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July 30, 2019

**JANET NAPOLITANO, PRESIDENT  
UNIVERSITY OF CALIFORNIA**

**RE: Final Report of the Non-Discrimination in Healthcare Task Force**

Dear Janet,

Earlier this year, I asked the UCFW Health Care Task Force (HCTF) to make recommendations about the University's relationships with external healthcare providers that may potentially conflict with UC's values, public trust, mission, and/or policies on non-discrimination. The HCTF formed a Non-Discrimination in Healthcare Task Force, led by former Council Chair Shane White.

In May, Council endorsed the Interim Report of the Task Force, and earlier this month, the Task Force released its final report, which more fully explores strategies to avoid or minimize conflicts and their consequences, and proposes principles to avoid discrimination in healthcare and to guide the formation of relationships with sectarian organizations and institutions. The Academic Council unanimously endorsed the final report at its July 24, 2019 meeting. It makes the following conclusions:

- The mission, values, and policies of the University of California are in conflict with the use of religious belief or doctrine that restricts, or expands, healthcare in discriminatory ways.
- Discriminatory practices based upon religious or other sectarian belief may pose harm to the delivery of healthcare, teaching, and research by UC.
- Subjection of faculty members and their students to restriction through discriminatory practices, based upon religious or sectarian belief, is contrary to academic freedom.
- UC should avoid an entity such as a corporation, partnership, limited liability company, or joint venture, or other forms of close legal affiliation, with any external entity that exercises discriminatory policies in healthcare.
- Business agreements with external entities that exercise discriminatory policies should be avoided unless overwhelming evidence as to the greater common good is found to reach a high bar. Should such a bar be reached, a set of clearly precepts, described in this report, must be realized before a business agreement is entered.

We hope this report will help guide the review of existing and future potential affiliation agreements between the university and external health care providers. Please do not hesitate to contact me if you have additional questions.

Sincerely,

A handwritten signature in brown ink that reads "R. C. May".

Robert C. May, Chair  
Academic Council

Encl:

cc: NDHC-TF Chair White  
Provost Brown  
Academic Council  
Senate Directors

**The UC Academic Senate Non-Discrimination in Healthcare Task Force**

**Final Report**

**July 24, 2019**

## Executive Summary

In January 2019, the Academic Senate of the University of California constituted the Non-Discrimination in Healthcare Task Force in response to serious concerns serially raised in recent years at the University Committee on Faculty Welfare (UCFW). The Task Force was charged with exploring potential conflicts between the University of California as a public trust, its mission and values, standards, and non-discrimination policies, with religiously-based practices and claims for accommodation or exemption, in the context of health care. This report explicates the university's mission and values; discusses the substantial role of religious hospitals in California; reviews areas of potential conflict and their consequences; and finally discusses strategies to avoid or minimize the consequences of such conflicts.

The report's key findings are:

- The mission, values, and policies of the University of California, as expressed in the California Constitution, Regents Policies, and the Academic Personnel Manual, are in conflict with the use of religious belief or sectarian doctrine that restricts or expands healthcare in discriminatory ways. Key Regental policies on non-discrimination include: The Statement of Ethical Values and the Standards of Ethical Conduct; The Policy on University of California Diversity Statement; Policy on Future Admissions, Employment, and Contracting; Policy on Nondiscrimination on Basis of Sexual Orientation; and the Report of the Working Group: Statement of Principles Against Intolerance. It is antithetical to the university's values to engage in any activity that will lift some, but discriminate against others, upon the bases of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, citizenship, or veteran status. These values apply to all groups operating under the Regents purview, including administration, faculty, students, programs sponsored by the University, and external contractors.
- Discriminatory practices based upon religious belief may pose harm to some in the delivery of healthcare, teaching, and research by the University of California, as well as to its employees' receipt of healthcare. These potential harms may include: conflicts directly affecting patient welfare arising from individual patient or student decisions, individual employee decisions or practices, notably with relationships with sectarian institutions that restrict health care; as well as conflicts in the areas of health promotion, teaching and research. Representative examples of conflicts and their harms are given in the text and in tables following the text.
- Subjecting faculty members and their students to restriction through discriminatory practices, based upon religious belief, is contrary to academic freedom. Academic freedom extends through faculty members to students, includes research, teaching, and other faculty activities, and is a foundation value of the University.
- The University of California should avoid an entity such as a corporation, partnership, limited liability company, joint venture, or other forms of close legal affiliation, with any external entity that exercises discriminatory policies in healthcare.
- Business agreements with external entities that exercise discriminatory policies should be avoided unless overwhelming evidence as to the greater common good is found to reach a high bar. Should such a bar be reached, a set of firm precepts, described in detail within this report, to protect the university community and the public, described in this report, must be met before a business agreement is entered.

This report is intended to guide the generation of future policy and process, particularly where gaps currently exist. Regental Policy is unambiguous on the core value of non-discrimination in all of the activities of the University.

## **The Non-Discrimination in Healthcare Task Force**

In January 2019, the Academic Senate of the University constituted the UC Non-Discrimination in Healthcare Task Force in response to serious concerns serially raised in recent years at the University Committee on Faculty Welfare (UCFW). The Task Force was, in summary, charged with exploring potential conflicts between the University of California as a public trust, its mission and values, standards, and non-discrimination policies, on the one hand, and religiously-based practices and claims for accommodation or exemption on the other, in the context of health care.

Subsequently, on April 2, 2019, during a time of active public discussion about one proposed affiliation between UCSF and Dignity Healthcare, the Task Force produced a brief Interim Report (1). At its May 22, 2019 meeting, the Academic Council unanimously endorsed the Task Force's Interim Report, which recommended that: *"UC's existing and potential affiliation agreements with entities whose values are in conflict with UC's role as a public trust for the people of California be paused, scrutinized with increased rigor, and curtailed until any area of conflict with University mission and values have been resolved."* Subsequently, the UCSF - Dignity affiliation proposal was withdrawn. This final report addresses the Task Force's broad systemwide charge.

It is clear that existing and future potential affiliation agreements between the university and external health care providers may give rise to conflict with the mission and values of the University. Such issues may affect teaching, research, and healthcare service activities. Faculty, other employees, students, and patients will bear the impacts. The purpose of this Final Report of the University of California Academic Senate UC Non-Discrimination in Healthcare Task Force is to explicate the university's mission and values; to review areas of potential conflict and their consequences; and finally, to discuss strategies to avoid or minimize the consequences of such conflicts.

## **Mission and Values of the University of California**

The University of California serves the people of California in a unique and distinctive way. Following the Organic Act of 1868, the California Constitution of 1879 affirmed that the University of California *"shall constitute a public trust, and that it shall be entirely independent of all political or sectarian influence"* (2). At that time, the University of California was granted autonomy in its affairs, in effect becoming a branch of state government. Such status conferred great responsibility upon the University in providing for the educational, social and economic needs of the people of California. Subsequent legislation, including the 1960 Donohue Act, gave the University jurisdiction and responsibility for public education in healthcare professions. The University mission is to provide: education, research, and service, including healthcare, for all the people of California.

The University of California's stated values reflect its commitment to serving all the people of California, without discrimination, in accordance with the law and professional standards.

In 2005, the University of California Regents approved two corollary documents, the Statement of Ethical Values and the Standards of Ethical Conduct as Regents Policy 1111 (3).

The Statement of Ethical Values asserts: *“We will respect the rights and dignity of others.”* The Standards of Ethical Conduct elaborates on the application of this value: *“The University prohibits discrimination and harassment and provides equal opportunities for all community members and applicants regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran.”*

The Standards of Ethical Conduct *“apply to all members of the University community, including The Regents, Officers of The Regents, faculty and other academic personnel, staff, students, volunteers, contractors, agents and others associated with the University.”* The standards state the expectation that members of the University community will abide by relevant laws and regulations, and that those governed by professional standards will comply with those standards. It should be noted that state law and state professional standards staunchly support access to health care with appropriate but limited accommodation for religious restrictions. These positions are reflected in briefs the State of California has submitted in *California v. Azar* (4), and in the California Medical Association’s motion to intervene in *Minton v. Dignity Health* (5).

Regents’ Policies 4400 Policy on University of California Diversity Statement; 4401 Policy on Future Admissions, Employment, and Contracting; 4402 Policy on Nondiscrimination on Basis of Sexual Orientation; and 4403 Report of the Working Group: Statement of Principles Against Intolerance, speak broadly to *“equal opportunity in its education, services, and administration, as well as research and creative activity”* (6); *“treating all students equally in the admissions process without regard to their race, sex, color, ethnicity or national origin, and by treating employees and contractors similarly”* (7); *“prohibit discrimination on the basis of sexual orientation”* (8); *“all groups operating under The Regents, including administration, faculty, student governments, University-owned residence halls, and programs sponsored by the University* (8);” and *“acts of discrimination that demean our differences, are antithetical to the values of the University and serve to undermine its purpose”* (9).

The principle of nondiscrimination runs consistently through statements addressing the University’s many roles and activities. For example, the University’s Nondiscrimination Statement *“covers admission, access, and treatment in University programs and activities”* (10), and the University Policy on Discrimination, Harassment, and Affirmative Action in the Workplace *“applies to all University employees and applicants for employment, and where stated in policy, to paid and unpaid interns, volunteers, participants in a training program leading to employment, and independent contractors”* (11).

The Faculty Code of Conduct explains that discrimination for reasons of sex, sexual orientation, gender, gender expression, or gender identity is unacceptable behavior (12). Much anti-discrimination law prohibits intentional discrimination, as well as rules or practices that have disparate or discriminatory effects. This report presupposes that University policies prohibit both of those forms of discrimination, i.e. discrimination through intent and discrimination through effect. The analyses that follow focus on restrictions on health care that have discriminatory impacts.

Such Regental and University policies and statements provide clarity as to the core institutional values of non-discrimination, compliance with the law and with professional standards, in the University’s many activities, including that of its sponsored programs and contractors, agents, and others associated with the University, as well as with access to healthcare.

Indeed, the State of California has passed legislation to prohibit state-funded and state-sponsored travel to states with laws that authorize or require discrimination on the basis of sexual orientation, gender identity, or gender expression (13). This law broadly applies to California state agencies including the University of California and the Board of Regents.

Conflicts in values between the University of California and other individuals or entities, which lead to restrictions of certain patient services in a discriminatory way, may create a range of harms, including harm to the University's mission, its reputation, as well as to its employees, students, and patients.

## **Hospitals, Secular and Sectarian**

This section provides a brief overview of the substantial role of sectarian hospitals in US and California healthcare. The overview is intended to contextualize and preface the analysis of potential conflicts and the *Principles for Avoidance of Discrimination in Healthcare* in the sections that follow.

The history of healthcare in the US and California, as everywhere else, is intertwined with religious belief systems and religious organizations. Spirituality and religion are of great importance, enriching the lives of people worldwide, and providing comfort and reassurance in times of ill health and suffering. Some religions view healthcare as an inseparable part of their ministry. Hence, some religious organizations carry out their health ministries through expansions or restrictions on care. Restrictions on care, based upon religious belief, rather than upon scientific evidence may profoundly impact the lives of some of the patients, the professionals who care for them, and learners-in-training for the health professions.

Of the 6,210 hospitals in the United States, 5,262 are community hospitals (14). The others are a mix of federal government hospitals, nonfederal psychiatric hospitals, and other. Community hospitals provide general medical and surgical care; many provide specialty care and have areas of expertise, such as cancer care. Community hospitals may be public (state or federal government), for-profit, or nonprofit. Approximately half of the community hospitals, 2,968, are nonprofit (14). Current 2019 data shows that there are 798,921 staffed beds in community hospitals. Hospitals may also be categorized as being secular or sectarian. One in six hospital beds in the US is in a Catholic hospital. In California, 22.7% of hospital beds are in sectarian hospitals, and 17.1% of all California hospital beds are in Catholic hospitals (Table1).

Sectarian providers include individual health care professionals, individual hospital facilities, hospital systems, and vertically integrated health systems. Most sectarian hospitals and systems in the U.S. are Judeo-Christian. They include, for example, Adventist, Baptist, Catholic, Episcopal, Jewish, Latter Day Saints, Lutheran, and Methodist hospitals. The role that religious values play in shaping health care in sectarian hospitals varies widely. In many sectarian facilities, religious belief and doctrine do not determine the range of health care services offered. In some systems, hospitals determine on a facility-by facility basis the role religious belief and doctrine in the range of health services provided. In other words, the role of religious values in health care is determined at a local level in many cases. In hospitals and systems that use religious values to shape health care delivery, religious values or mission may expand or restrict health services. For example, Mount Sinai Hospital in West Side Chicago chose to discontinue costly pediatric trauma care and to operate in deficit so as to best carry out its mission to serve a low income community abandoned by other health systems (15).

Most sectarian hospitals provide charity care as part of their religious mission, albeit to varying degrees (Table 1). A 2013 report on all US hospitals found that same amount of charity care, as an approximate percentage of overall patient revenue, was provided by secular nonprofit hospitals, Catholic nonprofit hospitals, and other religious nonprofit hospitals. For-profit hospitals tended to provide slightly less charity care than nonprofit hospitals. Public hospitals provided approximately twice the proportion of charity care as all others, but their numbers are in decline. Overall, across the US, sectarian hospitals do not broadly reach the underserved any better than other sectors (16). In California, on average, religious hospitals spend a slightly higher proportion of their operating costs on charity care than all other hospitals, and have a slightly higher net revenue from Medicaid than all other hospitals (Table 1). However, they discharge a slightly lower proportion of Medicaid patients and have a slightly lower proportion of inpatient Medicaid days than all other hospitals (Table 1). Public hospitals provide substantially more charity care and Medicaid care, and proprietary hospitals provide substantially more Medicaid care, than religious hospitals in California (Table 1). The contention that religious hospitals are more devoted to caring for the California underserved is not supported.

Catholic hospitals are distinct from other sectarian hospitals in a respect that is important for this report. All Catholic hospitals are governed by the Ethical and Religious Directives for Catholic Health Care Services (17). The ERDs are issued by the United States Conference of Catholic Bishops. Diocesan bishops have authority to interpret the ERDs, so there is some variation in interpretation where the ERDs permit. That said, health law and policy research indicates that Catholic hospitals and systems are the only sectarian systems subject to a uniform set of religious rules that the church hierarchy administers. The ERDs address different aspects of health care, including *“the social responsibility of Catholic health care services, the pastoral and spiritual responsibility of Catholic health care, the professional-patient relationship,”* and specific areas of care, including the beginning of life and care for the seriously ill and dying. Some Directives expressly address teaching and research. For example, Directive 4, states: *“A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the stewardship of health care resources. Such medical research must adhere to Catholic moral principles.”*

Some of the ERDS have the potential for discriminatory impact on patients and/or to impinge on the practice of medicine. Because the ERDS that restrict health care services focus significantly on reproduction, the restrictions primarily impact health care provided to patients who are women or transgender. In addition, because patients with disabilities are more likely to need services such as surgical abortion in a hospital setting, some restrictions disparately impact people with disabilities. Most reported conflicts between hospital and patient or hospital and individual provider arise in Catholic hospitals (18-21). Recent cases have included: the hospital’s refusal of a doctor’s request to provide tubal ligation during schedule cesarean surgery; refusal of a preauthorization request for surgery to treat gender dysphoria of transgender man; refusal of authorization for gender-affirming therapy - a hysterectomy - for a transgender patient; and a patient with preterm premature rupture of membrane and infection who was twice sent home from an emergency room without being told that she was undergoing miscarriage, or that continuing the pregnancy was dangerous (18-21).

The substantial presence of Catholic health systems in the National and California healthcare markets means that the ERDs have significant impact on the overall availability of services (Table 1). According to Becker’s Hospital Review, the five largest US nonprofit hospital systems were Catholic-owned in 2017, and the sixth largest was the Adventist Health System, now renamed as AdventHealth (22). The rankings shifted in early 2019 due to a merger between number two, Catholic Health Initiatives, and number five,



Dignity Health. The California Department of Justice approved the merger conditional on a number of significant requirements intended to minimize reductions in health care access by the people of California, but those conditions are time-limited (23). According to an ACLU/ MergerWatch report on acute-care hospitals, between 2001 and 2011 the number of Catholic hospitals increased by 16% and the number of for-profit hospitals increased by 46%; whereas, the overall number of hospitals nationwide declined by 6%, with a 31% decline in the public sector (16). That trend has continued (24). In California, approximately 14% of all California hospitals are Catholic facilities. In some areas of California, Catholic facilities may be the sole or primary health care provider (16,25). It is also important to note that the ERDs are often incorporated into lease agreements for medical offices that Catholic systems own (26). Thus, ERDs, which restrict health care services in ways that discriminate, affect patients and providers in local outpatient care settings as well as in hospital settings.

## **Conflicts and Consequences**

### Conflicts in Care

The University of California and its health care system (UC Health) offer education, patient care, health promotion, and research in numerous settings throughout California. Values that govern these activities, described in detail above, are foundational for setting evidence-based policy and practices within the University of California. This section of the report addresses potential conflicts arising from interactions between the University of California's public trust and stated values and decisions and practices based on religious policies that disparately impact particular patient groups and interfere with the University's educational and research mission in health care settings.

We propose *Principles for Avoidance of Discrimination in Healthcare*, below, to allow UC Health to anticipate and avoid physical, emotional, and in some cases even spiritual harm imposed by religious restrictions on legal, safe, and standard, medical care. Any partnership with a facility that restricts care based upon religion in conflict with science and medical standards presents the possibility of harm to some UC Health patients, providers, and learners. The separation of values and practices may not be possible within a partnership. Therefore, partnerships, limited liability companies, corporations, or joint venture with facilities or other entities bound by religious restrictions on care or other practices that have discriminatory effects must be avoided.

### Conflicts Arising from Individual Patient or Student Decisions

Patients may make treatment decisions or request treatment for religious or spiritual reasons that conflict with clinical standards and values at UC. Examples include declining a necessary blood transfusion, declining vaccination, or a request for female genital mutilation or elective circumcision. Existing principles of clinical ethics address conflicts arising from individual patient decisions (27-29). For example, generally if the requested treatment is available, not cost prohibitive, not medically contraindicated or risky, or if the decision does not compromise the rights and wellbeing of a dependent person (e.g. children or the elderly), the UC provider can use his or her own professional judgement about whether to accommodate the patient's belief.

Anti-discrimination laws and UC standards and values limit religious accommodation of individual patient requests. For example, a patient may request to change healthcare providers based on racial, ethnic, or religious bias (e.g. rejection of a Black provider or demand for a white-Christian provider). The

accommodation of such requests may violate state and federal anti-discrimination laws as well as UC's own standards by creating a hostile work environment for the targeted provider. It may be, at times be ethically and medically appropriate to accommodate certain concordance requests that are not based upon bias or animus, but the determination must be made on a case-by-case basis (30).

Other potential conflicts arise when individual employees or students attempt to circumvent requirements for vaccination in health care or classroom environments, based on religious or philosophical beliefs (31). As the current measles outbreak illustrates, unvaccinated students or employees increase the risk of widespread outbreaks of preventable and potentially dangerous infectious diseases. Because individual decisions to forgo vaccination may impact public health and endanger vulnerable individuals, the ethical principle of autonomy in decision making generally gives way to the principle of protecting the public health, in order to minimize harm and assure the greatest good.

#### Conflicts Arising from Individual Employee Decisions or Practices

When individual UC employees' own values conflict with those of the University, they sometimes object to providing care to their patients. For example, an employee may object, on religious grounds, to participate in providing abortion care, gender-affirming care, or end-of-life or palliative care.

Accommodations to excuse individual employees from providing needed care, services, or administrative support to religious work exemptions may become discriminatory, interfere with scheduling, cause unfair burdens on unexcused employees, and interrupt UC's ability to offer the full range of standard of care services.

Shortly after the Supreme Court decided *Roe v. Wade*, Congress enacted a series of federal laws authorizing individual and institutional provider refusals based on religious belief. The first 'conscience clauses' apply to abortion and sterilization. Subsequent federal and state laws have expanded the range of services and providers protected by refusal laws. Today, for example, obstetric and gynecologist physicians are protected when they refuse to provide contraception within their practice because of a deeply held religious belief that contraception is wrong. The US Department of Health and Human Services, Office of Civil Rights, recently issued a rule, entitled, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (32). This rule would expand authority for refusals to non-providers and to "moral," as well as "religious" objections. Twenty-six states and local governments, including California, have challenged the rule's legal validity. The rule's implementation has been delayed, pending the outcomes of litigation. Critics of broad 'conscience rights', including states, cities, and civil rights advocates, have raised two concerns relevant to this discussion. One is that broad religious refusal laws provide cover for discriminatory treatment of patients. The other is that religious refusals jeopardize continuity and quality of care,

The general principle UC Health should follow regarding a professional's refusal to provide care based on religious beliefs is that the patient must not be denied care or even made aware a provider has refused to provide care. An alternative must be provided without delay; and the institution(s) must be informed. Ideally, accommodations should be made in advance between the employee and the employer such that a plan for seamless transfer of care is anticipated and well-executed. Likewise, it is important that university employees and their dependents, or students, receiving care through the university's health plans do experience delay, denial, or other negative impacts when individual external providers claim religious exemption.

Although most conflicts involve restrictions in care, expansions in care may also create conflict. A potential conflict can arise when a health provider offers to pray with patients before surgery or during care and treatment. The guiding principle for the University of California must be respect for all persons. Prayer is routine for some religious people, but is not routine for all people. In addition, a provider's offer to pray may be a cause of anxiety for some patients. For example, a physician's offer to pray before surgery might suggest to the patient that the physician is not convinced the operation will succeed without it. In other cases, the mere suggestion of prayer may be demeaning, conveying that the provider finds the patient's own belief system inadequate. Worse yet, a patient may go along with the prayer with some loss of dignity in doing so, because they fear not participating in prayer will draw ill will (or any negativity) from the provider on whom their life depends. Given the power differential between provider and patient, UC Health must not condone the unsolicited offering of religious prayer by an individual care provider.

Religion offers comfort and improved coping ability to many people. The role of a patient's personal religious belief on her health, whether health care providers should become involved in the spiritual practices of patients, and the right of employees to interact with others around their personal beliefs in the workplace are controversial topics. There is some evidence of positive effects of religious or spiritual practices on patient health or well-being (33). Many healthcare institutions offer spiritual care and resources to patients through chaplaincies precisely because of this evidence (34, 35). Chaplains are trained in pastoral and spiritual care, and may reflect the values of their own beliefs and the ethos of their employer. Institutions are better positioned to provide pastoral care or chaplaincy in a systematic and non-discriminatory manner than are individual care providers acting spontaneously (35).

#### Conflicts Arising from Relationships with Sectarian Institutions that Restrict Health Care

Affiliations with entities or institutions that restrict health care based on religious doctrine or other ideological commitments present a specific set of potential conflicts. Generally, such affiliations raise two sets of concerns. One set is about the University's mission. Some private, sectarian organizations are bound by religious doctrine that requires limiting or denying care to particular groups of people and denying types of care that are standard in the practice of evidence-based medicine. This type of restriction is more likely to have discriminatory impact, to prevent use of evidence-based medicine, and to interfere with the training of health professionals. Another set of conflicts concerns university values and reputation. Affiliations that include co-branding and joint provision of care, education, and research are particularly likely to create confusion among patients, employees, and learners about University values and identity.

Catholic hospitals and health care systems are the most likely to generate institutional healthcare conflicts in California and the United States. Two factors account for this. One is prevalence. Catholic health systems constitute the largest group of nonprofit health care providers in the United States and account for over 70% of all religious hospitals (24, 36). The second is that Catholic hospitals, including most facilities of Dignity Health (CommonSpirit), follow the Ethical and Religious Directives for Catholic Health Care Services (ERDs) issued by the United States Conference of Catholic Bishops (17). A few Dignity Health hospitals follow a set of health care restrictions called the Statement of Common Values (37). Both the ERDs and the Statement of Common Values draw upon religious doctrine to substantively constrain care and information provided to patients. The resulting restrictions discriminate on the bases of both sex and gender. In particular, the ERDs prohibit highly utilized, standard reproductive healthcare such as contraception, tubal-ligation sterilization, abortion in all cases, assisted reproductive technology use, and in the case of transgender care, surgical procedures such as hysterectomy. Gender affirming

care such as hormones or mastectomy may be restricted as well due to positions proclaimed by ERD authors in separate texts (38, 39). The ERDs also may prohibit or religiously constrain common types of health promotion practices, such as sexual health counseling for family planning, child spacing, sexual identity and gender affirming care, as well as discussion about directives for desired care in the face of terminal illness.

Some of these conflicts in care may also arise in other religiously aligned but non-Catholic health care systems, which are less prevalent in California. A national study found that 52% of obstetrician-gynecologists who work in Catholic hospitals report conflict with their hospitals' religious policies for care, as compared with 17% for other Christian hospitals and 9% for Jewish hospitals (40). All potential affiliations must be scrutinized for potential conflicts with values and standards governing University of California entities.

Healthcare institutions that use religious restrictions on care commonly face particular conflicts affecting patients and individual providers (41). Please see Tables 2 and 3, below, for examples of clinical conflicts in Catholic hospitals following from the ERDs and the SCVs, as well as Table 4 for examples of impacts of Adventist Official Guidelines on patients, employees and learners (Tables 2-4). Restrictions in the ERDs and Common Values interfere with some professional and UC standards of care. As a result, they may undermine some patient outcomes. While international and domestic research has repeatedly demonstrated that evidence-based family planning methods are both widely embraced by women and critical to their family's health and wellbeing (42-46), the ERDs prohibit health professionals, both individual (regardless of the individual's own faith) and institutional, from providing family planning services. In a UC Health facility, a mother's contraceptive needs are addressed after delivery, before returning home, to take care of a newborn child. This is a critical window of opportunity, especially if she desires sterilization (47). Almost a quarter of women denied a sterilization procedure after childbirth will have an unintended pregnancy within one year (48). The ERDs prohibit tubal-ligation; therefore, a patient giving birth in a Catholic hospital can be at higher risk of subsequent unintended pregnancy, or the new mother must have a separate procedure elsewhere, with the attendant risks of a second round of anesthesia and surgery and potential financial costs.

Women having miscarriages who seek care at Catholic hospitals may receive care that is restricted by doctrine. Doctors in Catholic hospitals report that where a fetal heartbeat is detected, they must wait for signs of infection, before performing standard care, such as aspiration, dilation and curettage, to complete the miscarriage. This may cause distress to both patient and doctor (49-51). Such policies have led to patient death in other jurisdictions (52). Transgender care in Catholic hospitals is less well studied, but two cases under litigation in California indicate that denial can happen; such denial is consistent with statements that Catholic bishops have made condemning transgender surgery (39, 53, 54). Some end-of-life care, most notably removing medically delivered nutrition and hydration per the patient's request may not be allowed. In addition, Catholic hospital policies do not permit physicians to write prescriptions or refer patients for physician aid-in-dying per the ERDs, further substantiated by a recent survey (55, 56).

The ERDs negatively impact faculty, patients, other UC employees, and students. Religiously-based health care restrictions can constrain the freedom to teach to the accepted standard of care, to be compelled to knowingly endanger a patient's welfare, and to be constrained in health promotion.

Religious or sectarian definitions of family may differ from those used by the University. This may pose problems at both employee and institutional levels. Gay marriage partners, life partners, or surrogate

parents, for example, may not be recognized within the context of some religious belief systems. End-of-life decisions may be impacted, particularly when the patient is incapacitated or unable to communicate.

Patients and UC providers may not be able to seek alternative sites of health care. Medical emergency, geography, or employment can constrain access to health care. A University of California employee may have few options in their work assignments or in the providers covered by their benefits plan. It is important that provider networks in the University's health plans, for employees and their dependents, or for students, be sufficient to ensure that covered individuals will have the choice of receiving care in a non-discriminatory environment.

A focus on improving transparency could potentially help some patients avoid denials of care. In other words, disclosing to patients a list of specific restricted services would enable patients who are planning future health care services to avoid denials. This is a formidable challenge that neither UC hospitals nor affiliated entities may be truly incentivized to take on. In fact, Catholic hospitals have exhibited an increasing trend toward opaque branding (Catholic Healthcare West became Dignity; the new system created by the Dignity-Catholic Health Initiatives merger is becoming CommonSpirit). Generally, patients (and many individual providers) do not expect a facility's religious identity to affect the scope of services provided. Many patients are not even aware of their own hospital's religious identity. In a recent national survey, 37% of women whose primary hospital is Catholic, did not know it was (57). Low-income patients are even less likely to identify a Catholic hospital as being so (57). Likewise, the New York Times reported last year that it is quite difficult to determine from a hospital's website that it is Catholic (58). It is even less likely that women can anticipate the specific restrictions because few understand that care can be religiously restricted at all (59, 60). Women incorrectly believe that prohibited services are actually available in Catholic hospitals, e.g. abortion for serious fetal indication or anomaly (42%), abortion for personal reasons (24%), birth control pills (77%), and sterilization (70%) (47, 60). Educating all existing and potential patients to reduce these misperceptions would take considerable resources and perhaps a willingness for Catholic hospitals to affirmatively disclose the services they do not provide (61). In addition, transparency would not mitigate the impact of restrictions that apply to patients by identity or role. These patients include transgender patients and patients providing surrogacy services.

In light of the potential for future affiliations with institutions that use religious or ideological restrictions on health care, it is important to note that key recommendations in the Report of the UCSF September 2017 Joint Senate-Administration committee of the campus affiliation Review policy have not yet been enacted at UCSF (62). These included the creation of a UCSF Centralized Office to "*serve as a communications hub to the review committee*" amongst other functions (page 11); policy revisions to "*include guidelines for the expansion of existing affiliations, which is separate than entering into new agreements*" (page 12), and that issues related to standards of care must be addressed (page 13). All UC campuses may be impacted by affiliations with entities that use religious restrictions on healthcare, including their students, employees, faculty members, the families of UC employees availing of employer-provided health benefits, learners within the UC system, and non-associated members of the public.

### Health Promotion

Health promotion efforts of faculty, staff and learners, essential to the public good, may be in conflict with religious restrictions and beliefs in some cases. Examples may include: comprehensive sex education and birth control, addressing LGBT health, advocating for HPV vaccine in girls and boys and addressing domestic abuse or intimate partner violence (63, 64). Some discrimination may be effected by omission, for example, an absence of outreach to transgender patients. Objections to vaccination based upon some religious beliefs appear to be rising nationwide. Health promotion efforts span a spectrum from individual consultation, posters or pamphlets in a treatment room, the work of epidemiologists and public policy faculty members, to media campaigns. Of course, many religious belief systems broadly promote health and many kinds of health behaviors; however, UC's vigilance is required to ensure that all health promotion is evidence-based and unrestricted by religious or other discriminatory policies.

### Education

Teaching by UC faculty members is protected under the umbrella of academic freedom (65, 66). Healthcare teaching is delivered in a wide range of formats to a wide group of learners including members of the university community, students, residents, fellows, staff employees; the public; external care providers receiving continuing education or certification; and the employees of external organizations associating with the University.

Religious restrictions may impact the learning environment in different ways. Students, residents, and fellows who are mentored by providers who use religious restrictions on health care are denied opportunities to learn evidence-based standards of care and may come to normalize how services can be restricted per religious restriction (67-69). Those who learn, in full or in part, in institutions with religious restrictions, or work in health promotion programs run by religious organizations, may be forced to perpetuate partial and/or discriminatory information. They may become habituated to discriminatory policy as being normal or acceptable in the University of California's operations. UC Health should make sure that all sex education, medical practice related to sexual identity, and reproductive healthcare delivery are not constrained by religious beliefs that conflict with UC values. If a learner, health promotor, or faculty wears UC's name, they must not perpetuate incomplete or stigmatized versions of sexual, reproductive, end-of-life, or other affected care.

The ERDs and Statement of Common Values may constrain the University's educational mission in important disciplinary areas. More specifically, where health sciences students attend clinical practicums in ERD-observing institutions they may be forbidden to deliver the standard of care, particularly in reproductive and sexual health and end-of-life contexts.

Students, trainees, and residents must not receive a lesser educational experience. Nor should UC employees be compelled to teach nor students be compelled to receive instruction based on religious doctrine. In fact, Section 8 of the California Constitution prohibits instruction, directly or indirectly, of *"any sectarian or denominational doctrine . . . in any of the common schools of the State (2)."*

### Research and Academic Freedom

Inquiry relating to areas where religion-based discriminatory restrictions on healthcare exist present obvious challenges to research and the protection of academic freedom. Researching topics such as gender dysphoria or miscarriage management may be precluded or restricted in some religious health

facilities. In some cases pharmaceutical companies and investigators researching their products require that study subjects who are women use contraception, as the research undertaken could possibly have teratogenic or abortive effects. Because of this, some religious facilities may not be good partners or sites for some types of research (70). To date, there is a shortage of research concerning the patient outcomes and societal outcomes of health care influenced by religious doctrine (71). Social science and studies of ethical practice may be constrained within institutions that do not want their practices to be exposed to scrutiny or critique, particularly if such research brings to light practices that may not meet current standards of care. Institutional review boards (IRBs) at religiously affiliated entities may disallow studies that do not reaffirm religious constraints, although in secular contexts such studies might be considered entirely ethical.

#### Conflicts and Consequences Summary

UC must take care to articulate its values for comprehensive and evidence-based healthcare that takes the public's health as a priority and is not restricted beyond the law by religious beliefs of individuals or institutions. Success in the University's mission requires maintaining opportunity for teaching, service and patient care without discrimination. The Task Force understands that UC's schools, clinics and hospitals exist in a competitive marketplace, which is undergoing consolidation. However, UC must avoid partnerships or other forms of close legal affiliation with entities that constrain teaching, research, clinical care or other service, or that do not share UC's key values, fail to advance our mission, and undermine UC's public trust. Such affiliations may cause gaps in care or otherwise compromise quality of care for UC patients. In addition, the inherently discriminatory and medically regressive model of care resulting from such affiliations will jeopardize UC's reputation and quality of care.

### **Principles for Avoidance of Discrimination in Healthcare**

Success in the University mission demands provision of clinical patient care, teaching, research, and other types of service. The reality is that UC's schools, clinics and hospitals exist in a competitive marketplace which is undergoing consolidation. At the same time, the University's values mandate that the University provide equal opportunity for all in its activities, including education, services, administration, research, and creative activity. It is antithetical to the university's values to engage in any activity that will lift some, but discriminate against others, upon the bases of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, citizenship, or veteran status. These values apply to all groups operating under the Regents purview, including administration, faculty, students, programs sponsored by the University, and external contractors.

How may the University protect the people against discrimination as it engages its healthcare provision mission in a consolidating, competitive market, in which sectarian systems play a significant role? We propose the following principles as precepts for the formation of relationships with sectarian organizations and institutions.

(1) Academic freedom cannot be impinged upon, regardless of the site where University of California faculty members work or where their students learn. *"The exercise of academic freedom entails correlative duties of professional care when teaching, conducting research, or otherwise acting as a*

*member of the faculty*" (66). This includes healthcare provision, adherence to evidence-based practice and to established standards of care. Religious doctrine cannot constrain or restrict faculty activities. Any arrangement with a sectarian institution must explicitly reference the academic freedom of participating University faculty. It is important to note that students' academic freedom derives from that of their faculty, who have the responsibility for its protection.

(2) The University should not be a member in an entity such as a corporation, partnership, limited liability company, or joint venture that provides healthcare services with another member that has discriminatory practices or policies in healthcare. Joint ownership and management of an entity with an institution that has discriminatory practices or policies in healthcare should be precluded to avoid conflicts and to ensure transparency.

(3) The University generally should retain sufficient capacity to fulfill its teaching and research mission within its own facilities, using its own personnel and equipment. Should there be a long-term need for additional hospitals, facilities or beds, the University generally should build or wholly acquire existing facilities to satisfy these needs whenever possible.

(4) The following principles apply when the University enters into a lease, rental, or service arrangement with an external entity to provide healthcare services to fulfill the University's teaching and research mission or to provide healthcare services to employees, retirees, students, and family members:

- (a) The University should perform full due diligence to determine if an external entity has discriminatory practices or policies in healthcare. This due diligence includes requiring that an external entity disclose any of its practices or policies that could be considered to be discriminatory.
- (b) All contractual agreements entered into by the University to provide healthcare services should affirmatively include terms that require full compliance with the University principles, values, and practices. The terms and conditions of these agreements should be made available for review and comment by representatives of the faculty, in accordance with shared governance and the processes of the Academic Senate. The following principles apply to all agreements:
  - (i) University care providers working in rented facilities, or receiving services via a service agreement, must have the freedom to deliver medical care as practiced at the University. This includes all appropriate medical procedures and discussions with patients. Any contract should detail the expectations of University medical care within the rented or service facility, and be made available for review by representatives of the faculty before execution of any agreement.
  - (ii) Institutions providing rental facilities should be required to proactively cooperate fully with University facilities or personnel in the event that a patient transfer to a University facility is required.
  - (iii) If medical education of University students, or external learners, is conducted in another institution, any agreement should affirmatively include language that precludes any restriction of instruction according to religious or faith-based belief.
  - (iv) The University must not be dependent upon another institution whose values or practices



may not be fully aligned with those of the University. Hence, the University should be able to withdraw from any agreement on relatively short notice without putting its service, educational, or research programs at risk.

- (v) The external entity cannot use the University of California brand. It should be clear to everyone that an external entity that has discriminatory practices or values, or that refuses to fully comply with the University's principles, values, and practices is not affiliated with the University.
- (vi) All healthcare entities or vendors with which the University contracts for employee benefits, or other forms of insurance and services, must have demonstrated ability to provide seamless healthcare for any covered individual in a non-discriminatory environment.
- (c) An arrangement with an external entity that has discriminatory practices or policies, or that refuses to agree to fully comply with University values and practices, should be avoided unless overwhelming evidence as to the greater common good is found. This rule is not intended to prevent the University from entering into a lease, rental, or service arrangement with an external entity where the University has the ability to retain its own identity as a distinct and separate institution, and to control the terms of patient care, research, and instruction.
- (d) The University may enter into an arrangement with an external entity that has discriminatory practices or policies, or that refuses to fully comply with University values and practices, when overwhelming evidence as to the greater common good is found. The following principles govern in such a case:
  - (i) Full transparency must be provided to everyone - the public, patients, and all members of the university community. This includes full disclosure of all treatment options to patients, all care restrictions, and potential impacts of care restrictions. It is not enough to disclose only what is offered at a particular facility. In addition, ownership or sponsorship of hospitals or facilities must be evident to the public, and to University employees, students, and family members who may work in or receive health care from a facility.
  - (ii) Disciplinary carve-outs, by clinical unit, or work-arounds, may be helpful but are not sufficient to avoid all conflicts in agreements with entities that exercise discriminatory policies. The field of obstetrics and gynecology presents many obvious challenges to business arrangements with sectarian or religious organizations, notably Catholic or other organizations or facilities with similar faith-based restrictions. Avoidance of all such relationships with respect to obstetrics and gynecology would prevent some conflicts of values. However, this may not be sufficient. Irreconcilable conflicts of values may also exist in other areas, including end-of-life care, discrimination based upon sexual orientation, gender identity, and disability, for example. Furthermore, affiliations and other arrangements should anticipate that some patients seeking care or admitted for reasons that raise no apparent conflict may later face restrictions as health care needs expand, unexpected complications ensue, or when emergent care is necessary.
- (5) It is expected that additional principles and policies will need to be developed to regulate the interaction and relationship of the University and other institutions in providing healthcare, including but not limited to institutions that have discriminatory practices or policies in healthcare for religious

doctrinal, faith-based, or other reasons. These principles and policies should be developed on a system wide basis through a formalized review process that is consistent with the principle of shared governance.

(6) Some existing campus policies such as the 2013 UCSF Academic Administration Policy 100-10 on Affiliation Agreements lack the protection of university values as described above and must be suspended until systemwide policy has been developed, and until they are revised to be consistent with the extant Regents and University policies described above (72). Likewise, efforts to provide recommendations on university process and shared governance in the consideration of affiliation agreements must be revisited in a systemwide manner, e.g. the 2017 *Shaping UCSF's Clinical Mission: Campus Affiliation Policy, Clinical Affiliate Agreements and the Healthcare Landscape* (62).

(7) All pre-existing agreements with religious healthcare providers throughout the University of California system be identified and examined with respect to the above precepts

## Conclusions

- I. The mission, values, and policies of the University of California are in conflict with the use of religious belief or doctrine that restricts, or expands, healthcare in discriminatory ways.
- II. Discriminatory practices based upon religious or other sectarian belief may pose harm to the delivery of healthcare, teaching, and research by the University of California.
- III. Subjection of faculty members and their students to restriction through discriminatory practices, based upon religious or sectarian belief, is contrary to academic freedom.
- IV. The University of California should avoid an entity such as a corporation, partnership, limited liability company, or joint venture, or other forms of close legal affiliation, with any external entity that exercises discriminatory policies in healthcare.
- V. Business agreements with external entities that exercise discriminatory policies should be avoided unless overwhelming evidence as to the greater common good is found to reach a high bar. Should such a bar be reached, a set of clearly precepts, described in this report, must be realized before a business agreement is entered.

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**Table 1. California Hospitals, Religious, Secular Nonprofit, Proprietary and Public.** Hospital utilization and affiliation data from Definitive Healthcare, a health care informatics company that maintains an integrated comprehensive hospital database which is updated daily. This dataset was drawn in May, 2019.

	All California Hospitals	Catholic hospitals	Adventist hospitals	All Religious hospitals	Secular Nonprofit	Proprietary	Public
Hospitals	370	52	21	75	142	81	72
Percent Hospitals		14.1%	5.7%	20.3%	38.4%	21.9%	19.5%
Percent CA hospital beds in:	<b>N/A</b>	17.1%	4.6%	22.7%	42.6%	17.5%	17.3%
Total number of sole community hospitals that are:	<b>N/A</b>	11.1%	16.7%	27.8%	38.9%	5.6%	27.8%
Portion of hospital costs that are charity care costs:	<b>1.23%</b>	1.40%	1.86%	1.48%	0.75%	1.07%	2.05%
Portion of hospital inpatient discharges that is Medicaid:	<b>9.8%</b>	8.4%	12.5%	9.2%	6.5%	12.7%	16.6%
Portion of hospital inpatient days that is Medicaid:	<b>12.3%</b>	9.7%	16.3%	11.1%	9.2%	14.8%	18.7%
Portion of hospital patient net revenue that is Medicaid:	<b>20.5%</b>	22.6%	22.5%	21.8%	15.4%	24.7%	25.9%



**Table 2. Clinical Conflicts in Care in Catholic Hospitals. Policies/practices leading to discrimination in healthcare.** The Ethical and Religious Directives for Catholic Health Care Services (ERDs) issued by the United States Conference of Catholic Bishops prohibit abortion, IVF, contraception (including sterilization), and more (17). Abortion constraints can limit miscarriage management.

Anticipated Clinical Conflicts in Catholic Hospitals	Relevant Religion-Based Policy Statement or Directive (ERD)	Patients	Employees	Learners
Tubal-Ligation Sterilization	ERD #53: “Direct sterilization of either men or women, whether permanent or temporary, is not permitted...”	A patient giving birth in a Catholic facility cannot have a sterilization procedure as a post-partum inpatient or during C-section surgery. She will need to schedule a separate surgery later, doubling both anesthesia and surgical risks. She will be at higher risk for unwanted pregnancy and short interval birth (48).	UC Employees working in Catholic facilities may be professionally obligated by the policy to deny this desired, safe procedure despite personal, scientific, and public health support for it (73).	Learners will lack exposure to counseling for, medical training in, or aftercare of procedure.  Policy may teach learners that such denials are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.
Transgender Surgery	The National Catholic Bioethics Center firmly opposes any cooperation in gender affirming care (74).  ERD #53 (above) has also been referenced as reason to deny hysterectomy or other gender affirming surgeries that would result in infertility (38).	A UC patient who must be cared for in an affiliated-Catholic facility may be denied gender affirming care or procedures (38).  In some cases hysterectomies have been schedule successfully, but canceled last minute after Catholic hospital staff inquired about reason for the hysterectomy.	Same as above	Same as above
Abortion	ERD #45: “Abortion (that is, the directly intended	Patients needing an in-hospital abortion procedure for any	UC Employees working in Catholic facilities	Same as above

	<p>termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted...”</p> <p>Also ERD #73: “... a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.”</p>	<p>reason (gestational advancement, health conditions, lack of alternative provider etc.) will be denied a procedure. Patient will either need to find a different hospital or carry to term.</p>	<p>may be professionally obligated by the policy to deny a wanted procedure and referral despite personal, scientific, and public health support for it (26).</p>	
Surrogacy	<p>ERD #42: “... participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.”</p>	<p>Surrogates cannot not deliver in ERD facilities if they want birth certificate and parentage to reflect their wishes. LGBT families may be disproportionately impacted.</p>	<p>When attending births in Catholic facilities, UC Employees may be required to assign parentage to surrogate despite the wishes of the surrogate and the expecting parents.</p>	<p>Learners will lack exposure to surrogacy births.</p> <p>Policy may teach learners that such practices are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.</p>
IVF/fertility	<p>ERD #40: “Heterologous fertilization ... is prohibited because it is contrary to the covenant of marriage...”</p> <p>ERD #41: “Homologous artificial fertilization ... is prohibited...”</p>	<p>Patients will not be able to get some infertility services from a Catholic provider, specifically if egg and sperm are separated from the body and embryos are created. LGBT couples may be disproportionately impacted. IVF is usually done in an outpatient setting and the patient</p>	<p>UC Employees working in Catholic facilities may be professionally obligated by the policy to deny IVF, and possibly referrals as well.</p>	<p>Learners will lack exposure to the full range of infertility treatments.</p> <p>Policy may teach learners that such denials are sanctioned by UC, thereby normalizing a discriminatory model of</p>

		will be less affected by the prohibition if an IVF provider within the network is available.		care that learners may perpetuate in practice.
Physician-Assisted Dying	<p>ERD #60: “... Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way...”</p> <p>ERD #73: “...a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures...”</p>	Patients may not get information or referral while in a Catholic facility if they desire physician-assisted dying. Typically the process would take place at home, but the hospital is a key place for the family to get information, referrals, and counseling. Socio-economic disparities in information and access may be exacerbated.	UC Employees who are asked for information about physician-assisted death, or who come to understand that a patient may want this information, may not be able to inform or counsel the patient about their options.	<p>Learners will lack exposure to counseling for, medical training in, or family needs around aid-in-dying processes.</p> <p>Policy may teach learners that such denials or omissions about this option are sanctioned by UC, thereby exacerbating disparities and normalizing a model of care that learners may perpetuate in practice.</p>
Contraception  Varying tolerance for contraceptives by facility type and business arrangement is noted (75).	ERD #52: “Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church’s teaching on responsible parenthood and in methods of natural family planning.”	Contraceptives are not provided to patients in most Catholic facilities. Post-partum contraception, critical for child spacing and addressing disparities in access to care, may be absent. For patients with certain illnesses or treatments, or research protocols, pregnancy can be considered a serious health risk and contraception is recommended (76).	<p>UC Employees maybe have to deny post-partum contraception despite personal, scientific, and public health support for it.</p> <p>Outpatient provision can be affected and direct referrals, prohibited.</p>	<p>Learners lack exposure to counseling for contraception and medical training in normal and complex contraception.</p> <p>Policy may teach learners that such denials are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.</p>

Potentially Unavoidable Clinical Conflicts in Catholic Hospitals	Relevant Religion-Based Policy Statement or Directive (ERD)	Patients	Employees	Learners
Miscarriage and Other Obstetric Complications	<p>ERD #45: “Abortion ...is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion...”</p> <p>ERD #47 pathway: “[treatments addressing a] proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed...”</p>	Treatment of obstetric complications may be delayed in order to meet ERD prerequisites for intervention (i.e. fetal death or a proportionate pathological threat to mother’s life). If miscarriage is inevitable, but fetus has not yet passed, religious policies equate treatment to abortion. Delaying care until fetal death can incur increased risk of harm from infection, blood loss, or comparable threat and increased emotional and/or physical suffering (49, 50, 77).	UC Employees working in Catholic facilities may be required by ERD #47 religious policies to delay or deny care they judge as safest and standard. In some cases, employees find religious policies confusing and can commit malpractice while delaying care for per theological guidance (78).	Learners will lack exposure to evidence-based practices, patient-centered counseling for, medical training in, or aftercare in appropriate management of obstetric complications and previsible loss (79).  Policy may teach learners that such delays in care and denials of treatment are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.
Loss of Dignity or Emotional harm of denied care	All policies mandating denial of services for religious reasons	Denial or delay of care for purely religious reasons may increase stigma and distress, especially when care relates to sensitive and already stigmatized physical experiences such as pregnancy loss, abortion, and sexual identity. Most Catholic people disagree with Church doctrine on reproduction. However, all people, religious or not, may feel shamed by denial based upon religious principles (81).	UC Employees may experience moral distress, as described by Catholic hospital ob-gyns in qualitative research and media, if not allowed to provide this standard and needed care (50, 80).	Some learners may experience their own distress when witnessing denials that that violate patient autonomy or cause patients emotional and physical harm.

**Table 3. Impact of the Statement of Common Values (SCVs) on patients, employees and learners at religious non-Catholic hospitals affiliated with Catholic systems such as Dignity Health/Common Spirit (37).**

Anticipated Clinical Conflict	Relevant Religion-Based Policy Statement in SCV	Patients	Employees	Learners
Abortion	SCVs: “For Dignity Health, respecting the dignity of persons requires reverence at every stage of life’s journey from conception to natural death. Therefore, direct abortion is not performed.”	Patients needing an in-hospital abortion procedure for any reason (gestational advancement, health conditions, lack of alternative provider etc.) will be denied a procedure. Patient will either need to find a different hospital or carry to term.	UC Employees working in SCV facilities may be professionally obligated by the policy to deny a wanted procedure and referral despite personal, scientific, and public health support for it (26).	Learners will lack exposure to counseling for, medical training in, or aftercare of procedure.  Policy may teach learners that such denials are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.
IVF/fertility	SCVs: “Reproductive technologies in which conception occurs outside a woman’s body will not be part of Dignity Health’s services. This includes in-vitro fertilization.”	Patients will not be able to get some infertility services from an SCV facility, specifically if egg and sperm are separated from the body and embryos are created. LGBT couples may be disproportionately impacted. IVF is usually done in an outpatient setting and the patient will be less affected by the prohibition if an IVF provider within the network is available.	UC Employees working in SCV facility may be professionally obligated by the policy to deny IVF services to patients despite their own support for it.	Learners will lack exposure to the full range of infertility treatments.  Policy may teach learners that such denials are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.
Physician-Assisted Dying	SCVs: “Death is a sacred part of life’s journey; we will intentionally neither	It is unclear if patients would get information or referral while in a SCV facility if they	UC Employees who are asked for information about physician-assisted	Learners will lack exposure to counseling for, medical training in,

	hasten nor delay it. For this reason, physician- assisted suicide is not part of Dignity Health’s mission.”	desire physician-assisted death. Typically the process would take place at home, but the hospital is a key place for the family to get information, referrals, and counseling. Socio-economic disparities in information and access may be exacerbated.	death, or who come to understand that a patient may want this information, may not be able to inform or counsel the patient about their options.	or family needs around aid-in-dying processes.  Policy may teach learners that such denials or omissions about this option are sanctioned by UC, thereby exacerbating disparities and normalizing a model of care that learners may perpetuate in practice.
<b>Unanticipated Threat (i.e. may be unavoidable)</b>		<b>Patients</b>	<b>Employees</b>	<b>Learners</b>
Miscarriage and Other Obstetric Complications	SCVs: “For Dignity Health, respecting the dignity of persons requires reverence at every stage of life’s journey from conception to natural death. Therefore, direct abortion is not performed.”	Treatment of obstetric complications may be delayed in order to meet prerequisites for intervention (i.e. fetal death or a proportionate pathological threat to mother’s life). If miscarriage is inevitable, but fetus has not yet passed, religious policies equate treatment to abortion. Delaying care until fetal death can incur increased risk of harm from infection, blood loss, or comparable threat and increased emotional and/or physical suffering (49, 50, 77).	UC Employees working in SCV facilities may be required to delay or deny care they judge as safest and standard. In some cases, employees find religious policies confusing and can commit malpractice while delaying care for per theological guidance (78).	Learners may lack exposure to evidence-based practices, patient-centered counseling for, medical training in, or aftercare in appropriate management of obstetric complications and previsible loss (79).  Policy may teach learners that such delays in care and denials of treatment are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.
Loss of Dignity or	All policies mandating denial of services for religious reasons	Denial or delay of care for purely religious reasons may increase stigma and distress,	UC Employees may experience moral distress, as described by	Some learners may experience their own distress when witnessing denials that

<p>Emotional harm of denied care</p>		<p>especially when care relates to sensitive and already stigmatized physical experiences such as pregnancy loss, abortion, and sexual identity. Religious people may feel especially shamed by denial based upon religious principles when they want and need the prohibited care.</p>	<p>Catholic hospital ob-gyns in qualitative research and media, if not allowed to provide this standard and needed care (50, 80).</p>	<p>that violate patient autonomy or cause patients emotional and physical harm.</p>
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**Table 4. Impact of Adventist Official Guidelines on patients, employees and learners (82).** Little to no research exists about religious restrictions on care in Adventist health systems. Adventists do not have a centralized set of religious health policies and defer to the 5 health systems to devise their own policies. While the religion itself opposes assisted suicide, homosexuality, and abortion, the religious doctrine values individual choice. However, abortions are not provided in some Adventist hospitals based upon religious opposition (83).

Anticipated Clinical Conflict	Relevant Religion-Based Policy Statement	Patients	Employees	Learners
Abortion	Statement: Abortions for reasons of birth control, gender selection, or convenience are not condoned by the Church (84). Women, at times however, may face exceptional circumstances ... The final decision whether to terminate the pregnancy or not should be made by the pregnant ...	Some Adventist hospitals prohibit abortions unless the fetus has a fatal anomaly. Patients needing an in-hospital abortion procedure for any reason (gestational advancement, health conditions, lack of alternative provider etc.) may be denied a procedure. Patient will either need to find a different hospital or carry to term.	UC Employees working in Adventist facilities may be professionally obligated by the policy to deny a wanted procedure despite personal, scientific, and public health support for it.	Learners will lack exposure to counseling for, medical training in, or aftercare of procedure.  Policy may teach learners that such denials are sanctioned by UC, thereby normalizing a discriminatory model of care that learners may perpetuate in practice.
Loss of Dignity or Emotional harm of denied care	All policies mandating denial of services for religious reasons	Denial or delay of care for purely religious reasons may increase stigma and distress, especially when care relates to sensitive and already stigmatized physical experiences such as pregnancy loss, abortion, and sexual identity. Religious people may feel especially shamed by denial based upon religious principles when they want and need the prohibited care.	UC Employees may experience moral distress, as described by Catholic hospital ob-gyns in qualitative research if not allowed to provide miscarriage management or tubal-ligation during C-section (50, 80).	Some learners may experience their own distress when witnessing denials that violate patient autonomy or cause patients emotional and physical harm.



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## **Acknowledgements**

The taskforce members are grateful to all who provided insight and advice, especially to Ken Feer, Mark Gergen, the University Committee on Faculty Welfare (UCFW) and the Faculty Welfare Task Force on the Future of UC Health Care Plans (HCTF).