for-profit corporations are incapable of exercising religion

because their purpose is simply to make money flies in the face of modern corporate law. States, including those in which the plaintiff corporations were incorporated, authorize corporations to pursue any lawful purpose or business, including the pursuit of profit in conformity with the owners' religious principles." 134 S.Ct. at 2755-56. That case recognized that the rights of closely-held (secular) corporations are inseparable from the religious liberty rights of the individuals who created and control the business. This reasoning applies more powerfully where a religious entity creates and acts through a ministry to provide health care services in conformity with well-established, even if contemporaneously debated, religious principles.

Most recently, this Court indicated that the outcome of a conflict between religious protections and compelling state interest, such as anti-discrimination, depends upon a "reconciliation" between the competing forces. *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission,* 138 S.Ct. 1719, 1723-24 (2018). This conclusion applies more strongly here where the matter directly addresses the institutional exercise of fundamental religious tenets that are the ministry organization's very purpose for existence. *E.g., EEOC v. Catholic Univ. of Am.,* 83 F.3d 455, 466 (D.C. Cir. 1996). The *Minton* case is precisely in line with the need for solicitude and reconciliation of the important rights at issue.

Under these circumstances, the state should be required to find the least restrictive way to protect

against discrimination while permitting the hospital's undisputed religious practices as applied to the facts of this case. This was precisely the path taken by Dignity Health in rescheduling Mr. Minton's surgery for a facility not subject to the same religious standards governing its Catholic hospitals. But *Minton* contradicts this principle, and shows that punishing the religious organization for not performing a procedure prohibited by religious belief – when a referral out to another non-objecting practice is possible – would never be the least restrictive means for the state to accomplish its interest.[13] In the context of this Court's jurisprudence concerning the constitutional protections afforded to religious, nonprofit organizations, the constitutionally preferred choice is to allow an accommodation and not a constitutional infringement.

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[13] California previously charted this course, where a similar challenge occurred in the context of an individual employee's religious objections to providing a medical service at a secular, for-profit, organization. *North Coast Women's Care Med. Grp v. Super. Ct.*, 44 Cal.4th 1145 (Cal. 2008). There, the Supreme Court of California determined that no less restrictive means were available to accomplish the state's compelling interest in enforcing the anti-discrimination statute against individual physicians. Specifically, the majority found that the for-profit organization's failure could have been mitigated if it had provided the services at issue through other medical providers who did not harbor religious objections. 189 P.3d, at 969. See also. Id. at 971 (Baxter, J., concurring).

The alternative is to invite endless litigation over the future practice of medicine at Catholic and other religious hospitals. Ultimately, this could chip away at the freedom for Catholic hospitals to decide whether specific procedures can be permitted when consistent with the organization's Catholic identity, or must be foregone completely to avoid conflict with state law. Such a policy would mean that, for example, life-saving hysterectomies to mitigate uterine cancer would be denied to both transgender and cisgender patients, because the institution could no longer consider whether a hysterectomy reflected a method of treatment consistent with the Catholic faith. Communities across the United States could lose Catholic health care entirely if being forced to cease providing such procedures subverted the ability to remain operational.[14]

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[14] *See generally* Howard Brubaker, Ellie Rushing, "Mercy Hospital in West Philadelphia faces closure as an inpatient facility," Phila. Inquirer (Feb. 12, 2020), available at https://www.inquirer.com/business/health/mercy-philadelphia-hospital-closing-acute-care-hospital-20200212.html. "Trinity Health expects to end inpatient services at its 157-bed Mercy Catholic Medical Center-Mercy Philadelphia Campus, a Catholic stalwart that has served as a health-care safety net for poor families in West Philadelphia for more than 100 years. . . Mercy Philadelphia — which opened as Misericordia Hospital in 1918 as a mission of the Sisters of Mercy — has a very high load of Medicaid and Medicare patients and a high percentage of uncompensated care . . . Hospital officials said the facility has lost money for six of the last seven years."

It cannot be that a Catholic hospital's consistent application of the ERDs is permitted generally but becomes discriminatory when the same application applies to persons in a protected class. By way of illustration, consider that Catholic hospitals routinely permit organ transplants from living donors to critically sick patients. However, these procedures are limited by the ERDs to transplants that do "not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor". ERD Directive 30. A living-donor transplant might be refused under the ERDs if it was determined that the donor bore a disproportionate risk of death. Yet, applying the civil law to the religious practices as the *Minton* decision does here, the hospital could only decline a disproportionate-risk transplant to someone in an unprotected class, and could require performance of the transplant if the patient falls within a protected class for fear of litigation liability. Thus, the hospital would be compelled either to provide no living-donor organ transplants at all, or to provide living-donor transplants regardless of any resulting disproportionate harm to the donor, in violation of its religious beliefs and in forfeit of its Catholic identity. Both results do great harm that can be avoided by clarifying that religious healthcare ministry decisions are protected from civil scrutiny.

The counterargument would point to allegedly limitless discretion by a religious health care organization in choosing procedures and processes for

delivering health care. This argument goes too far. Catholic hospitals, like their secular counterparts, already comply with a broad range of standards including facilities licenses, medical licensing, state and federal regulations, and accreditation of patient care, safety standards and programmatic outcomes. None of these are in question here, only the choices made by the hospital in how its operation squares (or doesn't) with the teachings of the faith underlying the institution. Surely this basis for an institutional policy is no less protected than any other institution's policy to limit procedures based on its capacity, facilities, staffing, market niche, or fiscal outcome.

The crucial question joined by the instant case is substantial and critical for the future of religious healthcare. May state anti-discrimination requirements deny patients the option to choose Catholic health care by effectively preventing a Catholic hospital from putting its faith into practice? This consideration is not far afield from the question presented in the context of education in *Pierce v. Society of the Sisters of the Holy Names of Jesus and Mary*. 268 U.S. 510 (1925). There, this Court determined that state laws requiring students to forego private education violated the recognized right of parents and guardians to direct the education of their children. Prohibiting private schools impermissibly damaged these rights and the larger community by denying this range of religiously-inspired private action. *Id.* at 535. Similarly, this Court decided that state anti-discrimination rules could not fundamentally rework the character of

private associations in the service of some state-sanctioned ideal. *Boy Scouts of America v. Dale*, 530 U.S. 640 (2000) (recognizing an organization's right to expressive association based on the policies it maintained regarding leadership in the organization). In *Pierce* and *Dale*, as here, the general regulation of the business was not at issue, but whether it could be channeled or limited pursuant to a state's nondiscrimination objectives. So too here, California's non-discrimination rules cannot be allowed to dictate the content of religious practices and in contravention of the common good of the community. There is free space for religious healthcare, and the contrary agenda permitted by the *Minton* decision must be reviewed and reversed.

CONCLUSION

The lower court decision runs roughshod over First Amendment principles for religious organizations, and the petition for writ of certiorari should be granted.

Respectfully submitted,

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