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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN FRANCISCO

REBECCA CHAMORRO and PHYSICIANS FOR REPRODUCTIVE HEALTH, Petitioners, v. DIGNITY HEALTH; DIGNITY HEALTH d/b/a MERCY MEDICAL CENTER REDDING, Respondent.	Case No. CGC 15-549626 Hon. Harold E. Kahn **RESPONDENT DIGNITY HEALTH'S TRIAL BRIEF** Date: November 9-10, 2020 Time: 9:30 a.m. Dept.: 505

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I. INTRODUCTION

Health & Safety Code Section 1258 ("Section 1258") is a hospital licensing statute that does not and cannot prohibit Mercy Medical Center Redding's ("MMCR") faith-based process for allowing some tubal ligations at the hospital. Nor would any writ of mandate prohibiting MMCR's process be proper or in the public interest.

Section 1258 prohibits a hospital that allows sterilizations, for contraceptive purposes, from applying non-medical qualifications such as age, number of children, or marital status when deciding whether to permit a particular patient to have a sterilization procedure. At the same time, Section 1258 expressly allows such a hospital to consider the physical and mental condition of the patient. The evidence establishes that MMCR does not consider prohibited non-medical factors when evaluating requests for sterilization procedures. To the contrary, the evidence unequivocally establishes that MMCR engages in a faith-based review process, not for the purpose of contraception, that may allow a tubal ligation if the patient's physical condition and related medical factors, as provided by the patient's physician, reflect an increased risk of maternal morbidity and mortality associated with a future pregnancy: such as whether the patient has had previous Caesarean section procedures and the number of pregnancies the patient has carried to term. The patient's advanced maternal age may also be considered where it is a relevant exacerbating factor to the patient's medical condition. Section 1258 expressly permits MMCR to consider these factors. MMCR does not violate Section 1258 and the Court should deny the Petition on that basis.

However, even if the Court were to determine that MMCR does consider factors that Section 1258 prohibits, the Court nonetheless must deny the Petition because it violates both the church autonomy doctrine and Dignity Health's free exercise rights. The evidence establishes that MMCR is owned and operated by Dignity Health, a Catholic hospital system sponsored and controlled by the Roman Catholic Church. As such, MMCR is required to adhere to Catholic religious doctrine and moral teaching, including the Ethical and Religious Directives for Catholic Health Care Services ("ERDs"), which prohibit sterilization operations for contraceptive purposes. The decisions to apply the faith-based tubal ligation review process implemented at

MMCR—as well as at the other Dignity Health Catholic hospitals that provided discovery in this matter—were internal management decisions of Dignity Health and its Catholic hospitals that are essential to Dignity Health's central mission of providing health care services pursuant to the centuries-old healing ministry of Jesus, consistent with Catholic religious doctrine and moral teaching.[1] Judging whether the Catholic hospitals perform sterilization operations for contraceptive purposes directly interferes with the Catholic Church's regulation of Catholic facilities on a core issue of Catholic faith and doctrine and, therefore, interferes with the autonomy of the Catholic Church as a religious institution, in violation of the Religion Clauses of the U.S. Constitution.

Throughout this litigation, this Court has endeavored to answer the following question: "does Dignity have a religious/ethical right to determine for itself what medical factors do or do not warrant allowing contraceptive postpartum tubal ligations?" (Declaration of Colin M. McGrath ("McGrath Decl."), ¶ 2, Ex. 22 (July 22, 2019 Tr.), 44:7-10.)[2] To the extent the answer was ever subject to doubt, in July 2020, the Supreme Court emphatically answered: Yes. *Our Lady of Guadalupe Sch. v. Morrissey-Berru*, 140 S. Ct. 2049, 2060 (2020) makes clear that the U.S. Constitution protects religious institutions' "autonomy with respect to internal management decisions that are essential to the institution's central mission." Unlike this case, *Guadalupe* involved issues that had nothing to do with religion – specifically, whether teachers at Catholic schools could bring employment discrimination claims against their employers. Thus, *Guadalupe* presented a less compelling case for church autonomy than this case, but the Supreme Court had no trouble whatsoever holding that church autonomy extended broadly to all internal management decisions essential to the schools' central mission. Here, the internal decisions regarding the implementation of the sterilization policy at MMCR and the other Catholic Hospitals involve core

[1] The Court permitted discovery from six hospitals: MMCR, St. Elizabeth Community Hospital ("St. Elizabeth"), Mercy Medical Center Mt. Shasta ("Mercy Mt. Shasta"), Mercy General Hospital ("Mercy General"), Mercy San Juan Medical Center ("Mercy San Juan"), and Mercy Hospital of Folsom ("Mercy Folsom"). MMCR, St. Elizabeth, and Mercy Mt. Shasta are sometimes referred to as the "North State Hospitals." Mercy General, Mercy San Juan, and Mercy Folsom are sometimes referred to as the "Sacramento Hospitals. Together, the North State Hospitals and Sacramento Hospitals are referred to as the "Catholic Hospitals."

[2] The McGrath Decl. and exhibits attached thereto are located in the concurrently filed Respondent Dignity Health's Appendix of Declarations And Evidence In Support Of Trial Brief, Vol. II.

religious issues, including the interpretation and application of binding Catholic religious doctrine and moral teaching, which no court can judge or second-guess.

This protection for a Catholic entity's internal management decisions relating to its central mission is absolute; there is no balancing test. In January 2016, this Court identified the issue precisely when it recognized that this case "[is] about church and state. It's about exercise of religion, and how far, and to what extent, it can be regulated by a court." (McGrath Decl., ¶ 3, Ex. 23, at 32:14-18.) (Ruling of Judge Ernest Goldsmith). The Court also correctly found that "[r]eligious-based hospitals have an enshrined place in American history and its communities, and the religious beliefs reflected in their operation are not to be interfered with." (*Id.* at 35:2-9.) The Court's prior ruling, which also preliminarily rejected the claim under Section 1258 when denying petitioner's motion for a preliminary injunction to compel MMCR to allow a tubal ligation for Ms. Chamorro, was based on much of the same basic evidence that Petitioners still submit now.

As has become clear over the years of this litigation, Petitioners cynically seek an order compelling compliance with Section 1258 in a manner that would force Dignity Health to choose between (a) violating binding Catholic religious doctrine and moral teaching, including the ERDs, by permitting *all* requested post-partum tubal ligations at MMCR without regard to medical factors; or (b) supposedly avoiding moral conflict by prohibiting *all* post-partum tubal ligations at MMCR. Petitioners contend that Section 1258 requires Dignity Health to perform all requested tubal ligations and that if Dignity Health believes its Catholic faith prohibits that, then it is free to cease all tubal ligations and not violate either Section 1258 or Catholic religious doctrine. But, as *Guadalupe* makes clear, that argument misses the point. This Court cannot interfere with Catholic Hospitals' pastoral care-based review process because it is a faith-based organization's "internal management decisions essential to the institutions' central mission." *Guadalupe*, 140 S. Ct. at 2060.

Here, the Catholic Hospitals have decided that the ERDs permit tubal ligations under certain circumstances where particular medical factors exist and that it is consistent with the ERDs and the hospitals' healing mission to do so. This process is a paradigmatic internal

management decision essential to the institutions' central mission; indeed, it is a direct implementation of the Dignity Health's mission as defined by its Catholic sponsors, as set forth in its governing documents and as implemented by Catholic women religious who are members of the congregations that sponsored Dignity Health. Nor is there any concern that the Catholic Hospitals violate any applicable standard of care. They have been repeatedly inspected, licensed, and accredited by the relevant state and federal regulators for years and have never once found to have violated any standard of care or practice relating to their provision of obstetrical care or governance of the hospitals. *See* Section V(E), *infra*.

The writ Petitioners seek would interfere with the Dignity Health Hospitals' ability "to shape [their] own faith and ministry" through faith-based decision-making. *Hosanna-Tabor Evangelical Lutheran Church and Sch. v. E.E.O.C.*, 565 U.S. 171, 188-89 (2012).[3] And, Petitioners' claim that an order prohibiting MMCR from performing its constitutionally protected, faith-based review process—thereby forcing the hospital to eliminate *all* post-partum tubal ligations—would serve the public interest does not pass the straight face test. *See Rivera v. Div. of Indus. Welfare*, 265 Cal. App. 2d 576, 592 (1968) ("issuance of the writ is not a matter of right, but involves a consideration of its effect in promoting justice; likely public detriment warrants denial of relief").

In truth, this courtroom is the only place where the ACLU or Petitioner Physicians for Reproductive Health ("PRH") make the absurd suggestion that reduction in care serves the public interest. Ruth Dawson was counsel of record for Petitioners when she made a video and testified at the public hearings held by the Attorney General, imploring the Attorney General to, at a minimum, "ensure that all reproductive services . . . that are currently being provided at each Dignity Health facility, ***including those provided as exceptions to the ERDs***, be maintained and not discontinued after the merger." McGrath Declaration, ¶ 3, Ex. 24 (emphasis added). Ms. Dawson later signed on to a letter to the California Attorney General sent by the ACLU, PRH,

[3] *See also Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012, 2021 n.2 (2017) (citing *Hosanna-Tabor* and noting that a valid and neutral law of general applicability is not necessarily constitutional under the Free Exercise Clause of the U.S. Constitution where it interferes with "an internal church decision that affects the faith and mission of the church itself").

and others imploring the Attorney General to require that Dignity Health's Catholic Hospitals *maintain their sterilization review processes undisturbed*. The ACLU (through Ms. Dawson) and PRH wrote to the Attorney General:

> Many of the DH hospitals are located in the state's more rural areas. In some instances, these hospitals may be among the only available health providers in the area. Timely and adequate access to all health services is critical, *and this is particularly the case when it comes to reproductive health services and other essential health services.* ***The Attorney General should ensure that the conditions on any merger [of Dignity Health] require that DH hospitals maintain at least the levels and types of reproductive health services and essential health services currently*** provided *for a minimum of fifteen years post-merger*.[4]

Even the Petition complains that patients would have to drive 70 miles or more for maternity services unless they are served at a Dignity Health hospital.[5] (Petition, ¶ 37.) But Petitioners now have no problem pushing for an oppressive view of Section 1258, asking this Court to impose requirements on MMCR and other Dignity Health Catholic hospitals that inevitably will result in these hospitals discontinuing tubal ligation services in Redding, Shasta, and other parts of California served primarily by Catholic hospitals.

Ultimately, Petitioners ask the Court to ignore centuries of religious mission, decades of inspections, licensures, and accreditations by applicable state and federal regulators certifying that the Hospitals are in compliance with all applicable laws and regulations and providing the requisite standard of care, and the deference to hospital administrative decision-making required by case law, to impose a cramped interpretation of Section 1258 in order reduce care available in the community. *Lewin v. St. Joseph's Hospital of Orange*, 82 Cal. App. 3d 368, 384-85 (1978) (deference to hospital decisions is due "in large part" to the fact that the hospital's actions "substantially affect the public interest," as well as because of the "presumed expertise of administrative agencies in respect to matters within their jurisdiction.")

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[4] McGrath Decl., ¶ 4, Ex. 24 (https://healthlaw.org/wp-content/uploads/2018/11/Coalition-Letter-Dignity-CHI-Merger-Sept.-2018.pdf (emphasis added); Ex. 91 (ACLU FAQ and Guide to Providing Public Comments); https://www.aclusocal.org/en/ensure-health-care-access-all-californians. The video is available here: https://www.youtube.com/watch?v=0tC3sSWgM_w&feature=youtu.be.

[5] Petitioners never acknowledge the reasons that MMCR, a Catholic hospital, is the only hospital providing obstetrics services in the region. For-profit hospitals eschew obstetrics services as unprofitable; the county's public hospital closed decades ago after years of financial losses. MMCR, however, has continued to provide such services pursuant to its religious mission to do so.

Petitioners ignore that the women of Redding and Shasta will be hurt if MMCR and other Catholic hospitals must discontinue all tubal ligations. Many, including Petitioner Rebecca Chamorro herself, would find it difficult or prohibitively expensive to travel to San Francisco for medical care, or they may have insurance that does not cover other geographically proximate hospitals. While Petitioners are single-mindedly focused on eliminating Catholic health care, even at the expense of patients who could lose access to services, that is not the mission of this Court. The Court must respect both (i) the Catholic Church and MMCR's internal management decisions related to the Catholic faith and (ii) the public interest of women in MMCR's local community and those of other regions served by Catholic hospital. The U.S. and California Constitutions protect MMCR's faith-based process, and the very nature of the writ of mandamus requires the Court to consider the actual public interest before issuing any order requiring MMCR to make changes to its process. The Catholic Hospitals do not violate Section 1258, but even if the Court found a technical violation, the ACLU and PRH admit that the public is better served by the Catholic hospitals continuing to employ this faith-based process rather than the relief they quixotically seek here, which is contrary to everything they said when they began this litigation. The Court should deny the Petition.

II. FACTS

The Petition alleges that MMCR violates Section 1258 because it prohibits contraceptive sterilization procedures in accordance with the ERDs, but at the same time permits certain procedures that have a sterilizing or contraceptive effect based on the circumstances of particular patients. But MMCR does not violate Section 1258; and even if it did, Section 1258 cannot constitutionally be applied to deprive Dignity Health's MMCR of its religious freedoms. The relevant facts and evidence are summarized below.

A. Section 1258.

Section 1258 provides:

> No health facility which permits sterilization operations ***for contraceptive purposes*** to be performed therein, nor the medical staff of such health facility, shall require the individual upon whom such a sterilization operation is to be performed to meet any special ***nonmedical*** qualifications, which are not imposed on individuals seeking other types of operations in the health facility. Such

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> prohibited nonmedical qualifications shall include, but not be limited to, age, marital status, and number of natural children.
>
> ***Nothing in this section shall prohibit requirements relating to the physical or mental condition of the individual*** or affect the right of the attending physician to counsel or advise his patient as to whether or not sterilization is appropriate. This section shall not affect existing law with respect to individuals below the age of majority. (Emphasis added).

Section 1258 was enacted in 1972 in order to address a then-common practice of health care providers refusing to perform contraceptive sterilization procedures on women whom they paternalistically deigned too young to make the decision for themselves and/or women who had not already given birth to several children.

Until 1969, the American College of Obstetricians and Gynecologists ("ACOG") endorsed an "age-parity stipulation," which provided that a woman could not qualify for voluntary sterilization unless her age multiplied by the number of her children equaled 120.[6] Under such a rule, for example, a mother of three could not obtain a tubal ligation until she was 40 years old. This paternalistic test was plainly based upon arbitrary socio-economic factors and policies consistent with ACOG's "Rule of 120" that existed at hospitals across the country at that time.[7]

Before about 1970, tubal ligations were rarely performed, as the procedure required open abdominal surgery, general anesthesia, and a multiple-day hospital stay.[8] As less invasive procedures for tubal ligation became more common, demand for the procedure grew rapidly. However, the so-called "age/parity policies" imposed in the 1950s remained in place in most hospitals.[9]

In 1972, State Senator Anthony C. Beilenson recognized the growing demand for voluntary contraceptive surgical procedures, and stated his intent to eliminate the age/parity stipulations used to limit such procedures, while also preserving the rights of facilities to prohibit

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[6] McGrath Decl., ¶ 5, Ex. 25 (http://emedicine.medscape.com/article/266799-overview).
[7] *See, e.g.*, McGrath Decl., ¶ 7, Ex. 27 (Rebecca M. Kluchin, FIT TO BE TIED: STERILIZATION AND REPRODUCTION RIGHTS IN AMERICA 1950-1980 (2011)) at p. 69.
[8] *See id*.
[9] *Id*. at p. 22. According to Kluchin, many hospitals had even more restrictive policies of 150 or more "points." *See also* McGrath Decl., ¶ 8, Ex. 28 (Peter R. Forbes, *Voluntary Sterilization of Women as a Right*, 18 DE PAUL L. REV. 560 (1969)), at 562.

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such procedures. Senator Beilenson introduced Senate Bill No. 1358, which became Health & Safety Code Section 1258.[10] (McGrath Decl., ¶ 6, Ex. 26.) Senator Beilenson stated that the bill would eliminate "arbitrary" "non-medical qualifications [that] usually relate to the age of the patient and the number of children the patient already has . . . . Frequently, it boils down to a numbers game of sorts with 120 being the magic number. . . . SB 1358 would end this situation."[11] (*Id*.) Senator Beilenson "emphasized" that the bill "would not force any hospital or any clinic to offer sterilization services if they choose not to."[12] (*Id*.)

The legislative history of Section 1258 reflects no legislative intent to interfere with the ethical and moral decision-making of religious institutions. Rather, it makes clear that the intent was to eliminate the use of socio-economic factors, such as age, but only when those factors are used in an arbitrary, nonmedical way.[13] The staff analysis of the bill notes that "some hospitals and clinics have imposed certain non-medical criteria (usually as to age and number of children) as qualifications for voluntary sterilizations. The most common standard in this regard has been the so-called '120 point system' . . . ." (McGrath Decl., ¶9, Ex. 29.) The bill "would prohibit imposition of *such* non-medical standards." (*Id.* (emphasis added).) Indeed, less than ten years after Section 1258 was enacted, the Court of Appeal found that "[t]he 'nonmedical qualifications' named in the statute—age, marital status, number of children—*unambiguously* imply that the evil in mind is the use of socio-economic factors to determine whether or not to permit an individual

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[10] Senate Bill No. 1358 added several sections to the Health & Safety Code. However, Section 1416, the provision applicable to voluntary contraceptive procedures at general hospitals, was inadvertently deleted one year later. In 1974, the Legislature passed Senate Bill No. 1872, which re-added the statute as Section 1258. The legislative history reflects that Senate Bill No. 1872 was presented to address Section 1416's inadvertent deletion, and was "aimed at halting use of the so-called '120 point' system then employed at many hospitals." (McGrath Decl., ¶ 9, Ex. 29.)

[11] In finding earlier that "[n]othing in the language or the legislative history of [Section 1258] limits [its] reach only to consideration of arbitrary factors" (McGrath Decl., ¶ 10, Ex. 30), this Court overlooked Senator Beilenson's own words. He was specifically concerned about the 120-point test, which used age and number of children in an arbitrary, nonmedical way.

[12] *See also* McGrath Decl., ¶ 11, Ex. 31 ("The author's office advises that [the bill] results from a survey showing that a large number of hospitals have been refusing to permit contraceptive sterilization operations because of institutional policies requiring conformity with various ratios based upon age and number of children. The purpose is to require discontinuance of these practices *while preserving the authority to consider physical and mental conditions* . . . ." (emphasis added)).

[13] The COVID-19 pandemic illustrates how age can be a medical risk factor. Moreover, consideration of religious doctrine as required by the ERDs is not an arbitrary, socio-economic factor of the type listed in Section 1258. Under the doctrine of ejusdem generis, the statute should be interpreted to extend only to factors similar in nature to the listed terms—"the kinds of things that are listed in [the] series." *Armin v. Riverside Comm. Hosp.*, 5 Cal. App. 5th 810, 834 (2016).

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to be sterilized." *California Med. Assn. v. Lackner*, 124 Cal. App. 3d 28, 37 (1981) (holding that waiting periods and special forms are not nonmedical qualifications, but rather are permissible requirements related to patient's mental condition) (emphasis added).

While Section 1258 identifies "age" as a prohibited consideration when used as a "nonmedical qualification[]," the Legislature did not forbid consideration of advanced maternal age as it directly relates to the *medical* condition of the patient. To the contrary, the Section 1258 expressly provides that a hospital may consider the "physical . . . condition" of the individual, without limitation. This may include advanced maternal age, which when combined with other risk factors, is a well-recognized contributor to an increased risk of uterine rupture and maternal morbidity. *See infra* Part V(B).

B. Dignity Health and MMCR Are Part of the Catholic Church

Dignity Health, and the Catholic hospitals it owns and operates (including MMCR as well as the other Catholic hospitals at issue in this case), are fundamentally a part of the Catholic Church and their decision-making and operations are controlled by Catholic doctrine and teaching. This section demonstrates the essential connection of Dignity Health and its Catholic hospitals, and the health care they provide, to the Catholic Church.

Dignity Health is a California nonprofit public benefit corporation. Since February 2019, CommonSpirit has been the sole member of Dignity Health. CommonSpirit Health is a Colorado nonprofit corporation that was formed through the affiliation of Dignity Health and Catholic Healthcare Initiatives in 2019. (Declaration of Todd Strumwasser, M.D. ("Strumwasser Decl."), ¶¶ 5-6.) CommonSpirit is an official part of the Catholic Church and listed in the Official Catholic Directory ("OCD").[14] In particular, MMCR and Dignity Health's other Catholic hospitals are listed in the OCD as part of the Diocese of Sacramento.[15] The listings in the OCD reflect that the Bishop of Sacramento has made a determination that these entities are an official

[14] As set forth in Dignity Health's prior summary judgment motion, Dignity Health's structure before the ministry alignment was similar. The Sisters of Mercy were Dignity Health's founders and sponsoring congregations, and Sisters of Mercy and the Catholic Hospitals were all listed in the OCD.

[15] Petition, ¶¶ 51-54; Declaration of Sr. Brenda O'Keeffe (filed with Respondent Dignity Health's Appendix In Support Of Trial Brief, Vol. I) ("O'Keeffe Decl."), ¶ 9, Ex. 10; McGrath Decl.,¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1) at 25:3-4.

part of the Catholic Church. (O'Keeffe Decl., ¶ 9; Declaration of Michael Cox ("Cox Decl."), ¶ 2.)[16]

The Catholic Church is an hierarchical organization controlled locally by Catholic Bishops and ultimately by Pope Francis and the Vatican. The Catholic Church's control with respect to Dignity Health and its Catholic hospitals is asserted through legally binding documents, including articles of incorporation, corporate bylaws, medical staff bylaws and rules and regulations reflecting sponsorship by an appropriate ecclesiastical authority, commitment to the healing ministry of Jesus, and a prohibition on actions that violate Catholic religious doctrine and moral teaching, including the ERDs. Thus, under their governing documents Dignity Health and its constituent hospitals must comply with the ERDs.

Specifically, Dignity Health's Restated Articles of Incorporation state:

> This corporation's primary purpose is to provide health care services and related support functions. In fulfilling its purposes, this corporation continues the mission of service of the Roman Catholic Church (the "Church") through the health care ministry of Catholic Health Care Federation, a public juridic person within the meaning of the Code of Canon Law of the Church. *In furtherance of its purposes, **this corporation shall operate in conformity with the ethical and moral teachings of the Roman Catholic Church and the Ethical Religious Directives for Catholic Health Care Services as approved and amended by the United States Conference of Catholic Bishops***. (Strumwasser Decl., ¶ 13, Ex. 5 (emphasis added).)

Article III of Dignity Health's Amended and Restated Bylaws, entitled "Healing Ministry," provides that Dignity Health is committed to the healing ministry of Jesus,[17] shall follow and express the mission and values of the healing ministry in all of its operations,[18] and shall operate in conformity with the ERDs.[19]

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[16] *See also Means v. U.S. Conference of Catholic Bishops*, 2015 WL 3970046, at *7 (W.D. Mich. June 30, 2015) (IRS relies on the OCD to determine whether an entity is part of the Catholic Church), *aff'd* (6th Cir. 2016) 836 F.3d 643.

[17] "Healing Ministry. This Corporation, pursuant to the legacy of the Sponsor, as identified in these bylaws, is committed to continuing a healing ministry based on the life and works of Jesus in the provision of healthcare services in the communities it serves . . . ." Strumwasser Decl., ¶ 14, Ex. 6, § 3.1.

[18] "Expression of Ministry. This Corporation shall follow the mission and values of the healing ministry, which are intended to apply to all of its activities and operations. The mission of this Corporation is to deliver compassionate, high-quality, affordable health care; serve and advocate for those sisters and brothers who are poor and disenfranchised; and partner with others in its communities to improve the quality of life. In carrying out the healing ministry, this Corporation shall at all times embrace the values of dignity, collaboration, justice, stewardship, and excellence." *Id*., § 3.2.

[19] "Ethical and Religious Directives. *In striving to fulfill its healing ministry, this Corporation hall operate in conformity with the Ethical and Religious Directives for Catholic Health Care Services, as approved and amended from time to time by the United States Conference of Catholic Bishops.*" *Id*., § 3.3 (emphasis added).

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As for CommonSpirit Health, its Amended and Restated Articles of Incorporation provide in Section 3.1, entitled "Mission":

> The mission of the Corporation is to nurture the healing ministry of the [Catholic] Church, supported by education and research. Fidelity to the Gospel urges the Corporation to emphasize human dignity and social justice as it creates healthier communities. The Corporation, sponsored by a lay-religious partnership, calls other Catholic sponsors and systems to unite to ensure the future of Catholic health care. To fulfill this mission, the Corporation, as a values-based organization and in partnership with laity and others, will assure the integrity of the ministry in both current and developing organizations and activities; research and develop new ministries that integrate health, education, pastoral, and social services; promote leadership development throughout the entire organization; advocate for systemic changes with specific concern for persons who are poor, alienated, and underserved; and steward resources by general oversight of the entire organization. (*Id.*, ¶ 9, Ex. 3.)

Section 3.2 of CommonSpirit Health's articles provides that CommonSpirit Health's "Purpose" is to:

> perform the functions of, and/or to carry out the religious, charitable, scientific, and educational purposes, . . . of the Catholic Health Care Federation, a public juridic person within the meaning of the Code of Canon Law for the Roman Catholic Church ("Canon Law"), including by supporting such other charitable organizations, the purposes of which are to embody the mission of the healing ministry of Jesus in the Church through ownership, management, or governance of health ministries, or the offering of or supporting of charitable and religious programs or services consistent with such purposes, in keeping with the Gospel imperative. ***The Corporation shall be operated exclusively in furtherance of these purposes and in conformity with the ethical and moral teachings of the Roman Catholic Church and the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the United States Conference of Catholic Bishops***.

(*Id.*, ¶ 10, Ex. 3 (emphasis added).)[20]

CommonSpirit, the sole member of Dignity Health, is sponsored by the Catholic Health Care Federation ("CHCF"), which is a public juridic person under Canon Law. (*Id.*, ¶ 7.) Public juridic persons are the official constitutive parts of the Catholic Church and the primary means through which the Church acts in the world. *Medina v. Catholic Health Initiatives*, 877 F.3d

[20] *See also id.*, ¶ 11, Ex. 4 (CommonSpirit Health's Amended and Restated Bylaws), § 1.3 ("The Corporation was founded by Religious Institutes of the Roman Catholic Church. Health and human services are among the ministries of these Religious Institutes. The Corporation, as an ecclesiastical endeavor, functions as a public juridic person under the name Catholic Health Care Federation ("CHCF"). CHCF will serve as the canonical sponsor of all of the Catholic ministries that are a part of the Corporation."); § 1.8 ("The Corporation and all of the activities of the Corporation that are Catholic ministries shall be conducted in accordance with the Ethical and Religious Directives for Catholic Health Care Services, as promulgated from time to time by the United States Conference of Catholic Bishops".

1213, 1222 (10th Cir. 2017). A public juridic person must be established by an ecclesiastical authority and may acquire, retain, administer and alienate property in the name of the Catholic Church.[21] (Strumwasser Decl., ¶ 7.) The ecclesiastical authority that established CHCF is the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life (the "Congregation"), which was founded by Pope Sixtus V in 1586. (*Id.*, ¶ 7.)

As for CHCF, the sponsor of CommonSpirit Health, the Statutes of CHCF provide that its purpose is to:

> [E]mbody the mission of the healing ministry of Jesus in the Church through the ownership, management and governance of health ministries, and the offering of programs and services consistent with that purpose in keeping with the Gospel imperative. Its operation shall be conducted in a manner which is consistent with the teaching and laws of the Roman Catholic Church. It will adhere to the Ethical and Religious Directives for Catholic Health Care Services promulgated by the United States Conference of Catholic Bishops (or any successor organizations) as interpreted by the local Ordinary. (*Id.*, ¶ 7, Ex. 2, Article Two.)

The Statutes of CHCF further provide that the Congregation must "maintain vigilance that the integrity of the faith and morals is preserved" and must "monitor the use of the temporal goods of the juridic person to determine if the use is in accord with the purposes of the CHCF." (*Id.*, Article Five; *see also id.*, Article Eight ("The Members of [CHCF] shall administer the temporal goods of [CHCF] in accord with the Code of Canon Law.").) These "temporal goods" include the real estate on which MMCR and Dignity Health's other Catholic hospitals operate, which is owned and controlled by CHCF. (*Id.*; *see also id.*, ¶ 5, Ex. 1 (Ministry Alignment Agreement), § 4.4.) Similarly, CommonSpirit Health's Bylaws provide: "Under Canon Law, CHCF shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to CHCF. No alienation, within the meaning of Canon Law, of property considered stable patrimony of CHCF shall occur without the prior approval of CHCF." (Strumwasser Decl., ¶ 11, Ex. 4, Section 1.5.)

[21] Established pursuant to the Code of Canon Law, public juridic persons are aggregates of persons (universitates personarum) or of things (universitates rerum) which are constituted by competent ecclesiastical authority so that, within the purposes set out for them, they fulfill in the name of the Church, according to the norm of the prescripts of the law, the proper function entrusted to them in view of the public good. See Codex Iuris Conanici [hereinafter "CIC"] cc. 113-123 (1983) (available at http://www.vatican.va/archive/ENG1104/__PD.HTM) (last accessed September 17, 2020), c. 116 § 1.

[22] McGrath Decl., ¶ 17, Ex. 37 (https://www.dignityhealth.org/bayarea/locations/stmarys/about-us/history).

Thus, the governing documents of CHCF require that the real and personal property on which MMCR operates must be used in accordance with Catholic religious doctrine.

Finally, the Bylaws of the independent self-governing Medical Staff at the MMCR and the other Catholic Hospitals recognize that the Catholic Hospitals are bound to follow the ERDs, and commit the members of the Medical Staffs to do so as well. (Declaration of James De Soto, M.D. ("De Soto Decl."), ¶ 3, Ex. 18; McGrath Decl., ¶ 15, Ex. 35 (De Soto Depo Vol. 2), 48:3-49:6.) For instance, the Medical Staff Bylaws of MMCR recognize that "Mercy Medical Center Redding is a Catholic Health Facility . . . . As a Catholic Institution it is recognized that these Bylaws must conform to the [ERDs], as approved by the National Conference of Catholic Bishops." (De Soto Decl., ¶ 3, Ex. 18.) The Rules & Regulations of the MMCR Medical Staff, which also bind the members of the Medical Staff, provide that "[t]he medical staff, acknowledging that the hospital operates as an extension of the religious works of the Sponsoring Congregations of Dignity Health, agrees that the actions of the medical staff and its members, within the facilities, departments and programs of the hospital, shall conform to the [ERDs]." (*Id*., Ex. 19.) The Rules & Regulations further state that "any procedure that results in sterilization must be performed according to Hospital policies and procedures." (*Id*.)

C. Dignity Health's Long History of Ministering to the Sick and Carrying Out the Healing Ministry of Jesus.

Dignity Health's website explains that Dignity Health is "committed to furthering the healing ministry of Jesus. We dedicate our resources to: Delivering compassionate, high-quality, affordable health services; Serving and advocating for our sisters and brothers who are poor and disenfranchised; and Partnering with others in the community to improve the quality of life." (McGrath Decl., ¶ 16, Ex. 36.) In fact, Dignity Health and its hospitals have been recognized as Catholic entities and part of the Catholic Church for 150 years. That strong Catholic identity is at the heart of the dispute over sterilization services here and at the heart of Dignity Health's constitutional arguments based on freedom of religion. *See infra* Section VI.

Dignity Health operates 19 Catholic hospitals in California, Arizona, and Nevada. (O'Keeffe Decl., ¶ 3.) Dignity Health was founded in 1986, under the name Catholic Healthcare

West, through the merger of Catholic hospitals sponsored by the Sisters of Mercy Auburn and the Sisters of Mercy Burlingame. (O'Keeffe Decl., ¶ 4.) Religious orders that carry out the Catholic Church's mission in various ways, including through sponsorship relationships, are guided by Canon Law, and are themselves considered in Catholic doctrine to be acting on behalf of the Catholic Church. (O'Keeffe Decl., ¶ 5.)

The Sisters of Mercy is the second largest order of women religious in the world. Founded in Dublin over 200 years ago, the Sisters of Mercy is a teaching-nursing-social services congregation.[22] Service is one of the core values that inspires the Sisters of Mercy to carry out their mission of mercy: "We see Jesus in the most marginalized people and take a vow of service to perform works of Mercy that alleviate suffering. We strive to follow Jesus' example in all that we do."[23]

The Sisters of Mercy have served California's neediest continuously since 1854, starting in San Francisco. At the time, San Francisco was a public health disaster; it had only one hospital, which was closed to most people, including the indigent and minorities, and going to the hospital was wholly inadequate:

> [V]ery little can be said for manner in which [the hospitals'] deeds of mercy were conducted. The mortality was high, so high that entrance into the hospital was tantamount to entrance into the grave. . . . [I]nfection was the rule.[24]

In December 1854, eight Sisters of Mercy came to San Francisco from Ireland to care for the city residents, at the request of San Francisco's Archbishop. Upon arrival, the Sisters received Holy Communion from Father Hugh Gallagher who "placed their new foundation in the provident care of God and His Immaculate Mother, Mary."[25]

"Within a few days [of their arrival] things were different. Disgruntled but reluctantly industrious male attendants demoted from nursing to janitor service scrubbed and swept under the sharp eye of a minute but determined Sister of Mercy. Dirt flew out of corners. . . .

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[22] McGrath Decl., ¶ 17, Ex. 37 (https://www.dignityhealth.org/bayarea/locations/stmarys/about-us/history).
[23] McGrath Decl., ¶ 18, Ex. 38 (https://www.sistersofmercy.org/about-us/mission-values/).
[24] McGrath Decl., ¶ 19, Ex. 39 (Gardner, Frances Tomlinson, *The Gold Rush and a Hospital*, 11 BULLETIN OF THE HISTORY OF MEDICINE, no. 4, pp. 382-83 (1942), *available at* www.jstor.org/stable/44451970).
[25] McGrath Decl., ¶ 20, Ex. 40 Herron, Mary Eulalia, *The Works of the Sisters of Mercy in the Archdiocese of San Francisco* 1854-1921, 34 RECORDS OF THE AMERICAN CATHOLIC HISTORICAL SOCIETY OF PHILADELPHIA no. 2, 113, 121 (1923), *available at* www.jstor.org/stable/44209798.

Reorganization had begun."[26] In September 1855, when cholera ravaged San Francisco,[27] the Sisters of Mercy offered their services for the public welfare.[28] One newspaper observed:

> As soon as the Sisters of Mercy, whose convent is opposite the hospital, learned the state of things, they hurried to offer their services. They did not stop to inquire whether the poor sufferers were Protestant or Catholics, Americans or foreigners, but with the noblest devotion, applied themselves to their relief. . . . The idea of danger never seems to have occurred to these noble women; self was lost sight of.[29]

In October 1855, the County of San Francisco asked the Sisters of Mercy to take charge of the county hospital.[30] Their contract with the County provided that "the Sisters of Mercy known in this community as philanthropists who refuse all pecuniary reward for their self-sacrificing devotion to the sick and destitute—shall provide for the care and maintenance of the indigent sick."[31] Although the Sisters would receive no remuneration, the County agreed to continue paying the hospital's bills.[32] When the County reneged, the Sisters exhausted their own resources and then obtained loans to keep the hospital operating.[33] Finally, with support of the San Francisco Catholic community, the Sisters of Mercy bought the hospital in July 1857 and renamed it St. Mary's Hospital. This Dignity Health hospital is now the oldest continuously operating hospital in the city.[34] The Catholic Directory of 1857 chronicled the Sisters of Mercy's good works.[35] St. Mary's became "the principal private hospital in town and rapidly grew not only more and more efficient, but fashionable and elegant."[36]

The Sisters of Mercy's mission and the need for their services led them to Yreka in 1871,

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[26] Gardner, *supra*, at 384.
[27] McGrath Decl., ¶ 21, Ex. 41 (https://www.maritimeheritage.org/ships/Steamships_T-to-Z.html#SSUncleSam); *see also* Herron, *supra*, at 118, 124.
[28] Herron, *supra*, at 124.
[29] Herron, *supra*, at 125. "During this period the Sisters were everywhere, helping, nursing, and instructing." Gardner, *supra*, at 384.
[30] Herron, *supra*, at 125-26.
[31] Herron, *supra*, at p. 126; McGrath Decl., ¶ 22, Ex. 42 (https://history.library.ucsf.edu/1868_hospitals.html); ¶ 33, Ex. 33 (http://supportmercynorth.org/about-us/sisters-of-mercy/sisters-of-mercy-history-).
[32] Herron, *supra*, at 126.
[33] Herron, *supra*, at 128.
[34] *Id*.; McGrath Decl., ¶ 17, Ex. 37 (https://www.dignityhealth.org/bayarea/locations/stmarys/about-us/history).
[35] "The building . . . recently occupied as the State Hospital, is occupied by the Sisters of Mercy, who take care of the city and county sick, and have a Mercy House for all respectable servant girls that have no home . . . ." Herron, *supra*, at 123.
[36] Gardner, *supra*, at 384.

and then to Red Bluff, where they opened the Academy of Our Lady of Mercy (K-12) in 1882.[37] In 1907, they accepted a donation to operate what became known as St. Elizabeth Community Hospital.[38] In the late 1940s, the Sisters of Mercy assumed responsibility for St. Caroline's Hospital, now known as MMCR, and in 1986, they acquired the hospital in Mt. Shasta and renamed it Mercy Medical Center Mount Shasta.

The Sisters' tradition of carrying out the healing ministry of Jesus continues in Dignity Health hospitals today. The Dignity Health Sponsorship Council is composed of representatives of the Sponsoring Congregations who sponsor Dignity Health's Catholic facilities. (Declaration of Elizabeth Keith ("Keith Decl."), ¶ 6.) One of the roles of these Sponsoring Congregations is to ensure that Dignity Health operates with dedication to the healing ministry of Jesus Christ. As relevant to this case, MMCR's mission as a Catholic health care institution to provide care to everyone in the community, consistent with the tradition and mission of the Sisters of Mercy is the reason that MMCR maintains a labor and delivery ward—the only one in a 70-mile radius. (Petition, ¶ 37; McGrath Decl., ¶ 14, Ex. 33 (O'Keeffe Depo. Vol. 1), 56:7-22). The region's only public hospital, Shasta General Hospital, closed in 1987 because the county ran out of money to operate it.[39] And Shasta Regional Medical Center, a for-profit licensed acute care hospital less than two miles from MMCR, does not provide obstetrics or maternity care because it is not a profitable service line for hospitals.[40]

D. The Ethical and Religious Directives for Catholic Health Care Services Govern the Catholic Hospitals' Provision of Health Care.

This dispute arose because, as described above, MMCR (and Dignity Health's other Catholic Hospitals) is governed by and required to adhere to Catholic religious doctrine and moral teaching, including the ERDs.

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[37] McGrath Decl., ¶ 34, Ex. 54 (https://www.supportmercynorth.org/about-us/sisters-of-mercy/sisters-of-mercy-history-).

[38] *Id*.

[39] McGrath Decl., ¶ 23, Ex. 43 (https://www.latimes.com/archives/la-xpm-1987-12-06-mn-27160-story.html).

[40] McGrath Decl., ¶ 24, Ex. 44 (https://www.beckershospitalreview.com/finance/how-hospitals-can-tackle-the-profitability-crisis.html); ¶ 25, Ex. 45 (https://www.medscape.com/courses/section/891121); ¶ 26, Ex. 46 (https://www.shastaregional.com/about-us/about-prime-healthcare/). Ironically, under a prior owner Shasta Regional Medical Center was the location of one of the nation's worst False Claims Act scandals involving physicians allegedly performing hundreds of unnecessary cardiac procedures on healthy patients. McGrath Decl., ¶ 27, Ex. 47 (https://www.sfgate.com/health/article/A-heart-surgery-scandal-revisits-Redding-in-print-2616602.php).

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1. The ERDs.

The ERDs, which are promulgated by the U.S. Conference of Catholic Bishops, reflect the Catholic Church's internal decision-making regarding the scope and breadth of required Catholic health care services. (Declaration of the Most Reverent Bishop Jaime Soto ("Bishop Soto Decl."), ¶ 4; O'Keeffe Decl., ¶ 10, Ex. 11 (ERDs); Petition, ¶ 52.) The ERDs require all Catholic hospitals to serve and care for those most in need, in accord with the Gospel of Jesus Christ and the moral tradition of the Church, and are the culmination of centuries of efforts of Catholic health care practitioners to minister in accord with the Church's teaching. (O'Keefe Decl., ¶ 10, Ex. 11, p. 4, Directives 1, 3, 8.) The ERDs provide the theological basis for the Catholic health care ministry, and are adopted to provide uniform instructions to Catholic health care providers on ethical medical practices. (*Id*.)

The ERDs' purpose is to "reaffirm the ethical standards of behavior in health care that flow from the Church's teachings about the dignity of the human person" and "to provide authoritative guidance on certain moral issues that face Catholic health care today." *Means*, 2015 WL 3970046, at *3 (quoting the Preamble to the ERDs). "Individual bishops exercise authority under Canon law to bind all Catholic health care institutions located within their diocese to the ERDs as particular law within the diocese." *Id.* at *3; *see also* Bishop Soto Decl., ¶ 4. Thus, Directive 5 provides that "Catholic health care services [which include the Catholic Hospitals] *must adopt these Directives* as a policy, [and] *require adherence to them* within the institution as a condition for medical privileges and employment ...." (O'Keeffe Decl., ¶ 10, Ex. 11, Directive 5 (emphasis added).)

A Catholic hospital risks the Bishop's revocation of its Catholic status under Canon Law if it does not comply with the ERDs.[41] Petitioners concede that Dignity Health's Catholic

[41] As Sacramento's diocesan Bishop Soto explains, "I perform the triple apostolic functions of teacher of doctrine, priest of sacred worship and pastor of church governance." (Bishop Soto Decl. ¶ 2.) And, "[u]nder Canon Law, I exercise my authority to bind all Catholic health care institutions located within the Diocese to the … ERDs." (Bishop Soto Decl. ¶ 4.) Bishop Soto himself "was involved in the formulation and … review[] [of] the Sterilization Policy" to assure that it "comports with [his] interpretation of the ERDs." (Bishop Soto Decl. ¶ 5.) *See also* McGrath Decl., ¶ 30, Ex. 50 (O'Rourke et al., *A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services* (Dec. 2001) HEALTH PROGRESS), p. 18; ¶ 31, Ex. 51 (Dec. 21, 2010 Decree of Bishop Thomas J. Olmsted Revoking Episcopal Consent to Claim the "Catholic" Name regarding St. Joseph's Hospital and Medical Center in Phoenix, Arizona).

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hospitals are required to comply with the ERDs. (Petition, ¶¶ 51-54; McGrath Decl., ¶¶ 28-29, Exs. 48-49 (Petitioners' Responses to RFA No. 2).)

2. The ERDs Respect the Sanctity of Life.

The ERDs require Catholic hospitals to defend and protect "sanctity of life 'from the moment of conception until death.'" (O'Keeffe Decl., ¶ 10, Ex. 11, p. 16 (ERDs, Part Four, Introduction).) Directive 44 requires Catholic hospitals to provide "prenatal, obstetric, and post-natal services in a manner consonant with [their] mission." (*Id*., p. 18.) Directive 52 prohibits promoting or condoning contraceptive practices: "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." (*Id.*, p. 19.) Numerous ERDs impose requirements as to other specific procedures.[42]

Directive 53 bars direct sterilization procedures: "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. 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." (*Id.*, p. 19.)

Directive 70 prohibits cooperation with direct sterilization: "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as . . . direct sterilization." (*Id*., p. 25.)

3. The ERDs Emphasize Pastoral Care.

Delivery of pastoral care, directed to the spiritual needs of each person, is an integral part of Catholic health care, and the sterilization review process at the Catholic Hospitals is part of the delivery of pastoral care. Catholicism defines the concept of "pastoral theology" as "the care of souls."[43] "Canon law collects, correlates, and co-ordinates the laws of the Church; pastoral theology applies those laws to the care of souls. In brief, pastoral theology begins, where the

[42] Directive 41 prohibits artificial fertilization. Directive 42 prohibits surrogacy. Directive 45 prohibits abortion. (O'Keeffe Decl., ¶ 10, Ex. 11.)

[43] McGrath Decl., ¶ 32, Ex. 52 (Drum W., "CATHOLIC ENCYCLOPEDIA: PASTORAL THEOLOGY" (1912); *available at* http://www.newadvent.org/cathen/14611a.htm).

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other theological sciences leave off; takes the results of them all and makes these results effective for the salvation of souls through the ministry of the priesthood established by Christ."[44]

As stated in the ERDs,

> The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person." Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace. (O'Keeffe Decl., ¶ 10, Ex. 11, p. 10.)

With respect to the provision of health care:

> [T]he priest must not only know the nature of the sacraments, so far as dogmatic theology explains it, besides what is needed for their valid administration, as taught in moral theology, but must also possess such additional knowledge as may serve him in his spiritual ministrations — for instance, in attending the sick, *in advising what is lawful or unlawful in critical operations, especially in such as may affect childbirth*; in directing others, when necessary, how to baptize the unborn child; in deciding whether to confer extreme unction or other sacraments in cases of apparent death, etc.[45]

Additionally, pastoral care involves application of Catholic teaching to an ever-changing society, in conjunction with the priest's or clergyperson's own experiences:

> [A]s pastor, a variety of duties have to be mastered, which keep growing and varying in number constantly with the complicated conditions of modern life, especially wherever there is a tendency to mass people together in large cities, or wherever migration to and fro causes frequent change. This, perhaps, is the main part of pastoral theology. The organization of parishes; the maintenance of a church and other institutions that grow up around it; the management of parish schools; the formation of societies for men and women, young and old; the vast number of social works into which a priest in a modern city is almost necessarily drawn — all these points furnish material for instruction, which, as the fruit of experience, can rarely be conveyed through books.[46]

The ERDs recognize that "pastoral care is an integral part of Catholic health care." (O'Keeffe Decl., ¶ 10, Ex. 11, p. 10.) In modern Catholic hospitals, priests, deacons, women religious, and even lay persons can exercise pastoral care, and "many areas of pastoral care call upon the creative response of these pastoral caregivers to the particular needs of patients or

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[44] *Id*.
[45] McGrath Decl., ¶ 32, Ex. 52 (Drum W., "CATHOLIC ENCYCLOPEDIA: PASTORAL THEOLOGY" (1912); *available at* http://www.newadvent.org/cathen/14611a.htm). (emphasis added).
[46] *Id*.

residents . . . ." (*Id*.,, p. 10 (Directive No. 10), p. 15 (Directive No. 37).

E. MMCR's Sterilization Policy and Request/Review Process.

1. The Sterilization Policy.

Dignity Health does not have a single, system-wide sterilization policy. The sterilization policy (if any) for each Dignity Health hospital is prepared at the local hospital level and approved by the applicable Hospital Community Board. (Keith Decl., ¶ 5.) MMCR and the other Catholic Hospitals have sterilization policies. (O'Keeffe Decl., ¶ 13, Ex. 12; Cox Decl., ¶ 6.)

Like the ERDs, the Hospitals' respective sterilization policies reflect internal management decisions by entities that are part of the Catholic Church regarding the scope of services provided at each respective Catholic Hospital. As Sister O'Keeffe explains, the sterilization policies "govern[] our ability to adhere to the Ethical and Religious Directives for Catholic Health Care Services." (McGrath Decl., ¶ 12, Ex. 32, at 170:7-24.) In accordance with Catholic doctrine, Sacramento Bishop Soto "was involved in the formulation and … review[] [of] the Sterilization Policy" to assure that it "comports with [his] interpretation of the ERDs." (Bishop Soto Decl. ¶ 5.)

The Sterilization Policies state that the hospital's "Mission is accomplished in accordance with the teachings of the Roman Catholic Church ('Church'), and is specifically guided by the Ethical and Religious Directives for Catholic Health Care Services ('Ethical Directives'). In all aspects of Catholic health care ministry, the Ethical and Religious Directives for Catholic Health Care Services are adhered to."[47] (O'Keeffe Decl., ¶¶ 13 and 15, Ex. 12.) The Sterilization Policies were adopted to adhere to the ERDs, based on the policy drafted by the mission leader in Sacramento in concert with Bishop Soto. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 60:10-14; ¶ 33, Ex. 53 (O'Keeffe PMK Depo.), 15:3-13.) MMCR's sterilization policy was approved by MMCR's Policy Review Committee, Ethics Committee, Medical Executive Committee, and the North State Service Area Community Board. (McGrath Decl., ¶ 77, Ex. 97 (De Soto Depo. Vol. 1), 83:23-84:12.) The sterilization policies for the Sacramento Catholic

[47] The purpose of the Sterilization Policy is to make clear that the North State Hospitals "do not do any sterilizations for the purpose of contraception." (McGrath Decl., ¶ 13, Ex. 33, at 42:24-43:11.)

Hospitals also reflect approval by the Hospitals' respective Medical Ethics Committees, the Medical Staffs' Medical Executive Committees, consisting of physician leaders of the medical staffs, and the Hospital Community Boards. (O'Keeffe Decl., ¶ 14.)

The Sterilization Policies for all of the Catholic Hospitals uniformly state that "tubal ligations or other procedures that induce sterility for the purpose of contraception are not acceptable in Catholic moral teaching." (O'Keeffe Decl., ¶¶ 13 and 15, Ex. 12.) The Sterilization Policies also uniformly cite to ERD 53, and note that "[n]ot every procedure that induces sterility is done for the purpose of contraception. ERD #53 – Procedures that induce sterility are morally acceptable when their effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." (*Id*.)

2. The Process for Requesting a Sterilization Procedure at MMCR.[48]

Under the ERDs, sterilization for contraceptive purposes is prohibited at MMCR, unless the patient's physician makes a showing, based on the patient's medical history, that a patient has a medical need for a sterilization, so that the purpose of the procedure is not contraceptive even though that is its effect. MMCR's Sterilization Policy provides that "[w]hen an attending physician is concerned about the moral acceptability of a medically indicated procedure for a patient, he or she will consult with the VP of Mission Integration prior to scheduling the procedure." (O'Keeffe Decl., ¶ 13, Ex. 12.) MMCR receives a considerable number of physician requests for consultation under the policy. MMCR and the other Catholic Hospitals have developed a Request for Sterilization ("Request") form that is filled out by the physician seeking to perform the procedure. (O'Keeffe Decl., ¶ 18; Ex. 15.) At MMCR, these Requests are reviewed by a hospital committee (the "Committee") which currently includes Sister Brenda O'Keeffe—MMCR's Vice President of Mission Integration and Spiritual Care Services—and Dr. James Desoto—Vice President, Medical Affairs at MMCR. (O'Keeffe Decl., ¶ 19.) The Committee previously also included the Chief Nurse Executive.[49] (*Id*.)

[48] The process for requesting a sterilization at the other Catholic Hospitals is materially the same. McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 24:24- 25:5; 27:23-29:5); ¶ 36, Ex. 56 (Michael Cox Depo.) 6:1-5; 20:8-22:4; 22:18-19; 38:15-40:25; 45:21-46:18; 50:1-52:5; 65:18-66:6; 69:18-70:25; ¶ 37, Ex. 57 (Dr. Caroline Reyes Depo.), 30:2-31:7.

[49] The Sterilization Committees at the other North State Hospitals are similarly comprised of a Mission representative

As explained by Sister O'Keeffe at her deposition, "in Catholic and moral teaching, you always have to look at the intent of the purpose. The intent [in permitting a sterilization procedure to be performed at the Hospital] is never for contraception. The intent is to cure a present pathology that is there." (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 43:12-18.) "Not every procedure that induces sterility is done for the purpose of contraception. That's what the distinction is. [The Hospitals do not] do them for contraception. But when there is serious pathology [the Hospitals] can do it." (McGrath Decl., ¶ 12, Ex. 32 (O'Keeffe Depo. Vol. 2), 178:4-12).)[50]

Thus, the MMCR Committee aims to ensure that, if a sterilization procedure is performed at the Hospital, "the purpose or the reason and the moral intent [behind the performance of the procedure] is never for contraception, but rather is there a medical necessity to really be able to do this for the patient at that time." (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 76:3-16.) The purpose of the MMCR Committee is "to achieve a consensus about whether the requests for sterilization might meet medical necessity or are instead, just a request for contraceptive tubal ligation." (McGrath Decl., ¶ 15, Ex. 35 (De Soto Depo. Vol. 1), 19:13-18.) MMCR has admitted Requests "when there is a medical necessity," based on the physical condition of the patient. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 43:12-18.)

The MMCR Committee meets once or twice a month to review Request forms submitted by physicians. (*Id*., 21:21-22:9.) The physicians are responsible for completing the Requests and identifying any medical indications they believe are relevant to the Request based upon their knowledge of their patient's medical history. (*Id*., 52:13-53:13, 71:14-20.) The MMCR Committee performs a case by case review of each request, looking "at what is documented by the physician" to determine whether to approve the request. (*Id*., 22:13-23, 32:22-23:7, 74:6-16; ¶ 13, Ex. 32 (O'Keeffe Depo. Vol. 2), 145:12-146:1.) Dr. De Soto reviews the medical information submitted by the physician, and Sister O'Keeffe focuses upon whether the Request

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and a physician, and also used to include a nurse. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 24:24-25:5; 27:23-29:5.)

[50] Petitioners' expert witness, Dr. Rebecca Jackson, admitted that the MMCR Sterilization Review Committee's review process involves consideration of "the ERDs and/or the hospitals' sterilization policies," which "reflects religious or moral based decision making." (McGrath Decl., ¶ 46, Ex. 66 (Jackson Report), ¶ 49.)

fits with the Sterilization Policy by interpreting it under the ERDs and Catholic Doctrine. (McGrath Decl., ¶ 15, Ex. 35 (De Soto Depo. Vol. 1), 20:23-21:2; ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 34:12-15, 35:5-7.)

The MMCR Committee consults and applies the ERDs in every sterilization request review it performs. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 39:2-9, 72:11-24.) As noted, Directive 44 requires Catholic hospitals to provide "prenatal, obstetric, and post-natal services in a manner consonant with [their] mission." Thus, MMCR's and the Catholic Hospitals' sterilization review process is compelled by their religious mandate, and the Committee's process for reviewing requests for tubal ligations involves "a pastoral application" of "Catholic moral and ethical teaching," and consideration of the fact that the Committee is "speaking on behalf of the Catholic Church." (*Id.*, 50:17-51:17.) Sister O'Keeffe emphasized that the review Committee is a product of the dedication to pastoral care described in the ERDs. This "pastoral application" is a "process of value-based discernment. It's what [the Committee is] deciding within the Catholic moral teaching. Is it within the purview of the Ethical and Religious Directives? And above, all, is this what is right for this patient and this family at this moment in time." (*Id.*, 37:3-38:5, 50:17-51:24.)

If the Committee denies a request, the physician receives a letter explaining the denial, asking for any additional information about the patient's condition that has not already been provided, and stating that the Request may be resubmitted. (*Id.*, 40:5-18.)

3. MMCR Considers Only Factors Related to the Physical Condition of the Individual Patient.

MMCR's Sterilization Review Committee does not consider or base its decisions on any of the factors prohibited by Section 1258, either together or with other factors, and neither do the other Catholic Hospitals' sterilization review committees. Petitioners have never contended that the Catholic Hospitals consider the marital status of the patient and Dr. Jackson agrees that the Catholic Hospitals do not consider the number of children that the patient has. (McGrath Decl., ¶ 38, Ex. 58 (Jackson Depo.), 43:19-22.) Nor do the hospitals ever consider the product of the patient's age multiplied by number of children in connection with whether to permit the requested

procedure.[51]

The Review Committees also consider the number of a patient's prior Caesarian sections, which do not reflect the number of children a patient may have. (McGrath Decl., ¶ 15, Ex. 35(De Soto Depo. Vol. 1), 45:24-46:10.) Caesarian sections can leave scars in the uterus that increase the risk of uterine rupture, which can lead to maternal and infant morbidity and mortality. (De Soto Decl., ¶ 16.) The Review Committee also considers the multiparity of the patient, which reflects the number of times a woman has given birth, and relates to the physical condition of the patient's uterus. (McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 92:17-19, 90:19-91:2, 115:12-17; ¶ 25, Ex. 35 (De Soto Depo. Vol. 1), 45:24-46:10, 51:4-10, 51:21-52:9.)

Dignity Health produced over 3,660 pages of documents reflecting over 500 Requests and responses from the Catholic Hospitals, including those from MMCR from April 1, 2015 through July 31, 2017 and the requests and related responses submitted to the other North State and Sacramento Hospitals in 2017. McGrath Decl., ¶ 81. The documents confirm that the Catholic Hospitals only consider the physical condition of the patient in connection with determining whether to allow a tubal ligation and do not grant or deny requests based on age alone.[52] For instance, at MMCR over 30% of Requests were granted for women under 30 years of age, and over half the denials were for women over 30 years of age.[53]

4. CHAN Healthcare Confirmed That MMCR's Process Is Consistent With Its Catholic Identity.

Dignity Health's sponsors periodically review its hospitals' compliance with the ERDs. In June 2015, CHAN Healthcare[54] performed "a Structured Analysis of key elements of the

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[51] Petition, ¶ 61, Ex. 6; McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 22:13-23, 32:22-33:7, 34:12-15, 35:5-7, 37:3-38:5, 42:24-43:18, 50:17-51:24, 52:13-55:13, 71:14-20, 72:11-24, 74:6-16, 76:3-16; ¶ 12, Ex. 32 (O'Keeffe Depo. Vol. 2), 145:12-146:1, 178:4-12; ¶ 15, Ex. 35 (De Soto Depo.), 19:13-18, 20:21-21:21, 45:24-46:10; ¶ 36, Ex. 56 (Cox Depo.), 38:15-39:20, 44:9-25, 70:7-25; ¶ 39, Ex. 59 (Van Kirk Depo.), 92:17-19; 90:19-91:2, 115:12-17; ¶ 38, Ex. 58 (Jackson Depo.), 37:6-10, 143:22-144:8, 171:7-172:17; ¶ 37, Ex. 57 (Reyes Depo.), 30:2-31:7. However, the review committee necessarily must considers all of the medical issues and other physical conditions of each patient. (*Id.*, ¶ 12, Ex. 32 (O'Keeffe Depo. Vol. II), 103:2-104:1; 147:11-148:1; 154:16-156:7.)

[52] In the over 500 Requests, there appears to be one instance when the Sacramento Hospitals considered the fact that a patient's insurance covered the procedure at another non-Catholic hospital where the patient's physician also had privileges. There is no evidence of any pattern or practice of considering a patient's insurance coverage.

[53] The documents show that requests were granted for a 20-year-old woman who had given birth one time and denied for a 43-year-old woman who had given birth to three children. Requests have been granted to patients who had never given birth, and denied to a patient who had given birth six times.

[54] The acronym "CHAN" stands for Catholic Healthcare Audit Network. *See*

Catholic identity of" MMCR, including "a comprehensive review of policies, practices and procedures in agreed upon areas to evaluate [MMCR's] implementation of the principles of" the ERDs. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 63:22-64:9; O'Keeffe Decl., ¶ 26, Ex. 17, at MMCR000367.) Its analysis included a review of MMCR's sterilization request review process during the time period relevant to the Petition. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 63:22-64:9; O'Keeffe Decl., ¶ 26, Ex. 17 at MMCR000540.) CHAN Healthcare completed its analysis and issued its final report in March 2016. (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 63:22-64:9; O'Keeffe Decl., ¶ 26, Ex. 17 at MMCR000540.) The CHAN Healthcare Structured Analysis included a review of MMCR's implementation of Directive 53 of the ERDs, and noted that "[a] formal request and approval process involving Mission Integration and Medical Staff is adhered to prior to [a tubal ligation in conjunction with a C-section delivery] being performed. Information, statistics, and a draft policy regarding this practice were shared/discussed with the Diocesan Bishop in 2013." (McGrath Decl., ¶ 13, Ex. 33 (O'Keeffe Depo. Vol. 1), 63:22-64:9; O'Keeffe Decl., ¶ 26, Ex. 17 at MMCR000540.)

The CHAN Healthcare Structured Analysis recognized that "Dignity Health . . . with respect to its Catholic facilities, abides by the Ethical and Religious Directives for Catholic Health Care Services. The . . . Ethical and Religious Directives are considered, as appropriate, in the development and application of policies and in the provision of health care services [at the Catholic facilities]." (O'Keeffe Decl., ¶ 26, Ex. 17 at MMCR000541.) CHAN Healthcare, through its Structured Analysis, "[c]onfirmed that in its practices and culture, . . . [MMCR] . . . ha[s] implemented the principles of the ERDs," and CHAN Healthcare "[f]ound no evidence that . . . [MMCR] . . . had practices that were inconsistent with the ERDs related to . . . direct sterilization based on substantive patient chart testing procedures." (*Id.* at MMCR000371.)

F. <u>Petitioners and Their Relevant Witnesses.</u>

1. Petitioner Rebecca Chamorro.

Chamorro is a married woman who already had two children when she became pregnant in 2015. Chamorro and her physician, Dr. Van Kirk, determined that her pregnancy would be

https://www.bloomberg.com/profile/company/6743684Z:US.

delivered by Caesarian section at MMCR, and Chamorro and her husband decided that she wanted to have a tubal ligation at the same time. Although Chamorro claims that she knew that MMCR was a Catholic hospital, it never "crossed her mind" that Catholic hospitals may not permit certain procedures for religious reasons. (McGrath Decl., ¶ 41, Ex. 61 (Chamorro Depo.), 13:8-14:5.)

On September 15, 2015, Dr. Van Kirk submitted a Request for a sterilization procedure on Chamorro's behalf, noting as the basis of the Request her "desire[] to have a tubal ligation." (Petition, ¶ 14, Ex. 2); McGrath Decl., ¶ 75, Ex. 95 (Chamorro Decl.), ¶ 9.) Dr. Van Kirk never explained the Request process to Chamorro or why a Request was required. (McGrath Decl., ¶ 41, Ex. 61 (Chamorro Depo.), 29:11-30:2.) The Request was reviewed by the MMCR Sterilization Review Committee, and was denied on September 18, 2015, consistent with MMCR Sterilization Policy and the ERDs. (Petition, ¶ 49, Ex. 3.) Dr. Van Kirk was informed by letter that the Request "does not meet the requirement of [MMCR's] current sterilization policy or the Ethical and Religious Directives for Catholic Health Services. Therefore, we cannot admit material cooperation to perform a tubal ligation at Mercy Medical Center Redding."[55] (Petition, Ex. 3.)

Chamorro understands that her physician's request for sterilization on her behalf was denied for religious reasons. (Petition, ¶ 4.) She alleges that as a result of MMCR's Sterilization Policy, she was prevented her from obtaining a postpartum tubal ligation, she incurred additional expenses related to contraception.[56] (Petition, ¶ 16.) Thus, Chamorro filed this lawsuit because she wanted a postpartum tubal ligation for contraceptive purposes: "I wanted to get a tubal ligation, and this was the route that could potentially give me the tubal ligation because I had been denied." (McGrath Decl., ¶ 41, Ex. 61 (Chamorro Depo.), 43:6-17; ¶ 76, Ex. 96 (Chamorro Decl.), ¶ 7; Petition, ¶¶ 13, 48.)

2. Petitioner Physicians for Reproductive Health.

PRH is an organization comprised of medical providers who work "to improve access to

[55] The Responses of Dignity Health hospitals to the Requests that Petitioners have cited uniformly cite the ERDs as the reason for denial of the procedure.

[56] Chamorro would have had the same expenses if MMCR prohibited all tubal ligations.

comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients."[57] Currently, PRH's website says, "Together, with our allies, we can build a future where no one goes without the reproductive health care they need."[58]

PRH alleges that its member physicians have patients who wanted tubal ligations, but could not obtain them based upon the Catholic Hospitals' Sterilization Policies, which prohibit contraceptive sterilization procedures based upon the ERDs. (Petition, ¶ 5.) As PRH's then-President and CEO, Jodi Magee, testified at deposition, "We are a part of this lawsuit because we want to see women get the care that they need and deserve, and we have an institutional stake in women getting care and doctors being able to provide best practices and standards of care across the country. That's part of the work we do in our mission." (McGrath Decl., ¶ 43, Ex. 63 (Magee Depo.), 39:22-40:12.) Yet, prior to filing this suit, PRH had not received any complaints regarding MMCR from physicians or patients (*Id.*, 32:4-22; 119:13-21; 138:1-21), nor could PRH identify any instance where a member complained about the sterilization policy at MMCR or at any other Dignity Health Catholic Hospital. (*Id.*, 62:6-16).[59]

PRH filed this lawsuit because it sought an order that the Catholic Hospitals cannot prohibit tubal ligation procedures based upon religious doctrine or belief. (*Id.*, 20:1-11, 72:7-17, 110:8-19; 122:24-123:8.) In deposition, Ms. Magee refused to acknowledge that an order resulting in MMCR stopping all tubal ligations would have a negative effect on access to health care. (*Id.*, 40:16-44:13.) However, in September 2018, PRH clearly communicated that view to the Attorney General, when it signed onto the letter (cited above) urging the Attorney General to require Dignity Health hospitals to

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[57] McGrath Decl., ¶ 44, Ex. 64 (https://prh.org/mission-and-history/).

[58] McGrath Decl., ¶ 45, Ex. 65 https://prh.org/. PRH continues, "We are doctors who use evidence, training, and organized action to champion your health care rights." Ironically, in this case, PRH's case would ensure that women in the North State Service Area cannot get the reproductive health they need. And PRH simply ignores the religious rights of Catholic institutions.

[59] PRH did submit a declaration in this case from Dr. Lindsey Dawson, a physician who is involved in another pending case alleging that Dignity Health improperly declined a transgender man's request for a hysterectomy. *Minton v. Dignity Health*, 39 Cal. App. 5th 1155, 1159 (2019) *petition for certiorari pending* Mar 17, 2020 (No. 19-1135). The fact that PRH could only identify *one* member physician with purported issues with Catholic Hospitals' sterilization policies—a physician who has repeatedly flouted the applicable hospital rules and regulations of a Catholic hospital—confirms that PRH members in general have not experienced the problem of which PRH complains at Dignity Health hospitals.

maintain their current levels of reproductive services as "exceptions" to the ERDs because "[m]any of the DH hospitals are located in the state's more rural areas. In some instances, these hospitals may be among the only available health providers in the area. Timely and adequate access to all health services is critical, and this is particularly the case when it comes to reproductive health services and other essential health services."[60]

3. Dr. Van Kirk

Dr. Van Kirk was Chamorro's obstetrician.[61] (McGrath Decl., ¶ 41, Ex. 61 (Chamorro Depo.), 17:11-14, 19:24-20:4; Petition, ¶ 57, Ex. 3.) Dr. Van Kirk believes that tubal ligations should be available at MMCR to any patient who requests one, and he objects to MMCR's sterilization Request and review procedure. (Petition, ¶ 26; McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 14:6-9, 116:2-120:11.) However, Dr. Van Kirk understands that MMCR is a Catholic hospital, and admitted that, to become a member of MMCR's medical staff, he agreed to follow the Medical Staff Bylaws and its Rules & Regulations. (McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 15:19-16:5, 42:9-44:3; 45:24-47:22; ¶¶ 28-29, Exs. 48-49, RFA No. 7.) Dr. Van Kirk knows that sterilization procedures at MMCR require approval by the Review Committee. (McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 15:19-16:5, 24:4-18).[62]

Dr. Van Kirk has had multiple conversations with Sister O'Keeffe and Dr. De Soto regarding MMCR's Sterilization Policy, beginning in 2010 when he joined MMCR's Medical Staff. (*Id.*, 49:22-52:25; ¶ 77, Ex. 97 (De Soto Depo. Vol. 2), 48:3-49:6.) At that time, Sister O'Keeffe explained to him that a written Request from the physician for a sterilization was required. (*Id.*) These discussions continued, through and including a detailed email from Dr. De Soto quoting *Uterine Rupture in Pregnancy* by Gerard G. Nahum, MD, FACOG,[63] two months before this lawsuit was filed. (Petition, Ex. 6.) Dr. De Soto "provide[d] a list of medical

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[60] McGrath Decl., ¶ 4, Ex. 24 (https://healthlaw.org/wp-content/uploads/2018/11/Coalition-Letter-Dignity-CHI-Merger-Sept.-2018.pdf).

[61] He also was the obstetrician of Rachel Miller and Lynsie Brushett, who were identified by the ACLU in correspondence with Dignity Health prior to the filing of this lawsuit but who did not file suit against Dignity Health or MMCR.

[62] However, he also testified that he does not believe that members of the medical staff are "required to review the medical staff bylaws." (*Id.*, 28:16-22.)

[63] http://reference.medscape.com/article/275854-overview

indications" considered in connection with tubal ligation requests and pointed Dr. Van Kirk to a scholarly article on the subject. (Petition, Ex. 6.)

Despite agreeing to comply with the ERDs, the Medical Staff Bylaws, and the Rules and Regulations, Dr. Van Kirk repeatedly ignores MMCR's instructions. In connection with submitting Requests for a sterilization, he *never* reviews his patients' medical records, because he personally believes such information is irrelevant; nor does he provide the medical information that MMCR has requested to determine whether to allow a tubal ligation procedure. (McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 99:10-100:7; 120:-121:11; 122:17-21; Ex. 37.) Dr. Van Kirk even refuses to use MMCR's Request form, and instead uses his own pre-printed form with an electronic signature, which his medical assistant prepares. (*Id.*, 89:1-90:18; 124:6-9; ¶ 98, Ex. 98 (Van Kirk Request for Sterilization).) Although the physical condition of each of Dr. Van Kirk's patients is different, every Request he has submitted is materially *identical*—down to the same typographical error. (McGrath Decl., ¶ 78, Ex. 98 (Van Kirk Requests for Sterilization); ¶39, Ex. 59 (Van Kirk Depo.), 97:7-24; 123:18-23.) For example, Dr. Van Kirk provided *identical* information regarding "medical indications" and other factors for Chamorro and another patient, and he failed to note one patient's acute chorioamnionitis and another's severe preeclampsia. (McGrath Decl., ¶ 78, Ex. 98 (Van Kirk Requests for Sterilization); ¶¶ 28-29, Exs. 48-49 (Chamorro Responses to RFAs), Nos. 30, 21, 33-34; Petition ¶ 58.)

Dr. Van Kirk referred Chamorro to the ACLU when MMCR denied her Request for a sterilization, and he did the same for other patients when their Requests were denied. (McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 7:1-15; ¶ 41, Ex. 61 (Chamorro Depo.), 35:17-36:5; Petition, Ex. 4.)

4. Dr. Jackson

Dr. Jackson is Petitioners' expert witness. Like PRH and Dr. Van Kirk, Dr. Jackson believes there should be no restrictions on the availability of postpartum tubal ligations if a healthy patient over the age of majority wants one. Dr. Jackson has no experience working at any Catholic hospital, nor did she do anything to learn about them in connection with her engagement. (McGrath Decl., ¶ 38, Ex. 58 (Jackson Depo.) 33:9-34:24.) Dr. Jackson is publicly hostile

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towards Catholic health care and Dignity Health specifically. In 2019, she signed a petition urging the University of California to refrain from an affiliation with Dignity Health that would have allowed the UC system to provide health services to thousands of patients that the UC system could not service in the Bay Area. (*Id.*, 180:17-183:8; ¶ 79, Ex. 99 (CHAM001738-815).)

When rendering her opinion and written report, Dr. Jackson was not shown and did not consider the second paragraph of Section 1258, which permits health facilities to consider the "physical … condition" of the patient, and did not understand what it means. (McGrath Decl., ¶ 46, Ex. 66, ¶ 8; ¶ 38, Ex. 58 (Jackson Depo.), 100:15-103:25.) Dr. Jackson agreed that the Hospitals do not consider the number of children a patient has, and she agreed that advanced maternal age can be a risk factor for uterine rupture. (McGrath Decl., ¶ 38, Ex. 58 (Jackson Depo.), 43:17-22; 155:22-156:8.) Dr. Jackson further testified that from her perspective the Hospitals appear to review the patients' medical history, *i.e.*, the "physical condition of the patient"; however, she could not know the Hospital's "purpose" in permitting an exception to its sterilization policy. (*Id.*, 111:12-112:19; 184:6-185:23; 229:15-23.) Dr. Jackson also admits that contraceptive devices may be used for purposes other than contraception, and that patients may seek remedies that have a contraceptive effect for reasons other than contraception. (*Id.*, 81:19-82:6; 109:15-109:4.)

G. The Attorney General Has Already Rejected the ACLU's Efforts to Require the Catholic Hospitals to Provide On-Demand Sterilizations in Violation of the ERDs.

Finally, the very relief Petitioners seek in this case has been rejected by California's Attorney General and is in fact contrary to requirements imposed on Dignity Health by that office.

In 2018, Dignity Health asked the Attorney General to approve its Ministry Alignment Agreement with CHI. (*See* Section II(B), *supra*; Strumwasser Decl., ¶ 24, Ex. 9 (Public Hearing Tr., 9:9-13).) Such approval was required because the transaction involved a change in control of Dignity Health, under which Dignity Health became a CommonSpirit subsidiary. (*Id.*, 9:1-8.)

In connection with the approval process, the Attorney General received comments and held a series of public hearings at which members of the public testified regarding the proposed

transaction. The ACLU set-up a website to drive public comment in response to the transaction.[64] On or about August 21, 2018, while she was counsel of record in this action, Ruth Dawson participated in the ACLU's "Rapid Response Webinar" regarding the proposed transaction.[65] The webinar reviewed the materials posted on the ACLU's website, and provided a series of talking points that the ACLU believed would "protect patients and the community."[66] The ACLU's materials and webinar implore the Attorney General to condition approval of the transaction on maintaining the status quo for at least ten years because, especially in rural areas where the Catholic hospital is the only provider, "[t]imely and adequate access to care is crucial, and this is particularly the case for reproductive services."[67]

A week later, Ms. Dawson provided testimony at a public hearing on August 29, 2018.[68] (Strumwasser Decl., ¶ 24, Ex. 9 (Public Hearing Tr.), 162:20-168:13.) In her testimony, Ms. Dawson noted that she was counsel for Petitioners in this case and based her requests in part on her description of the facts of this case. Speaking on behalf of the ACLU, Ms. Dawson asked the Attorney General to "require Dignity Health hospitals to expand their health services to include a full range of reproductive health services, including those prohibited by the ERDs," which she called a "nonmedical document." (*Id.*, 165:19-166:8.) Recognizing immediately that this might be "not possible," Ms. Dawson alternatively urged the Attorney General to "require this expansion of reproductive health services at Dignity Health's non-Catholic hospitals" and to ensure that the status quo at the Catholic Hospitals in terms of these services be maintained and not discontinued "including those [services] provided as *exceptions to the ERDs*."[69] (*Id.*) The

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[64] https://www.aclusocal.org/en/ensure-health-care-access-all-californians.

[65] https://www.youtube.com/watch?v=0tC3sSWgM_w&feature=youtu.be at 9:02-9:17. McGrath Decl., ¶ 71, Ex. 91 (ACLU FAQ and Guide to Providing Public Comments); https://www.aclusocal.org/en/ensure-health-care-access-all-californians.

[66] *Id.*; McGrath Decl., ¶ 71, Ex. 91 (ACLU FAQ and Guide to Providing Public Comments).

[67] https://www.youtube.com/watch?v=0tC3sSWgM_w&feature=youtu.be at minutes 14:38-15:31, 27:55-28:31; McGrath Decl., ¶ 71, Ex. 91 (ACLU FAQ and Guide to Providing Public Comments).

[68] Ruth Dawson filed a notice of dissociation as counsel on September 18, 2018.

[69] The latter request is at least somewhat consistent with the ACLU's since-forgotten mission to protect the constitutional freedom of religion. Previously, the ACLU conceded that it is inappropriate to require procedures where doing so would "compel devout Catholics to engage in behavior . . . in violation of their Faith." (ACLU Amicus Brief in *Benitez v. North Coast Women's Care Medical Group*, Cal. S.Ct. No. S142892 (Apr. 2, 2007), p. 2; ACLU Amicus Brief in *Catholic Charities of Sacramento v. Sup. Ct.*, Cal. S.Ct. No. S009982 (Jan. 18, 2001), p. 37; https://www.aclu.org/legal-document/aclu-amicus-brief-catholic-charities-sacramento-v-superior-court-sacramento-county.) Similarly, in arguing in support of the Religious Freedom Restoration Act (RFRA), 42 U.S.C. § 2000bb, the

ACLU even asked that the Attorney General require annual reports to ensure that the Hospitals maintain their then-current level of services. (*Id.*, 167:16-168:3).

Following Ms. Dawson's testimony, she and possibly others submitted a letter on behalf of numerous groups, including Petitioner PRH and ACLU California, to Deputy Attorney General Wendi A. Horwitz. (McGrath Decl., ¶ 4, Ex. 24.) The letter specifically referenced this case, and made it clear PRH and the ACLU purported to speak on behalf of "community interests." (*Id.*) PRH and the ACLU urged the Attorney General to impose "robust and enforceable conditions that protect the community interests. In particular, we urge conditions that ensure community members can access the health care services they need, including reproductive health services . . . ." (*Id.*) Thus, the letter continued,

> Many of the DH hospitals are located in the state's more rural areas. In some instances, these hospitals may be among the only available health providers in the area. Timely and adequate access to all health services is critical, and this is particularly the case when it comes to reproductive health services and other essential health services. *The Attorney General should ensure that the conditions on any merger require that DH hospitals maintain at least the levels and types of reproductive health services and essential health services currently provided* for a minimum of fifteen years post-merger.

(*Id.* (emphasis added).) The same letter concludes with "specific recommendations", the first of which urged that "[w]here reproductive health services are currently being provided as exceptions to the ERDs, those services must be maintained". (*Id.* Pg. 6.).

In November 2018, the Attorney General conditionally approved the Dignity Health – CHI transaction, rejecting the ACLU's request for any expansion of services that would put Dignity Health in violation of the ERDs. (McGrath Decl., ¶ 49, Ex. 69.) However, consistent with the ACLU's request, the Attorney General required, among other things, that Dignity Health's Catholic hospitals "maintain and provide women's healthcare services including women's reproductive services at current licensure and designation with the *current types and/or*

ACLU stated that "RFRA was plainly intended to protect religious organizations like Petitioners here from being forced to participate in the provision of healthcare benefits that conflict with their religious beliefs." Nadine Strossen, then president of the ACLU, testified in support of RFRA, noting that the statute safeguarded "such familiar practices" as "*permitting religiously sponsored hospitals to decline to provide abortion or contraception services*." (The Religious Freedom Restoration Act: Hearing on S. 2969 Before the S. Comm. on the Judiciary, 102d Cong. 192 (1992) [Prepared Statement of Nadine Strossen, pp. 80-81] [emphasis added], https://www.justice.gov/sites/default/files/jmd/legacy/2014/07/13/hear-99-1992.pdf.)

levels of service" for five years from the closing date of the transaction. (*Id.*, p. 3 (emphasis added); Strumwasser Decl., ¶ 23, Ex. 8.) The Attorney General's approval states that the conditions are "legally binding" on Dignity Health. (McGrath Decl., ¶ 49, Ex. 69, p. 1.)

III. PROCEDURAL HISTORY.

Petitioners filed their Complaint in December 2015, alleging violations of the Unruh Act, the Government Code, the Business & Professions Code, Section 1258, and the Unfair Competition Law ("UCL") on December 28, 2015. On January 14, 2016, the Court denied their Motion for Preliminary Injunction. (McGrath Decl., ¶ 72, Ex. 92.) In particular, the Court found that Dignity Health "did not violate Health & Safety Code section 1258 because it does not permit 'sterilization operations for contraceptive purposes.'" (*Id.*) On August 1, 2016, the Court sustained Dignity Health's demurrers without leave to amend as to all causes of action, except the UCL claim based upon an alleged violation of Section 1258. (McGrath Decl., ¶ 73, Ex. 93.) On February 9, 2017, the Court granted Dignity Health's Motion for Judgment on the Pleadings, and granted Petitioners leave to file the operative Verified Amended Petition for Writ of Mandate. (McGrath Decl., ¶ 74, Ex. 94.)

Petitioners filed the Petition on March 1, 2017. The parties then took in-depth discovery. Dignity Health filed a Motion for Summary Judgment on April 5, 2019. After holding two hearings, on July 22, 2019 and November 19, 2019, the Court denied Dignity Health's motion, finding triable issues of fact.

IV. LEGAL STANDARD FOR WRIT REVIEW UNDER CODE OF CIVIL PROCEDURE SECTION 1085

The "highly deferential" standard of review under Code of Civil Procedure section 1085 provides that mandamus lies: (1) to compel the performance of a clear, present, and ministerial duty where the petitioner has a beneficial right to performance of that duty, or (2) to correct the exercise of legislative power, but only if the action taken is so palpably unreasonable and arbitrary as to show an abuse of discretion as a matter of law. *Carrancho v. California Air Res. Bd*., 111 Cal. App. 4th 1255, 1265 (2003). As explained *in Unnamed Physician v Bd of Trustees of Saint Agnes Medical Center* 93 Cal. App. 4th 607, 618 (2002), "[m]andate will not issue to

compel action unless it is shown the duty to do the thing asked for plain and unmixed with discretionary power or the exercise of judgment…. Thus, a petition for writ of mandamus under … section 1085 may only be employed to compel the performance of a duty which is purely ministerial in character.") (emphasis added; citations omitted)

The Catholic Hospitals have discretion to adopt any policy or practice lawful under Section 1258, and a writ will not lie to compel the Hospitals to permit sterilizations contrary to its lawful policies.[70] Code Civ. Proc. § 1085(a) (a traditional writ of mandamus may only be brought to "compel performance of an act which the law specifically enjoins"); *Ridgecrest Charter Sch. v. Sierra Sands Unified Sch. Dist.*, 130 Cal. App. 4th 986, 1003 (2005) ("the District was obligated to follow the law . . . but how it did that was largely a matter committed to its discretion"). The Court evaluates the Sterilization Policies "on [their] face because legislative discretion is not subject to judicial control and supervision." *San Joaquin Local Agency Formation Com'n v. Sup. Ct.,* 162 Cal. App. 4th 159, 171 (2008). On their face, the Sterilization Policies reflect the Catholic Hospitals' internal management decisions regarding how their faith impacts the services that are provided at the Catholic Hospitals.

The "general rule" is that "the court should not substitute its judgment for that of an administrative agency which acts in a quasi-legislative capacity." *Pitts v. Perluss*, 58 Cal. 2d 824, 832 (1962); *see also State Bd. of Chiropractic Examiners v. Sup. Ct.*, 45 Cal. 4th 963, 977 (2009) ("Writ review under Code of Civil Procedure section 1085 is . . . deferential"). This rule of deference "is also appropriately applied to judicial review of rule-making or policy-making actions of a nonprofit hospital corporation." *Lewin v. St. Joseph's Hospital of Orange*, 82 Cal. App. 3d 368, 384 (1978). Deference to hospital decisions is due "in large part" to the fact that the hospital's actions "substantially affect the public interest," as well as because of the "presumed expertise of administrative agencies in respect to matters within their jurisdiction." *Id.* at 384-85 ("A managerial decision concerning the operation of the hospital made rationally and in good faith by the board to which operation of the hospital is committed by law should not be

[70] The Catholic Hospitals' Sterilization Policies were approved by the hospital's requisite committees and boards. (McGrath Decl., ¶ 15, Ex. 35 (De Soto Depo. Vol. 1), 83:23-84:12; O'Keeffe Decl., ¶ 14; Keith Decl., ¶¶ 4-5.

countermanded by the courts unless it clearly appears it is unlawful . . ."); *see also Mateo-Woodburn v. Fresno Community Hosp. & Med. Ctr.*, 221 Cal. App. 3d 1169, 1184 (1990) ("An important public interest exists in preserving a hospital's ability to make managerial and policy determinations and to retain control over the general management of the hospital's business.").

As the *Lewin* court noted:

> The operation and administration of a hospital involves a great deal of technical and specialized knowledge and experience, and the governing board of a hospital must be presumed to have at least as great an expertise in matters relating to operation and administration of the hospital as any governmental administrative agency with respect to matters committed to its authority. . . . Judges are untrained and courts ill-equipped for hospital administration, and it is neither possible nor desirable for the courts to act as supervening boards of directors for every nonprofit hospital corporation in the state. . . . .

Lewin, 82 Cal. App. 3d at 384-85. There is nothing arbitrary, capricious, or unlawful about a Catholic hospital adopting and implementing a sterilization policy that it determines is consistent with the hospital's faith-based mission and the ERDs. This deference to a nonprofit hospital's internal decision-making is all the more appropriate in a case such this one involving a Catholic hospital because the First Amendment protects the autonomy of the Catholic Church and prohibits interference by the courts in internal decision-making regarding matters essential to its core mission.

V. THE CATHOLIC HOSPITALS' STERILIZATION POLICIES AND REVIEW PROCESS DO NOT VIOLATE SECTION 1258.

A. The Hospitals Do Not Permit Sterilization Operations for Contraceptive Purposes; Therefore, Section 1258 Does Not Apply.

Section 1258 applies *only* to hospitals that "permit[] sterilization operations for contraceptive purposes." Section 1258 does not apply at all to hospitals that *prohibit* sterilizations for contraceptive purposes. MMCR and the other Dignity Health hospitals never permit sterilizations for contraceptive purposes, and thus are not subject to Section 1258. Care must be taken to not rewrite the plain text of the statute to conflate the contraceptive effect of a sterilization procedure with the "purposes" of the Catholic Hospitals, which is never "contraceptive" as a matter of both undisputed evidence and Catholic faith. Code Civ. Proc. §1858 ("In the construction of a statute…, the office of the Judge is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted, or

to omit what has been inserted…."); *Stop Youth Addiction, Inc. v Lucky Stores, Inc.*, 17 Cal. 4th 553, 573 (1998) (citing section 1858, stating: "[w]e are not authorized to insert qualifying provisions not included, and may not rewrite the statute to conform to an assumed intention which does not appear from its language.")

The ERDs prohibit sterilization procedures for contraceptive purposes. The Sterilization Policies uniformly state that "tubal ligation or other procedures that induce sterility for the purpose of contraception are not acceptable in Catholic moral teaching." (O'Keeffe Decl., ¶ 13, Ex. 12.) MMCR may permit sterilizations for patients who meet certain medical and physical condition requirements even though the procedure has a contraceptive effect, however, the Catholic Hospitals do not allow the procedure for contraceptive *purposes*. In the absence of a medical or physical condition that the hospital concludes warrants the procedure, a tubal ligation request must be denied because it is for contraceptive purposes and therefore prohibited by the ERDs. Dignity Health's witnesses uniformly testified that the Catholic hospitals never permit sterilization procedures for contraceptive purposes, and that the only "purpose" of a permitted sterilization is to address medical risks to the mother.[71] The testimony of Dignity Health witnesses confirms that tubal ligations are permitted only when the physical condition of the patient discloses that a tubal ligation will prevent serious and potentially life-threatening conditions.

The Court found that there was a triable issue of fact regarding whether MMCR and the other Catholic hospitals performed sterilizations for contraceptive purposes. (McGrath Decl., ¶ 10, Ex. 30 (April 30, 2020 Order), p. 2). At the summary judgment hearing, the Court indicated that it was considering adopting a secular and medical interpretation of the phrase "contraceptive purposes" that would equate the *purpose* of the procedure with its medical *effect* and that disregards the purposes of the Catholic Hospitals. That would be a prejudicially improper rewriting of the statute and it would intrude on the Catholic Hospitals' exercise of their faith and

[71] McGrath Decl., ¶ 13, Ex. 33, (O'Keeffe Depo. Vol. I, at 22:13-23; 32:22-33:7; 34:12-15; 35:5-7; 37:3-38:5; 42:24-43:18; 50:17-51:24; 52:13-53:13; 71:14-20; 72:11-24;74:6-16; 76:3-16); ¶ 12, Ex. 32 (O'Keeffe Depo., Vol. II, at 145:12-146:1; 178:4-12); ¶ 15, Ex. 35 (De Soto Tr., 19:13-18; 20:21-21:21; 45:24-46:10); Petition, ¶ 61, Exhibit 6; McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Tr., 92:17-19; 90:19-91:2; 115:12-17); ¶ 38, Ex. 58 (Jackson Tr., 43:17-22; 111:12-112:19; 155:22-156:8; 184:6-185:23; 229:15-23); ¶ 36, Ex. 56 (Cox Tr., 38:15-39:20; 70:7-25).

core mission. See discussion *infra* at Section VI.A.

The phrase "for contraceptive purposes" in Section 1258 plainly excludes the Catholic Hospitals from the reach of the statute. The phrase should be interpreted as it would be understood by a Catholic hospital because the word "for" signifies a limitation that excludes any health care entity that does not act with a contraceptive purpose. *See Vacco v. Quill*, 521 U.S. 793, 807, n. 11 (1997) (applying doctrine of double effect which is believed to have originated from the writings of St. Thomas Aquinas: "Just as a State may prohibit assisted suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death"); Joseph T. Mangan, An Historical Analysis of the Principle of Double Effect, 10 Theological Stud. 41, 42 (1949)("[B]efore the time of St. Thomas Aquinas there is no indication of a definitely formulated principle of the double effect").

While one effect of a tubal ligation may be contraceptive, that does not mean that a Catholic hospital's purpose in permitting the procedure is contraceptive. The same point is well illustrated in the case of a hysterectomy. The effect of a hysterectomy is contraceptive in that it forecloses pregnancy. However, the purpose of a hysterectomy may be to treat uterine cancer. Similarly, the effect of a tubal ligation may be contraceptive, but its purpose may be to avoid life-threatening conditions such as uterine rupture associated with a future pregnancy in women whose medical history discloses specific medical risk factors. Notably, the hospital's purpose (the only purpose relevant to a hospital licensing statute) may not be the same as the purpose of the patient or her physician. (McGrath Decl., ¶ 38, Ex. 58 (Jackson Depo.), 229:2-23.) While the patient may seek a tubal ligation as contraception, the hospital's purpose in permitting the procedure may be to avoid the risk of uterine rupture.

This difference between purpose and effect is expressly recognized in Health & Safety Code section 1367.25, which generally requires that health plans provide contraceptive coverage. Section 1367.25(c) provides an exemption to the contraceptive coverage requirement for religious employers for health plan offered to their employees. However, Section 1367.25(e) provides that the exemption does not apply to "contraceptive supplies as prescribed by a provider . . . for

reasons *other than contraceptive purposes*, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause . . . ." (Emphasis added.) The administration of contraceptive supplies will invariably have a contraceptive effect, but if they are prescribed for the *purpose* of decreasing an unrelated medical risk to the insured, then the Legislature has recognized such supplies are not provided for a "contraceptive purpose." Health & Saf. Code § 1367.25(e). Here, when the Catholic Hospitals permit a sterilization, such as when a patient presents a risk of uterine rupture, the Hospital's *purpose* is not contraceptive.[72] Accordingly, the Catholic Hospitals do not permit sterilizations for contraceptive purposes and Section 1258 does not apply.

B. <u>The Hospitals Do Not Consider Prohibited Non-Medical Qualifications.</u>

Section 1258 prohibits a hospital from considering "nonmedical qualifications" in providing contraceptive sterilizations, but it plainly allows a hospital to consider medical and physical condition factors. The evidence shows that MMCR and the other Catholic hospitals do not violate this statute.

Despite several years of litigation, Petitioners have failed to present evidence that establishes MMCR or any of Dignity Health's Catholic hospitals considers "special nonmedical qualifications not imposed on individuals seeking other types of operations in the health facility." To the contrary, the evidence shows that the hospitals consider only those factors that relate to the "physical or mental condition" of the individual. The Court found a triable issue of material fact as to whether the hospitals consider the age of the individual in a manner prohibited by Section 1258. However, this evidence establishes that the hospitals consider only "advanced maternal age," and only in connection with other risk factors. As discussed in Section II.E.3, *supra*, advanced maternal age refers to the physical condition of the individual and it is a documented medical risk factor for uterine rupture. Therefore, consideration of advanced maternal age does not violate Section 1258.

Petitioners mistakenly contend that the hospitals consider age because they consider

[72] The phrase "contraceptive purposes" as used in Section 1258 should be deemed to have the same meaning as used in Section 1367.25. "[W]ords should be given the same meaning throughout a code unless the Legislature has indicated otherwise." *Hassan v. Mercy Am. River Hosp.*, 31 Cal. 4th 709, 716 (2003).

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whether the patient is of advanced maternal age (over 35), if that is a relevant exacerbating factor with respect to another existing medical condition.[73] However, "advanced maternal age" and "age" are not the same thing. "Advanced maternal age is an independent medical risk factor for certain adverse outcomes in pregnancy."[74] Advanced maternal age is a well-recognized medical factor that relates to the physical condition of the individual, and when combined with other factors, is a well-recognized contributor to an increased risk of uterine rupture and maternal morbidity. Indeed, Dr. Jackson admitted that advanced maternal age can be a risk factor for uterine rupture. (McGrath Decl., ¶ 38, Ex. 58 (Jackson Depo.), 43:17-22; 155:22-156:8.) Therefore, it is expressly permitted by the second paragraph of Section 1258. For example, *Uterine Rupture in Pregnancy* by Gerard G. Nahum, MD, FACOG,[75] identifies "[c]ongenital uterine anomalies, multiparity, previous uterine myomectomy, the number and type of previous cesarean deliveries, fetal macrosomia, labor induction, uterine instrumentation, and uterine trauma" as well as "grand multiparty" and advanced maternal age as risk factors for uterine rupture, a serious medical complication with a high incidence of fetal and maternal morbidity.[76] (De Soto Decl., ¶ 17, Ex. 21).

Advanced maternal age is so significant to the risk involved in a pregnancy that Chamorro's obstetrician, Dr. Van Kirk, informs his patients that, "If you will be age 35 or older (AMA [advanced maternal age]) on the baby's due date, you will be referred for a genetic consult and level II ultrasound during your second trimester with a perinatal specialist." (McGrath Decl.., ¶ 62, Ex. 82.[77] Petitioners' expert Dr. Jackson agrees. (McGrath Decl., ¶ 38, Ex. 58 (Jackson

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[73] Advanced maternal age is defined as childbearing women over 35 years of age, and average maternal age has increased significantly since 1972. McGrath Decl., ¶ 50, Ex. 70 (Lean, Samantha C. *et al.*, *Advanced maternal age and adverse pregnancy outcomes: A systematic review and meta-analysis*, 12 PLOS ONE 10 e0186287 (Oct. 17, 2017), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5645107/.

[74] McGrath Decl., ¶ 51, Ex. 71 (M. Jolly *et al.*, *The risks associated with pregnancy in women aged 35 years or older*, 15 HUMAN REPRODUCTION 2433 (Nov. 2000), *available at* https://academic.oup.com/humrep/article/15/11/2433/635079.

[75] http://reference.medscape.com/article/275854-overview

[76] Other factors that the committees may consider include placenta accreta, history of uterine rupture, diabetes mellitus, heart disease, multiple scars in the uterus, a single uterine scar with factors that may have retarded healing of the scar, congestive heart failure, or renal failure. (McGrath Decl., ¶ 15, Ex. 35 (De Soto Depo. Vol. 1), 33:22-34:21, 52:13-23.) The Sacramento Catholic Hospitals consider similar factors that could compromise a patient in a subsequent pregnancy. (McGrath Decl., ¶ 37, Ex. 57 (Dr. Carolina Reyes Depo.), 30:2-31:7.)

[77] Dr. Van Kirk testified that "para," "grava," "grand multiparity" and "advanced maternal age" are all medical terms. (McGrath Decl., ¶ 39, Ex. 59, at, 92:17-19; 90:19-91:2; 115:12-17.)

Depo.), 37:6-10; 143:22-144:8.) Indeed, numerous publications note the significance of advanced maternal age:

- A patient's multiple prior uterine scars, when considered in connection with other risk factors, may greatly increase the risk of maternal morbidity and mortality in pregnancy, as may a patient's advanced maternal age.[78]
- "Increasing maternal age is independently associated with specific adverse pregnancy outcomes. Increasing age is a continuum rather than a threshold effect."[79]
- "Some severe morbid conditions had the lowest rate among teenage mothers, with the rate increasing with maternal age, e.g., obstetric embolism, AFE, acute cardiac morbidity, uterine rupture, and hysterectomy. The rates of severe PPH, renal failure, DIC, complications of obstetric interventions, and potentially life-saving procedures increased rapidly in women above [age] 39."[80]

MMCR made no secret of its use of advanced maternal age as a medical factor, and provided this information to Dr. Van Kirk to clarify its denial of Chamorro's request. (Petition, Ex. 6.) Moreover, Dr. Jackson is well aware of the importance of advanced maternal age as a medical risk factor. She *deleted* the following sentence from her report because it "may not be supported by the literature": "And younger women present just as much risk in terms of carrying future pregnancies as older women, as they have more years ahead of them in which they could potentially become pregnant." (McGrath Decl., ¶ 46, Ex. 66, at CHAM002198.)

Thus, the Committees may consider advanced maternal age, not as an arbitrary socio-economic concern reflecting a paternalistic judgment about whether young women should choose to be sterilized, but as it relates to the physical condition and medical history of the patient and as

[78] One study found the risk of uterine rupture is three times as high for women over 30 years old. *See* Shipp, Thomas D *et al.*, *The association of maternal age and symptomatic uterine rupture during a trial of labor after prior cesarean delivery*, 99 OBSTETRICS AND GYNECOLOGY 4 (2002).

[79] McGrath Decl., ¶ 54, Ex. 74 (Cleary-Goldman, J. *et al.*, *Impact of maternal age on obstetric outcome*, 105 OBSTET GYNECOL. 5, pt 1(2005), available at https://pubmed.ncbi.nlm.nih.gov/15863534/.

[80] McGrath Decl. ¶ 55, Ex. 75 (Lisonkova, S. *et al.*, *Maternal age and severe maternal morbidity: A population-based retrospective cohort study*, PLOS MED. (May 30, 2017)). "The main causes of death among older mothers were hemorrhage, embolism, and hypertensive conditions." Chervenak, J.L. & Kardon, N.B., *Advancing maternal age: the actual risks*, FEMALE PATIENT 17 (NOV, 1991).

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an indicator for certain adverse outcomes in pregnancy.[81] (Petition, Ex. 6; McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.), 37:6-10, 90:19-91:2, 92:17-19, 115:12-17, 143:22:144:8; ¶ 62, Ex. 82. But alone, "[age is] just one of the factors – it wouldn't weigh either way." (McGrath Decl., ¶ 12, Ex. 32 (O'Keeffe Depo. Vol. II), 107:9-15.)

Section 1258 should not be interpreted to prohibit consideration of advanced maternal age because doing so would contradict the unmistakable purpose of the legislation and would impose a new limitation on the statute's unqualified reference to the "physical … condition" of the patient. (McGrath Decl., ¶ 6, Ex. 26 MSJ.) Section 1258 itself makes clear that it was intended to *permit* the consideration of medical qualifications as well as the physical condition of the patient. This is confirmed by the legislative history of the provision which shows Section 1258 was intended to prohibit the use of age as a socio-economic qualification, as it had been in ACOG's age-parity stipulation or the 120-point test that had commonly been applied as a qualification for a tubal ligation. *See* Section II.A, *supra*.[82] A hospital's consideration of advanced maternal age in connection with other factors indicating a higher risk of uterine rupture is thus precisely the type of medical qualification or requirement related to the physical condition of the individual that is expressly allowed by the statute.

It is irrelevant that Petitioners and their expert do not agree with the hospital's use of advanced maternal age because they believe that a tubal ligation should be permitted simply whenever the individual wants one. That interpretation is contrary to the plain language of the statute. Section 1258 expressly permits requirements broadly "relating to" the physical condition

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[81] At the July 22, 2019 hearing, the Court suggested "certainly the legislature knows that back in 1974 that there's going to be a variety of ages of women of childbearing years." (McGrath Decl., ¶ 2, Ex. 22, at 35:14-21.) In fact, the number of pregnancies of women over 35 has increased dramatically over the last 50 years. (McGrath Decl., ¶ 56, Ex. 76 (https://evidencebasedbirth.com/advanced-maternal-age/).) Considering that births over age 35 were rare in 1972, and the fifty years of studies since then documenting a connection between advanced maternal age and other risk factors increasing the risk of maternal morbidity and mortality, there is no reason to believe that the Legislature gave this an iota of consideration.

[82] Petitioners have miscast the Legislature's focus as a "problem of hospitals refusing on moral grounds to allow patients to undergo tubal ligation." (Petitioners' MSJ Opp. 6/27/19, 2:2-3.) That's plainly wrong and would pit the Legislature against religion, something it knows it could not do under the Constitution. Secular hospitals practice paternalism; they have no legally cognizable "moral" rights in that regard. *See, e.g., Valley Hosp. Ass'n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963, 972 (Alaska 1997) ("[Valley Hospital] is not affiliated with any religion and cannot raise a free exercise claim."). The only hospitals with cognizable moral objections are religious hospitals, and those objections are protected by the free exercise provisions of the state Constitution and the First Amendment.

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of the individual. *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) ("The ordinary meaning of [relating to] is a broad one—'to stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with'"); *Bono v. David*, 147 Cal. App. 4th 1055, 1067 (2007) ("relating to" is interpreted broadly). Advanced maternal age clearly "relates to" the physical condition of the individual and there is no contrary evidence in this record. Therefore, it may permissibly be considered.

C. Neither the ERDs Nor the Review Process Are Prohibited Nonmedical Qualifications.

The only other purported non-medical "qualifications" that Petitioners' have argued for are the ERDs themselves and the faith-based review process under the Sterilization Policies. However, neither constitutes a qualification placed upon individuals, and any determination that Section 1258 prohibits a faith-based review process or the application of the ERDs clearly would be precluded by Dignity Health's First Amendment right to free exercise and expression and would be contrary to the historic respect accorded faith-based hospitals. *See infra*, Section IV.

Section 1258 prohibits a health facility from requiring an "individual" seeking a sterilization operation "to meet any special nonmedical qualifications, which are not imposed on individuals seeking other types of operations in the health facility." The ERDs are not a "qualification" that an individual must "meet" when seeking a tubal ligation. The ERDs are directives that are imposed on Catholic health care *providers*, not "individuals." (O'Keeffe Decl., ¶ 10, Ex. 11 (ERDs); McGrath Decl., ¶¶ 28-29, Exs. 48-49 (RFA #2)); Bishop Soto Decl., ¶ 4.) Consistent with the ERDs, the Dignity Health Bylaws, the MMCR Bylaws, and the MMCR Rules & Regulations of the Medical Staff all uniformly provide that all care provided to any patient at MMCR shall conform to the ERDs.[83] To the extent adherence to the ERDs has an effect on patients, the ERDs apply to all patients, and they include affirming the rights to pastoral care, confidentiality, and respect and the protection for the "inherent dignity of the human person" regardless of health or social status, and mandating informed consent (O'Keeffe Decl., ¶ 10, Ex. 11, Directives, 10, 23, 26, and 34.) Thus, because the ERDs are rules that apply institutionally to

[83] McGrath Decl., ¶ 39, Ex. 59 (Van Kirk Depo.) 29:22-31:17); ¶ 77, Ex. 72 (De Soto Depo., Vol. II), 48:3-49:6); ¶¶ 28-29, Exs. 48-49 (RFAs 5-6); De Soto Decl., ¶ 3, Ex. 18, p. 5, Ex. 19 §§ 5, 16.

Catholic hospitals and also apply to "other types of operations in the health facility," compliance with the ERDs is not barred by Section 1258.

Likewise, the review process itself is not a non-medical qualification, but rather a review of the patient's circumstances to determine whether the patient has any *medical* qualifications that might mean the procedure is permitted under the ERDs.

Moreover, the ERDs as well as the Sterilization Policies and their application through the review process are quintessential "internal management decisions that are essential to the institution's central mission," which are afforded First Amendment protection. *Guadalupe*, 140 S. Ct. at 2060 (citing *Hosanna-Tabor*). *See* Section VI, *infra*.

D. <u>The Court Should Be Guided by the Doctrine of Constitutional Avoidance.</u>

The doctrine of constitutional avoidance is the "well-established principle that th[e] Court will not decide constitutional questions where other grounds are available and dispositive of the issues of the case." *Santa Clara Local Transp. Auth. v. Guardino*, 11 Cal.4th 220, 230 (1995); *see also People v. Williams*, 16 Cal.3d 663, 667 (1976) ("we do not reach constitutional questions unless absolutely required to dispose of the matter before us"). Where, as here, the Court may choose between two reasonable interpretations of a statute, only one of which raises constitutional doubts, the Court should choose the reasonable interpretation that does not raise such doubts. *See Shealor v. City of Lodi*, 23 Cal.2d 647, 653 (1944) (if a statute is susceptible of two constructions, one of which will render it constitutional and another that would raise "serious and doubtful constitutional questions, the court will adopt the construction which, without doing violence to the reasonable meaning of the language used, will render it valid in its entirety, or free from doubt as to its constitutionality"); *Clark v. Martinez*, 543 U.S. 371, 381-82 (2005) ("The canon is thus a means of giving effect to congressional intent, not of subverting it."); *People v. Morera-Munoz*, 5 Cal. App. 5th 838, 856 (2016) ("The doctrine of constitutional avoidance 'command[s] courts, when faced with two plausible constructions of a statute—one constitutional and the other unconstitutional—to choose the constitutional reading.'").

Here, as discussed, Section 1258 is properly interpreted—and at a minimum is susceptible to an interpretation—not to conflict with the constitutionally protected religious rights of the

Catholic Hospitals. Therefore, this case can be decided on non-constitutional grounds.[84] Specifically, Dignity Health has presented two interpretations that avoid constitutional doubts. First, the phrase "for contraceptive purposes" in Section 1258 makes the statute inapplicable to MMCR and Dignity Health's other Catholic hospitals because the hospitals' purpose in allowing the procedure is not contraceptive. Second, Section 1258 express permits the process implemented at MMCR and the other Dignity Health Catholic hospitals because the Catholic Hospitals apply only "requirements relating to the physical condition" of the individual including risk factors such as "advanced maternal age" that are indisputably "related to" maternal morbidity and mortality in a future pregnancy. At the July 22, 2019 hearing on the summary judgment motion, the Court noted that Dignity Health's interpretation of the phrase "contraceptive purposes" as referring to the hospital's purpose was "a reasonable interpretation," although the Court believed it was "not the best one." (McGrath Decl., ¶ 2, Ex. 22, at 26:6-9.) But under the doctrine of constitutional avoidance, Dignity Health's interpretation of the phrase "contraceptive purposes" is indeed the best interpretation because it avoids constitutional doubts regarding the application of Section 1258 urged by Petitioners.

E. A Catholic Health Facility's Decision Not to Permit a Procedure Is Not Conduct Below the Standard of Care.

Petitioners assert that by failing to unquestioningly permit every requested post-partum tubal ligation, the Catholic Hospitals violate the acceptable standard of care with respect to post-partum tubal ligations. This is wrong.[85] The Catholic Hospitals' practices with respect to post-partum tubal ligations meet the standard of care applicable to hospitals and physicians practicing within them. The Catholic Hospitals are subject to intensive regulation at the state and federal levels in order to ensure that they do meet all applicable standards of care. No state or federal regulator has ever

[84] The application of the constitutional avoidance doctrine is another factor that distinguishes this case from *Catholic Charities of Sacramento, Inc. v. Superior Court*, 32 Cal. 4th 527 (2004), in which there was no alternative statutory interpretation that did not raise constitutional doubts.

[85] To the extent Petitioners are asserting that the "standard of care" for tubal ligations is to provide them whenever a patient requests it, that is simply not true. Many publicly available medical sources discuss the potential risks inherent in a tubal ligation procedure, including the types of patient populations with enhanced risk profiles for whom a tubal ligation may not be appropriate (*e.g.*, diabetic and/or obese patients). *See, e.g.*, McGrath Decl., ¶ 57, Ex. 77 (https://www.mayoclinic.org/tests-procedures/tubal-ligation/about/pac-20388360); ¶ 58, Ex. 78 (https://www.plannedparenthood.org/learn/birth-control/sterilization/how-safe-tubal-ligation;); ¶ 59, Ex. 79 https://www.today.com/health/post-tubal-ligation-syndrome-women-discuss-side-effects-getting-tubes-t152367.

cited MMCR for a violation, or found it below the standard of care. This is compelling evidence that refusing to provide sterilization operations for contraceptive purposes – which is expressly permitted by Section 1258 – has nothing to do with the standard of care. The various regulators and regulatory schemes are summarized below.

1. California Statutes and Regulations; Department of Public Health.

All Dignity Health hospitals are licensed as "general acute care hospitals" by the California Department of Public Health ("CDPH").[86] CDPH requires that every acute care hospital have its own license, that the hospital license be renewed on an annual or biannual basis, and that the hospital be inspected at least every two years, at which point CDPH notifies the hospital of any deficiencies in compliance with licensing statutes and regulations. Cal. Code Regs., tit. 22, §§ 70101(c), 70103, 70117. "Every health facility for which a license or special permit has been issued shall be periodically inspected by [CDPH] or by another governmental agency under contract with [CDPH]." Health & Saf. Code § 1279(a). One of the licensure requirements that CDPH oversees is Section 1258.

CDPH (and its predecessor, the Department of Health Services ("DHS")) has issued regulations regarding the standard of medical care provided at general acute care hospitals. For example, Cal. Code Regs., tit. 22, section 70701(a)(7) requires an acute care hospital to have a governing body that in turn requires the hospital's self-governing medical staff to "establish controls that are designed to *ensure the achievement and maintenance of high standards of professional ethical practices* including provision that all members of the medical staff be required to *demonstrate their ability to perform surgical and/or other procedures competently* and to the satisfaction of an appropriate committee or committees of the staff at the time of original application for appointment to the staff and at least every two years thereafter." (Emphasis added.)

CDPH has issued regulations specifically governing sterilization procedures, including specifying the requirements for informed consent for sterilization procedures and requiring

[86] Each of the Hospitals' respective licenses may be found here: https://www.cdph.ca.gov/programs/chcq/lcp/calhealthfind/Pages/Home.aspx.

hospitals to submit quarterly reports to CDPH on tubal ligations, vasectomies and hysterectomies. Cal. Code Regs., tit. 22, §§ 70707.2, 70707.3, 70736. Of course, CDPH is and has always been well aware that the Catholic Hospitals it inspects are governed by the ERDs as it relates to these procedures.

CDPH regulations also specifically address perinatal matters. These include requirements for "written policies and procedures developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. These policies and procedures *shall reflect the standards and recommendations of the American College of Obstetricians and Gynecologists 'Standard for Obstetric-Gynecologic Hospital Services," 1969 . . .*' Policies shall be approved by the governing body. Procedures shall be approved by the medical staff and administration where such is appropriate . . . ." Cal. Code. Regs., tit. 22, § 70547(b) (emphasis added). The referenced policies set forth the standard of care.[87]

Further, guidance issued by CDPH requires hospitals to be surveyed no less than every three years. CDPH *Center for Health Care Quality General Acute Care Hospital Relicensing Survey Process Guidance* (https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/GACHRLS-ProcessGuidance.pdf) at p. 1. The guidance states that, among other things, surveyors are to "assess the care and services provided, *including the appropriateness of the care* and services within the context of the regulations." *Id.*, p. 7 (emphasis added). Also included are "[o]bserv[ation of] the actual provision of care and services to patients and the effects of that care in order to *assess whether the care provided meets the needs of the individual patient*." *Id.* (emphasis added).

The CDPH enforces Section 1258 through its district offices as well as by the district attorney.[88] Health & Saf. Code §§ 1290, 1293; Cal. Code Regs., tit. 22, § 70135(a). CDPH has the power, expertise, and statutory mandate to regulate and enforce Section 1258. Yet, the Hospitals have never been cited by CDPH or DHS for failure to meet the applicable standard of

[87] ACOG's 1969 standards recognized that "[i]n a few hospitals committee review, like that for therapeutic abortion, is required."

[88] Members of the public can easily report alleged violations to the CDPH here: https://www.cdph.ca.gov/programs/chcq/lcp/calhealthfind/Pages/Home.aspx.

care with respect to their obstetric/gynecological services. Strumwasser Decl., ¶ 17.

2. The Joint Commission and Medicare Conditions of Participation.

Acute care hospitals that participate in the Medicare program, including the Catholic Hospitals, are required to satisfy certain "conditions of participation." 42 C.F.R. § 482.1 *et seq.*[89] One condition is that "[t]he hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws." 42 C.F.R. § 482.11(c). The Joint Commission is an independent, not-for-profit organization that is the nation's oldest and largest standards-setting and accrediting body in health care. Strumwasser Decl., ¶ 18.

Medicare rules provide that a hospital accredited by The Joint Commission is "deemed" to satisfy the conditions of participation for participation in the Medicare program. *Id.* § 488.10(b); https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf.

The Joint Commission's *2020 Comprehensive Accreditation Manual for Hospitals* includes an entire section on Provision of Care, Treatment, and Services. The Joint Commission standards provide that "the hospital accepts the patient for care, treatment, and services based upon its ability to meet the patient's needs." (PC.01.01.01) Moreover, the Joint Commission standards provide that a hospital must assess and reassess its patients to identify and deliver the proper care and treatment, and that services are to be provided in accordance with law and regulation. (PC.01.02.01 and Intro and Rationale; PC.02.01.03.) Specifically, the Joint Commission requires that hospitals "reduce the likelihood of harm related to maternal hemorrhage" and "related to maternal severe hypertension/preeclampsia." (PC.06.03.01.) Section MS.03.01.01, addressed to the requirements for hospital medical staff, provides, "*The organized medical staff oversees the quality of patient care*, treatment, and services provided by practitioners privileged through the medical staff process. Rationale: The organized *medical staff*

[89] Medicare's Conditions of Participation apply to all patients at the hospital. *See* "Licensing and Certification Survey Basics Web Seminar," California Hospital Ass'n, Aug. 21, 2012, at 15, *available at* http://www.calhospital.org/sites/main/files/file-attachments/licensing_survey_web_ppt_final.pdf ("CoPs apply to all patients, not just Medicare (or Medicaid) patients.").

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is responsible for establishing and maintaining patient care standards and oversight of the quality of care, treatment, and services rendered by practitioners privileged through the medical staff process." (Emphasis added). The Joint Commission also has accreditation standards for Medicare participation to "reduce the likelihood of harm related to maternal hemorrhage." (PC.06.01.01.) (Strumwasser Decl., ¶ 20, Ex. 7.)

The Hospitals have been continuously accredited by The Joint Commission during the entire period that they have been owned and operated by Dignity Health. Strumwasser Decl., ¶ 19. This means that it has found the Hospitals' Sterilization Policies a lawful response to The Joint Commission's accreditation requirements. *Id.*

3. The Medicare Integrity Program.

The Medicare statute imposes on all healthcare providers, including hospitals, the obligation "to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under [Medicare]… will be of a *quality which meets professionally recognized standards of health care* …." 42 U.S.C. 1320c–5(a)(2) (emphasis added). A hospital's failure to substantially comply with these obligations "in a substantial number of cases" subjects the hospital to exclusion from Medicare participation. 42 U.S.C. 1320c–5(b)(2). These obligations are implemented through regulations, 42 C.F.R. § 1004.1 *et seq.*, which provide authority to the Office of Inspector General of the Department of Health and Human Services ("OIG") to impose monetary sanctions or exclusion from Medicare on a hospital that fails to meet the requirements. 42 C.F.R. § 1004.20. The OIG's regulations reiterate the statutory obligation to provide services "of a quality that meets professionally recognized standards of health care…." 42 C.F.R. § 1004.10.

The Catholic Hospitals have never been sanctioned under these rules either. Strumwasser Decl., ¶ 21.

4. Quality Improvement Organizations.

Medicare statutes and regulations provide for review of the services of Medicare providers, including hospitals, by "quality improvement organizations ("QIOs"). 42 U.S.C. 1320c–3(a); 42 C.F.R. § 476.70 *et seq.* To participate in Medicare, the Catholic Hospitals are

required to contract with a QIO to permit the QIO to perform reviews of the Hospital's services. (Strumwasser Decl., ¶ 22); 42 U.S.C. 1395cc(a)(1)(F); 42 C.F.R. § 476.78(a). QIO duties include determining whether the quality of the services provided "meets professionally recognized standards of health care." 42 U.S.C. 1320c–3(a)(1)(B).

QIOs are required, among other things, to investigate complaints by a Medicare beneficiary about the quality of healthcare provided to the beneficiary, 42 C.F.R. § 476.120(a), and to "review at least a random sample of hospital discharges each quarter and submit new diagnostic and procedural information to the Medicare administrative contractor, fiscal intermediary, or carrier if it determines that the information submitted by the hospital was incorrect." 42 C.F.R. § 476.71(c)(1). A hospital is required, upon request by the QIO, to deliver all medical information requested within 14 days of such request. 42 C.F.R. § 476.160(b). Medicare hospitals are required to inform Medicare beneficiaries in writing at the time of admission that Medicare-covered care is subject to review by the QIO. 42 C.F.R. § 476.78(b)(3).

In its review of services provided, the QIO must determine (in accordance with its contract), among other things, "whether the quality of the services meets professionally recognized standards of health care and "the completeness, adequacy and quality of hospital care provided." 42 C.F.R. § 476.71(a). The QIO must use "evidence-based standards of care to the maximum extent practicable. If no standard of care exists, the QIO will use available norms, best practices and established guidelines to establish the standard that will be used in completing the review." 42 C.F.R. §§ 476.130(a)(2), 476.160(a)(3).

None of the QIOs with which the Catholic Hospitals have contracted have ever determined that their practices with respect to post-partum tubal ligation after C-section and sterilization do not meet professional recognized standards of health care. Strumwasser Decl., ¶ 22.

In sum, Petitioners' contention that the provision of health care by Catholic hospitals in accordance with their binding religious principles falls below the standard of care and is not "accepted medical practice" is flatly wrong and "evidences" only Petitioners' hostility to religion. Throughout American history, the one health care provider the poor and indigent could

consistently rely upon was the Catholic Church. This Court identified the "enshrined" place Catholic hospitals have in in our society for the thankless work they do. The number of public, government-owned, community hospitals continues to decline because these hospitals are too costly to operate. According to the ACLU, as of 2016 there were 548 Catholic hospitals in the United States that complied with the ERDs. [90] The ACLU further asserts that 1 in 6 hospital beds in the United States is in a Catholic hospital and 20 percent of hospital beds are in religious hospitals, Catholic or otherwise. It makes no sense and is unsupported to assert that these hospitals' care is substandard by virtue of their reliance on religious principles. Further, as a purely regulatory matter, Petitioners improperly are asking this Court to second guess expert regulators tasked with aggressive oversight of the Catholic Hospitals, none of which have ever found the Catholic Hospitals to violate Section 1258 or any of the myriad other laws that regulate the quality of obstetrical and other care provided in the Catholic Hospitals.

VI. SECTION 1258 CANNOT BE ENFORCED IN A MANNER THAT VIOLATES THE CATHOLIC HOSPITALS' CONSTITUTIONAL RIGHTS.

A. Petitioners Seek to Impermissibly Involve the Court in Church Affairs and Matters of Church Governance.

1. Application of Section 1258 to the Catholic Hospitals Would Interfere With the Internal Decisions of a Religious Institution Regarding Faith and Doctrine.

In *Guadalupe*, 140 S. Ct. at 2060 (2020), the Supreme Court made clear that the First Amendment broadly protects the autonomy of religious institutions with respect to "internal management decisions that are essential to the institution's central mission." Here, that protection clearly covers the process employed by MMCR and the other Catholic hospitals to determine whether to allow a tubal ligation procedure at the hospital. [91]

Guadalupe, which involved intentional discrimination claims under Title VII, is the most recent, though emphatic, reminder from the Supreme Court that "[t]he First Amendment itself [] gives special solicitude to the rights of religious organizations." *Hosanna-Tabor*, 565 U.S. at 189; *see, e.g., Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-Day*

[90] https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied
[91] At the November 19, 2019 hearing, the Court did *not* address the church autonomy doctrine.

Saints v. Amos, 483 U.S. 327 (1987); *N.L.R.B. v. Catholic Bishop of Chicago*, 440 U.S. 490, 502 (1979) (declaring NLRB practice of examining whether a school is "completely religious" or merely "religiously associated" was a prohibited intrusion).

In fact, "the Religion Clauses protect the right of churches and other religious institutions to decide matters 'of faith and doctrine' without government intrusion." *Guadalupe*, 140 S. Ct. at 2060 (citing *Hosanna-Tabor*). "State interference in that sphere would obviously violate the free exercise of religion, and any attempt by government to dictate or even to influence such matters would constitute one of the central attributes of an establishment of religion. The First Amendment outlaws such intrusion." *Id.* The "ministerial exception"—courts are bound to stay out of employment disputes involving those holding certain important positions with churches and other religious institutions—was "based on this insight." *Id. Guadalupe* also reaffirmed that the church autonomy doctrine is far broader than a mere "ministerial exception" and that it also applies to matter of "doctrine or faith" of a Church-affiliated organization. *Id*. at 2060.

Thus, while individuals and institutions may be religious, and both have free exercise rights, religious *institutions* also have missions that are separately protected by the church autonomy doctrine. Religious institutions do not "enjoy a general immunity from secular laws," but the First Amendment "does protect their autonomy with respect to internal management decisions that are essential to the institution's central mission." *Id.* at 2060. The United States Supreme Court has recognized "a spirit of freedom for religious organizations, an independence from secular control or manipulation, in short, power to decide for themselves, free from state interference, matters of church government *as well as those of faith and doctrine*." *Kedroff v. St. Nicholas Cathedral of Russian Orthodox Church in N. Am.*, 344 U.S. 94, 116 (1952) (emphasis added); *New v. Kroeger*, 167 Cal.App.4th 800, 815 (2008) ("Civil courts cannot interfere in disputes relating to religious doctrine, practice, faith, ecclesiastical rule, discipline, custom, law, or polity"); *Nally v. Grace Comm. Church*, 47 Cal.3d 278, 299 (1988) (refusing to impose a duty of care on pastors).

Freedom of religion is more than "mere freedom of worship"; it encompasses "respect for

freedom of conscience" as well.[92] MMCR and the other Catholic hospitals have a constitutionally protected right to engage in a faith-based decision-making process, informed by medical risk factors for maternal morbidity and mortality, to determine whether to allow a tubal ligation. And that religious process is entitled to the full protection of the federal and state constitutions-whether the decision is to admit or deny the procedure. The First Amendment absolutely prohibits burdening free exercise rights where the burden interferes with a religious institution's mission. Petitioners have cited no case to the contrary.

Guadalupe gives expression to Justice Brown's observations in her dissent in *Catholic Charities of Sacramento, Inc. v. Superior Court*: that although church autonomy and the ministerial exception have been applied narrowly, "the ministerial exception and the church autonomy doctrine are ways of describing spheres of constitutionally required protection, *but these categories are not exhaustive*." *Catholic Charities of Sacramento, Inc. v. Superior Court*, 32 Cal. 4th 527, 575 (2004) (Brown, J., dissenting) (emphasis added); *Guadalupe*, 140 S. Ct. at 2060; *see also Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2407 (2020) (Ginsburg, J., dissenting) (citing *Guadalupe* and noting the "broad scope the Court today attributes to the 'ministerial exception'").[93]

The essential inquiry for application of the church autonomy doctrine is three-fold. To be entitled to the protection from judicial interference afforded by the doctrine, (i) the entity

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[92] Pope Benedict XVI, Address to the Bishops of the United States of America from Region IV on Their *Ad Limina* Visit (Jan. 19, 2012), available at http://w2.vatican.va/content/benedict-xvi/en/speeches/2012/january/documents/hf_ben-xvi_spe_20120119_bishops-usa.html.

[93] Two weeks after *Guadalupe*, Justice Kavanaugh recognized that *Guadalupe* – not *Employment Division, Dep't of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990) – provides the rule that applies to neutral laws of general applicability when they interfere with a religious institution's internal decisions regarding faith and doctrine:

> To be sure, [neutral laws of general applicability], although not differentiating between religious and secular organizations, can still sometimes impose substantial burdens on religious exercise. If so, a religious organization may seek an exemption in court (if not also in the legislature) to the extent available under federal or state law and permissible under the Establishment Clause. *See, e.g., Our Lady of Guadalupe School v. Morrissey-Berru*, —— U.S.——, ——, 140 S.Ct. 2049, 2070, —— L.Ed.2d —— (2020); *Gonzales v. O Centro Espírita Beneficente União do Vegetal*, 546 U.S. 418, 126 S.Ct. 1211, 163 L.Ed.2d 1017 (2006).

Calvary Chapel Dayton Valley v. Sisolak, 140 S. Ct. 2603, 2611 (2020) (Kavanaugh, J., dissenting from denial of application for injunctive relief).

claiming protection must be a church or religious organization; (ii) the challenged decisions must be internal management decisions; and (iii) the decisions must be essential to the institution's central mission. *Guadalupe*, 140 S. Ct. at 2060. The test is easily satisfied in this case by mountains of irrefutable, publicly available evidence in the record here.

2. The Sterilization Policies and the ERDs Are Religious Institutions' Religious Decision-Making Protected by the First Amendment.

As discussed in Section II(B), the evidence shows that MMCR and the other Catholic Hospitals are owned by Dignity Health which is owned and controlled by CommonSpirit Health, which is sponsored and controlled by CHCF, which itself is sponsored and controlled by the Congregation, and which was founded by the Pope in 1586. There is a clear line of control by the Catholic Church that is documented in CHCF's Statutes, the articles of incorporation and bylaws of CommonSpirit Health and Dignity Health, as well as the medical staff bylaws and rules and regulations of each Catholic Hospital required to comply with Catholic religious doctrine and moral teaching including the ERDs. The Catholic Hospitals are part of the Roman Catholic Church as evidenced by their listing in the OCD and they are controlled by the Church through their governing documents.[94] Moreover, the Sterilization Policies of each hospital are based on Catholic religious doctrine and the ERDS, they are approved by the Bishop of Sacramento, and they are implemented by a Sister of Mercy or someone with theological background.

There is simply no question that the establishment and application of the Sterilization Policies constitutes an internal management decision that is essential to Dignity Health's central mission – the healing ministry of Jesus. As such, the Catholic Hospitals' decisions to adopt and apply the Sterilization Policies based upon their interpretation of the Catholic faith are protected from intrusion by this or any other court. (McGrath Decl., ¶ 80, Ex. 100 (Nov. 19, 2019 Hearing Tr.), 31:11-23.) It makes no difference whether such decisions are contrary to general laws of neutral applicability, such as Section 1258 or Title VII. Such laws simply cannot be applied to

[94] "Religious organizations warrant First Amendment protections in part because 'religious activity derives meaning in large measure from participation in a larger religious community. Such a community represents an ongoing tradition of shared beliefs, an organic entity not reducible to a mere aggregation of individuals. For many Americans, religion cannot be exercised apart from religious organizations, and therefore 'these organizations must be protected' by the First Amendment." *Duquesne Univ. of the Holy Spirit v. Nat'l Labor Relations Bd.*, 947 F.3d 824, 828 (D.C. Cir. 2020) (citing *Amos*) (internal citations omitted).

religious decision-making. "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992).

The Court has acknowledged that Petitioners challenge the religious decision-making of the Catholic Hospitals about matters of faith and doctrine. This meets the second part of the test. At the November 19, 2019 hearing, in a colloquy with Petitioners' counsel regarding the constitutionally permitted scope of any inquiry into the Catholic Hospitals' religious affairs, the Court clearly recognized that the review process is an exercise of religious decision-making, which the Court cannot overrule. (McGrath Decl., ¶ 80, Ex. 100, at 32:8-33:4.)

Petitioners admit that they challenge the Catholic Hospitals' values-based discernment process, which involves applying the ERDS to a patient's Request for sterilization, informed by the patient's medical condition. (MSJ Opp. 6/27/19, 2:18-21; Supp MSJ Opp, III(E)(3).) Petitioners' expert witness, Dr. Jackson, admitted that the MMCR Sterilization Review Committee's review process involves consideration of "the ERDs and/or the hospitals' sterilization policies," which "reflects religious or moral based decision making." (Jackson Report in Opp. to MSJ, p. 7, ¶ 49.) Chamorro specifically asserts that her Request was denied for religious reasons.

Petitioners have argued that "[t]here is a disputed issue of fact . . . as to how the practice of the Catholic hospitals interacts with the religious directives" and "a disputed issue of fact as to whether the practice of the Catholic hospitals in allowing some patients to undergo tubal ligation is a 'pastoral application of Catholic doctrine.'" (Supp MSJ Opp, 18:10-11; 20:19-22.) But, interpretation of the ERDs is an interpretation of Catholic theology, which the church autonomy doctrine prohibits. *Id.*; *Means*, 2015 WL 3970046, at *13. In *Means*, the plaintiff (also represented by the ACLU) asserted a negligence claim alleging that a Catholic hospital "did not provide the standard of medical care because it is a Catholic hospital that adheres to Defendant USCCB's Ethical and Religious Directives ("ERDs" or "Directives"). *Id.* at *2. The *Means* court found that the church autonomy doctrine required the Court to abstain from such dispute. The Court rejected the plaintiff's arguments that secular standards could be applied, or that the Court

could adjudicate a claim involving whether the hospital permitted or prohibited "direct abortions" as defined under the ERDs. *Id.* at *13 ("Plaintiff's complaint about the unavailability of "direct abortions" under the ERDs would require a nuanced discussion about how a "direct abortion" is defined in Catholic doctrine.")

For the same reason that the *Means* court could not insert itself into a dispute regarding the meaning of "direct abortions" under the ERDs, this Court cannot adjudicate whether a Catholic Hospital has permitted a "direct sterilization" – a sterilization for contraceptive purposes. *Id.* at *13. For the same reason, the Court cannot decide that, as Petitioners argue, the Catholic Hospitals are not following the ERDs from a "medical perspective," the very assertion of which wholly ignores the religious decision-making at the heart of the review process. (McGrath Decl., ¶ 46, Ex. 66 (Jackson Report), ¶¶ 52-55). The Court cannot adjudicate Petitioners' Section 1258 claim without adjudicating whether the Catholic Hospitals complied with the ERDs. But there can be no disputed issue of fact when it comes to a religious organization's application of its own doctrine to its own activities. That is mission-centric religious decision-making, immune from Petitioners' and the Court's influence and inquiry. Petitioners cannot interfere with how MMCR interprets and implements the ERDs by imposing their preferred interpretation on it.

The Court understands that application of the ERDs and the Sterilization Policies is an internal church decision and has recognized that Petitioners challenge a religious institution's internal decisions essential to its central mission. [95] The Court described Dignity Health's argument as follows:

> [Y]our argument really . . . is much more nuanced than just the ERDs. It's that the decision making process on a case by case basis as we looked at the totality of the person and what's best for the patient and taking into account our ethical teachings. All of that informs our determination as to what we believe are medical

[95] As Petitioners admit, "the Dignity Health Catholic hospitals each have a special tubal ligation review committee that exists solely to decide whether individual requests for tubal ligation accord with the hospital's interpretation of the religious directives and its related sterilization policy." (MSJ Opp, 14:13-15.) [96] *See also Duquesne Univ.*, 947 F.3d at 832 ("This case begins and ends with our decisions in *Great Falls* and *Carroll College*. . . . The Board lacks jurisdiction" over cases involving religious schools and their teachers if the school (1) holds itself out to the public as a religious institution (i.e., as providing a religious educational environment); (2) is nonprofit; and (3) is religiously affiliated). *Carroll Coll., Inc. v. N.L.R.B.*, 558 F.3d 568, 574 (D.C. Cir. 2009) ("That [Carroll College] is a nonprofit affiliated with a Presbyterian synod is beyond dispute. From the Board's own review of Carroll's publicly available documents [] it should have known immediately that the college was entitled to a *Catholic Bishop* exemption from the NLRA's collective bargaining requirements).

> criteria in determining whether a tubal ligation is or is not permitted, whether or not medical standards would consider it to be a contraceptive postpartum tubal ligation. Much more nuanced, and it meets what's happening on the ground. These committees and their review, and I think implicit if not explicit in your papers is your belief that all of that is covered by the state and federal free exercise clause.

However, the Court did not consider the "independence of religious institutions in matters of 'faith and doctrine.'" *Guadalupe*, 140 S. Ct. at 2060.

The Sterilization Policies reflect the ERDs. Both are internal management decisions by Bishops who bind the Hospitals to follow them. Both are central to the Catholic Hospitals' mission to further the healing ministry of Jesus. Each Catholic Hospital is bound by Catholic law and doctrine to comply with the ERDs. The Sterilization Policy is drafted and implemented specifically to ensure compliance with Directive 53.

3. The Catholic Hospitals' Decisions on Sterilization Requests Are Essential to the Catholic Hospitals' Central Mission.

"Determining that certain activities are in furtherance of an organization's religious mission . . . is [] a means by which a religious community defines itself." *Amos*, 483 U.S. at 342 (conc. opn. of Brennan, J.). The Catholic Hospitals' mission is to further the healing ministry of Jesus by delivering pastoral care in accordance with the ERDs and Catholic faith and doctrine to those who need it. The sterilization Request review process is part of the Catholic Hospitals' pastoral care, the provision of which is essential to their mission. (O'Keeffe Decl., ¶¶ 22-23.)

As the Court has already recognized, a Court may not second-guess a Catholic hospital's decisions in this area. The church autonomy doctrine's protection is absolute; no balancing is permitted. Where the Court must scrutinize religious doctrine to assess the merits of a legal position, the Court risks excessively entangling the law in the free exercise of religion. *Guadalupe*, 140 S. Ct. at 2063 ("In considering the circumstances of any given case, courts must take care to avoid 'resolving underlying controversies over religious doctrine.'"); *Means*, 2015 WL 3970046, at *12. "[I]t is well established, in numerous other contexts, that courts should refrain from trolling through a person's religious beliefs." *Mitchell v. Helms*, 530 U.S. 793, 828 (2000) (plurality opinion). Thus, courts are prohibited from inquiring into the orthodoxy of adherence of religiously affiliated entities. *See, e.g., N.L.R.B. v. Catholic Bishop of Chicago*, 440

U.S. 490, 502 (1979) (declaring NLRB practice of examining whether a school is "completely religious" or merely "religiously associated" was a prohibited intrusion); *University of Great Falls v. N.L.R.B.*, 278 F.3d 1335, 1340 (D.C. Cir. 2002) ("the very inquiry . . . into the University's religious character" is unconstitutional); *see also Universidad Cent. De Bayamon v. N.L.R.B.*, 793 F.2d 383, 402-03 (1st Cir. 1985) (noting *Catholic Bishop* "sought to minimize" entanglement with religious affairs); *Overall v. Ascension*, 23 F. Supp. 3d 816, 832 (E.D. Mich. 2014) (plaintiff's "argument regarding religious orthodoxy is prohibited by the Constitution").[96] Even *Catholic Charities*, discussed in Section VI.A.4 *infra*, recognized that the Court is prohibited from engaging in any effort "to verify that [a religious organization's] purpose was the inculcation religious values, and that it primarily employed and served persons who shared its religious tenets." *Catholic Charities*, 32 Cal. 4th at 547.

Petitioners contend that patients, not hospitals, "should be the moral decision-makers for healthcare." (McGrath Decl., ¶ 43, Ex. 63 (Magee Depo.), 80:2-6.) But that is just more evidence of Petitioners' animus towards the Catholic Hospitals, which are private institutions that have operated lawfully for hundreds of years. Patients are not the autonomous moral decision-makers inside a Catholic Hospital, which is bound to its own decision-making process by a constitutionally protected religious mission that dates back centuries. The Court has correctly rejected Petitioners' previous attempts to argue that the Catholic Hospitals are not acting Catholic "enough." (McGrath Decl., ¶ 80, Ex. 100 (Nov. 19, 2019 Hearing Tr.), 32:8-33:4.) Only the unquestioned sincerity of the Catholic Hospitals' religious belief and matters to establishing the applicability of the church autonomy doctrine to their decisions; the existence of contrary viewpoints is irrelevant.[97] "While it is generally inappropriate for a court to judge the truth or

[96] *See also Duquesne Univ.*, 947 F.3d at 832 ("This case begins and ends with our decisions in *Great Falls* and *Carroll College*. . . . The Board lacks jurisdiction" over cases involving religious schools and their teachers if the school (1) holds itself out to the public as a religious institution (i.e., as providing a religious educational environment); (2) is nonprofit; and (3) is religiously affiliated). *Carroll Coll., Inc. v. N.L.R.B.*, 558 F.3d 568, 574 (D.C. Cir. 2009) ("That [Carroll College] is a nonprofit affiliated with a Presbyterian synod is beyond dispute. From the Board's own review of Carroll's publicly available documents [] it should have known immediately that the college was entitled to a *Catholic Bishop* exemption from the NLRA's collective bargaining requirements).

[97] In this regard, neither the existence of competing religious viewpoints nor Petitioners' understanding of the Catholic Hospital's religious decision-making process (or lack thereof) is relevant.

validity of a religious practice or belief, it is not illegitimate to inquire whether or not claims to religious belief are sincerely held or merely a sham put forth in an effort to avoid the reach of laws." *Kelly v. Methodist Hosp. of S. Cal*., 22 Cal. 4th 1108, 1123 (2000). In *Thomas v. Review Bd*., 450 U.S. 707, 714 (1981), the Supreme Court made clear that it is the religious motivation of a belief of the affected religious entity, and not the orthodoxy of that belief, that matters. In *Thomas*, the Petitioner, a Jehovah's witness, was denied unemployment benefits after he was fired for refusing, for religious reasons, to manufacture war materials. *Id*. at 710. The Indiana Supreme Court, persuaded by testimony by other Jehovah's Witnesses that they "had no scruples about working on tank turrets," affirmed the denial of benefits. *Id*. at 713.

The Supreme Court reversed, holding that "the guarantee of free exercise is not limited to beliefs which are shared by all of the members of a religious sect. Particularly in this sensitive area, it is not within the judicial function and judicial competence to inquire whether the petitioner or his fellow worker more correctly perceived the commands of their common faith. Courts are not arbiters of scriptural interpretation." *Id*. at 715-16; *see also Frazee v. Illinois Dep't of Employment Sec*., 489 U.S. 829, 834 (1989) ("It is also true that there are assorted Christian denominations that do not profess to be compelled by their religion to refuse Sunday work, but this does not diminish Frazee's protection flowing from the Free Exercise Clause. *Thomas* settled that much. Undoubtedly, membership in an organized religious denomination, especially one with a specific tenet forbidding members to work on Sunday, would simplify the problem of identifying sincerely held religious beliefs, but we reject the notion that to claim the protection of the Free Exercise Clause, one must be responding to the commands of a particular religious organization."); *Great Falls*, 278 F.3d at 1344 ("Religious beliefs need not be acceptable, logical, consistent, or comprehensible to others to merit First Amendment protection").

4. *Catholic Charities* Does Not Control the Result Here.

The California Supreme Court's decision in *Catholic Charities* does not prevent application of the church autonomy doctrine to protect the Hospitals' decisions here. *Catholic Charities* was decided under a narrow view of church autonomy that is rejected in *Guadalupe*, 140 S. Ct. at 2060. No California decision – published or otherwise – has considered the effect of

Guadalupe on the application of the church autonomy doctrine. *See People v. Suarez,* 10 Cal. 5th 116, 138 (2020) (California Supreme Court may not depart from the United States Supreme Court ruling as to the United States Constitution); *People v. Johnson*, 53 Cal. 4th 519, 528 (2012) ("Lower courts may decide questions of first impression, including the effect that subsequent events, such as a United States Supreme Court decision, have on decisions from a higher court, including this one.").

Catholic Charities involved a dispute over a Catholic organization's refusal, on religious grounds, to provide health care coverage for contraception to its employees. The organization sued state entities, seeking to enjoin enforcement of a state law requiring contraceptive coverage as violative of the organization's religious rights. The case was a statutory challenge that had nothing to do with a Catholic health care organization's provision of patient care under the ERDs. The *Catholic Charities* Court affirmed the denial of a preliminary injunction, in part because the dispute implicated the relationship between a non-profit and its employees, many of whom did not belong to the Catholic Church. *Catholic Charities*, 32 Cal. 4th at 542 ("Only those who join a church impliedly consent to its religious governance on matters of faith and discipline.").

But the point of the ministerial exception cases (and *Catholic Bishop*) is that the impact of a religious organization's decisions on its employees is irrelevant to whether those decisions are protected under the First Amendment. *Guadalupe* confirms that the objections of, impact on, and religious practices of employees are irrelevant. *Guadalupe*, 140 S. Ct. at 2068 ("insisting [that the church autonomy doctrine only applies to affected members of the same faith] as a necessary condition would create a host of problems"). The plaintiffs in *Guadalupe*, *Hosanna-Tabor*, and other "ministerial exception" cases who were terminated are plainly impacted by the internal management decision of the religious institution. But the decision still is entitled to protection and judicial non-intervention under the First Amendment. The policy reasons for wrongful termination or discrimination claims outside of a religious context are not at issue.[98] This result is

[98] Thus, the church autonomy doctrine protects the Catholic Hospitals' decisions even if Petitioners believe that Section 1258 is about "ensuring equal treatment in accessing health care." (McGrath Decl., ¶ 80, Ex. 100 (Nov. 19, 2019 Hearing Tr.), 14:12-15.) Aside from the fact that all patients are treated equally under the Catholic Hospitals' sterilization policies, Section 1258 does not apply for the same reason that Title VII does not apply where the ministerial exception is applicable: both improperly interfere with religious institutions' constitutionally protected

compelled by the First Amendment. *See Hosanna-Tabor*, 565 U.S. at 199 ("In a case like the one now before us—where the goal of the civil law in question, the elimination of discrimination against persons with disabilities, is so worthy—it is easy to forget that the autonomy of religious groups, both here in the United States and abroad, has often served as a shield against oppressive civil laws.") (Alito, J. joined by Kagan, J., concurring).

Petitioners have repeatedly and falsely attempted to liken this case to a discrimination case. But this Court long ago dismissed their "discrimination" claims and the Catholic Hospitals' internal management decisions about the services they will provide based upon Catholic faith and doctrine in order to carry out their healing ministry means that some services may lawfully not be provided. The church autonomy doctrine provides that the Court can pass no such judgment upon what Petitioners, Dignity Health, and the Court all agree is religious decision-making, however Petitioners attempt to cast it. The First Amendment affords no forum to object, appeal, or second guess the Catholic Hospitals' decisions.

Catholic Charities also relied upon distinguishable cases that did not involve non-profit religious institutions. *Tony & Susan Alamo Found. v. Sec'y of Labor*, 471 U.S. 290, 292 (1985) involved a cult's scheme to avoid the Fair Labor Standards Act requirements in its multiple for-profit businesses. *Id.* The Court held that the FLSA applied because the defendant was engaged in ordinary commercial activities, and the employees were not volunteers because they were paid wages "in another form." In *United States v. Lee*, 455 U.S. 252, 256 (1982), the Supreme Court held that the exemption for payment of social security taxes available to self-employed religious objectors did not apply when two (or more) persons of the same faith engage in an employee-employer relationship. *Lee* applies to "followers of a particular sect [that] enter into commercial activity as a matter of choice," not to the religion's institutions. *Id.* at 261.

Unlike *Tony & Susan Alamo* and *Lee*, the non-profit Catholic Hospitals are not engaged in commercial activity. *See Kelly v. Methodist Hosp. of S. Cal.*, 22 Cal. 4th 1108, 1124 (2000) ("[W]hat of a soup kitchen located in a church basement? It may be argued that the technical purpose of a soup kitchen is to provide food to the hungry rather than to make an immediate

religious decision-making. The policy behind the law is irrelevant.

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manifestation of devotion to a divine entity. . . . Nevertheless, while providing food is an arguably secular function, the church's underlying motivation for feeding the destitute remains a matter of religious motivation and faith."); *Amos*, 483 U.S. at 337 (explaining that a not-for-profit gymnasium built over 75 years ago as part of a religious mission is not a commercial activity subject to government regulation).[99] The healing ministry of Jesus dates back two millennia, and many centuries before any government cared about providing health care, let alone attempted to regulate it. Nothing could be further from a commercial enterprise than religious hospitals that care for all who need and seek care, established at a time when it was well-known there was no profit to be had. Today, the hospitals remain non-profit enterprises, and continue to exist as an expression of faith and for the purpose of carrying out Jesus' healing ministry.

Further, although the *Catholic Charities* Court recognized that the church autonomy doctrine, "may place an outer limit on the [contraceptive coverage] statute's constitutional application," the Court focused narrowly on the ministerial exception. *Catholic Charities*, 32 Cal. 4th at 543. Rather than recognizing the ministerial exception is but one "component" of the church autonomy doctrine, the Court simply concluded that the doctrine did not apply because the employees were not ministers. Justice Brown explained this too in her prescient dissenting opinion. *Catholic Charities*, 32 Cal. 4th at 575. *Guadalupe* makes clear that the church autonomy doctrine is far broader.

B. The Hospitals' Sterilization Review Process Is Protected by the Free Exercise Clause.

Petitioners' claim also is barred by the guarantees of religious freedom and freedom of expression enshrined in the California and federal Constitutions. Petitioners' interpretation of Section 1258 would impermissibly burden the Catholic Hospitals' free exercise of their religion. Cal. Const., art. I, §§ 2, 4; U.S. Const. amend. I; *People v. Woody*, 61 Cal. 2d 716, 718, n.1, 727 (1964) (religious freedom is "guaranteed" under the California Constitution, and "the right to free religious expression embodies a precious heritage of our history"). Specifically, enforcing Section 1258 in a manner that would force the Catholic Hospitals to choose between violating

[99] In this regard, Petitioners' offensive swimming pool analogy does not work because church swimming pools are not public swimming pools and private Catholic Hospitals cannot be treated like secular hospitals in all respects.

Catholic religious doctrine by performing tubal ligations on demand or entirely prohibiting tubal ligations places an unacceptable burden on the Catholic Hospitals' constitutional rights of free exercise and free expression. These violations could not pass any level of scrutiny.

Petitioners have argued that their interpretation of Section 1258 can survive constitutional scrutiny because the Catholic Hospitals can comply with the law by prohibiting all tubal ligations. But that ignores the entire concept of pastoral care—which requires the Catholic Hospitals to consider each individual patient's unique condition and circumstances—as well as ignores the specific directive of the ERDs to provide "prenatal, obstetric, and post-natal services in a manner consonant with [their] mission." It also ignores The Joint Commission's standards of accreditation, which are also legal obligations on the Catholic Hospitals which must remain certified to participate in the Medicare and Medi-Cal Programs.

The suggestion that the Catholic Hospitals can comply with the law and their faith by simply not performing any tubal ligation procedures is overly simplistic and more evidence of hostility to the Catholic Hospitals' religion. Just as requiring the Catholic Hospitals to provide tubal ligations that are not allowed under Catholic doctrine would violate constitutional guarantees, so too would precluding the Catholic Hospitals from carrying out their healing ministry by allowing tubal ligation procedures when the procedures can be allowed under Catholic religious doctrine.

1. The California Constitution Prohibits the State From Compelling the Catholic Hospitals to Perform Tubal Ligation Procedures Prohibited By Religious Doctrine and From Prohibiting Tubal Ligations When the Procedures Are Permitted by Religious Doctrine.

The California Constitution provides that "free exercise and enjoyment of religion without discrimination or preference are guaranteed." Cal. Const., art. I, § 4. "The Attorney General of this state has observed that '[i]t would be difficult to imagine a more sweeping statement of the principle of governmental impartiality in the field of religion' than that found in the 'no preference' clause . . . ." *Sands v. Morongo Unified Sch. Dist.*, 53 Cal.3d 863, 883 (1991) (quoting 25 Ops.Cal.Atty.Gen. 316, 319 (1955)). California courts have repeatedly noted that the "guaranteed" protection for free exercise and enjoyment of religion in the California Constitution

is broader than that under the federal constitution. *See, e.g., Carpenter v. City and County of San Francisco*, 93 F.3d 627, 629 (9th Cir. 1996) ("In general, the religion clauses of the California Constitution are read more broadly than their counterparts in the federal Constitution."); *Fox v. City of Los Angeles*, 22 Cal.3d 792, 796 (1978) (free exercise of religion clause in California Constitution is more "comprehensive" than in federal Constitution). However, a palpable contrary direction, evinced by *Guadalupe*, is well underway.[100]

a. Strict Scrutiny Should Be Applied to the Application of Section 1258 to the Catholic Hospitals.

The California Supreme Court has not expressly determined what level of scrutiny applies to freedom of religion claims under the California Constitution, concluding in each case to raise the issue that an express determination of the standard was not necessary. *North Coast Women's Care Med. Grp., Inc. v. Sup. Ct.*, 44 Cal. 4th 1145, 1158 (2008); *Catholic Charities*, 32 Cal.4th at 559.[101] However, in each case, the Court has in fact applied strict scrutiny. *North Coast*, 44 Cal.4th at 1158; *Catholic Charities*, 32 Cal.4th at 562. The application of strict scrutiny is consistent with the broad protection of religion in the California Constitution. Under strict scrutiny, a state law that substantially burdens a party's free exercise of religion may not be enforced unless it serves a compelling state interest and there is no less restrictive means to accomplish that compelling interest. *North Coast*, 44 Cal.4th at 1158; *Catholic Charities*, 32 Cal.4th at 562. That standard is not met with respect to Section 1258 as applied here.

b. Petitioners' Claims Would Substantially Burden the Catholic Hospitals' Free Exercise of Religion.

As the Court put it in *Catholic Charities*, "a law substantially burdens a religious belief if it 'conditions receipt of an important benefit upon conduct proscribed by a religious faith, or

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[100] As Jeffrey Toobin observed, the Supreme Court is moving in the "clear" direction of "allow[ing] religious people to exempt themselves from obligations that are binding on other citizens." *See, e.g.*, https://www.newyorker.com/news/daily-comment/the-supreme-court-is-quietly-changing-the-status-of-religion-in-american-life. (March 2019**)**. Indeed, as discussed *infra*, in addition to the religion cases decided in the last Term the Supreme Court's grant of certiorari in *Fulton v City of Philadelphia* speaks forcefully to the changes in religious freedom jurisprudence that (like *Guadalupe*) relate directly to this case**.**

[101] As discussed in the next section, the Supreme Court articulated a rational basis standard for claims under the U.S. Constitution in *Employment Division, Dep't of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990). The *Smith* standard does not apply to claims under the California Constitution. *North Coast*, 44 Cal.4th at 1158; *Catholic Charities*, 32 Cal.4th at 560.

where it denies such a benefit because of conduct mandated by religious belief, thereby putting substantial pressure on an adherent to modify his behavior and to violate his beliefs . . . .'" *Catholic Charities*, 32 Cal.4th at 562 (quoting *Thomas v. Review Bd.*, 450 U.S. 707, 714 (1981)); *see also Trinity Lutheran Church of Columbia v. Comer*, 137 S.Ct. 2012, 2022 (2017) ("the Free Exercise Clause protects against indirect coercion or penalties on the free exercise of religion, not just outright prohibitions") (internal quotation marks omitted).

It is no answer to the constitutional problem to argue that MMCR can comply with Directive 53 and Section 1258 by simply performing no sterilization procedures. This ignores the fact that pastoral care is an integral part of Catholic health care and in some cases would support provision of sterilization services. Further, a decision to perform no sterilizations would cause the Catholic Hospitals to violate Directive 44, which requires Catholic hospitals to provide "prenatal, obstetric, and post-natal services in a manner consonant with [their] mission."

Here, the substantial burden test is clearly met. PRH and the ACLU recognize that if a Catholic Hospital "run[s] afoul of the ERDs [it] could simply be cut loose from the broader health system – which could mean sudden death for a facility."[102] Further, Section 1258 is a hospital licensing statute that, if violated, could result in the suspension or revocation of a hospital's license. Health & Safety Code § 1294(a).[103] In addition, a violation of Section 1258 is a misdemeanor punishable by a fine not to exceed $1,000 or by imprisonment in county jail for a period not to exceed 180 days or both. Health & Safety Code § 1290(a). Thus, if Section 1258 is interpreted to require a hospital to perform tubal ligations on demand, it would condition receipt of a hospital license on conduct that is proscribed by Catholic religious doctrine. And, if Section 1258 is interpreted to prohibit a Catholic hospital from allowing a tubal ligation through a faith-based review process that is part of the hospital's healing ministry, it would deny the hospital the benefit of a hospital license based upon conduct (the provision of health care) mandated by religious belief and would in fact criminalize the hospital's pursuit of Jesus' healing ministry.

[102] McGrath Decl., ¶ 4, Ex. 24 (https://healthlaw.org/wp-content/uploads/2018/11/Coalition-Letter-Dignity-CHI-Merger-Sept.-2018.pdf).

[103] Section 1258 appears within the "Licensing Provisions" for health facilities in Chapter 2, Article 1 of the Health & Safety Code.

See Trinity Lutheran, 137 S. Ct. at 2022 (government cannot deny "benefits" by conditioning participation on disavowal of applicant's religious character).

c. Application of Section 1258 as Sought By Petitioners Is Not the Least Restrictive Means of Achieving a Compelling Interest.

Once it is determined that applying the law in the manner sought will substantially burden a religious belief or practice, the next step is to determine whether application of the law "represented the least restrictive means of achieving a compelling interest or, in other words, was narrowly tailored." *Catholic Charities*, 32 Cal.4th at 562 (citing *Thomas*, 450 U.S. at 718 and *Sherbert v. Verner*, 374 U.S. 398, 403 (1963)). The Supreme Court has made clear that when applying the compelling interest test, "context matters" and that "strict scrutiny takes "relevant differences into account—indeed, that is its fundamental purpose." *Gonzales*, 546 U.S. at 431–32.

In *Catholic Charities*, when applying strict scrutiny to the application of the contraception coverage statute, the Court looked to the legislative history of the statute. The Court held, based on that legislative history, that the statute was expressly intended to serve the compelling state interest of eliminating gender discrimination by generally requiring that all businesses, except narrowly defined religious employers, provide employee prescription drug coverage to provide coverage for prescription contraceptives. *Catholic Charities*, 32 Cal.4th at 564 (noting the evidence before the Legislature that women spent as much as 68 percent more than men in out-of-pocket health costs due in part to the costs related to prescription contraceptives and the various costs of unintended pregnancies). On that basis, the Court held that the elimination of gender discrimination was clearly a compelling interest. It further held that enforcement of the statute was the least restrictive alternative to achieve that interest, and any exemptions broader than already provided in the statute would increase the number of women affected by discrimination. *Id*. at 564-65.[104]

[104] The *Catholic Charities* court also emphasized that regulation of the content of insurance policies was a traditional state regulatory function. 32 Cal. 4th at 549. In contrast, California does not require private hospitals to provide obstetrical-gynecologic services as among the eight "basic services" for a licensed acute care hospital. See Cal. Code Regs., tit. 22 § 70005(a) ("General acute care hospital means a hospital, licensed by the Department, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical,

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Thus, it is clear that the "compelling interest" analysis would require a court to look at the legislative history of the law in question. As set forth in Section II.A, *supra*, the text and the legislative history of Section 1258 show that its purpose was to eliminate application of arbitrary, nonmedical, socio-economic considerations, like the 120-point rule, to elective sterilization procedures. Section 1258 increased access to elective sterilization procedures only insofar as it eliminated arbitrary restrictions improperly imposed at secular hospitals. To the extent the state has a compelling interest in ensuring that hospitals' decisions whether to permit a tubal ligation not be based upon special nonmedical qualifications, that interest is in the elimination of the arbitrary use of nonmedical factors by secular hospitals. Religious directives that Catholic hospitals are required to follow—and entitled to follow under the Constitution—are not remotely in the same category of factors, like age, number of children, and marital status, that could be impermissibly used in a nonmedical way. Nothing in the text or legislative history of Section 1258 indicates an intent to interfere with the discernment process employed at religious hospitals, which may result in permitting certain operations with contraceptive effect that would otherwise be prohibited by religious rules. In addition, the state has no compelling interest in restricting the Catholic Hospitals from considering a patient's advanced maternal age, when used in connection with the medical condition of the patient, to determine whether they can permit a requested sterilization. There is zero state interest in tying the hands of hospitals in that regard. Moreover, Section 1258 does not require any hospital to perform elective sterilizations; every hospital in California could lawfully cease providing elective sterilization operations tomorrow in full compliance with Section 1258.

The Court must review the legislative history and the state's compelling interest in context, and consider the stark differences between the Catholic Hospitals' religious missions and the 120-point rule. In doing so, even assuming for purposes of argument that increasing access to elective sterilization is a compelling state interest, enforcement of Section 1258 in the manner sought by Petitioners to require the Catholic Hospitals to allow tubal ligations on demand or prohibit them altogether, is not the least restrictive alternative to achieve the state's interest. That

anesthesia, laboratory, radiology, pharmacy, and dietary services".)

application of Section 1258 would *decrease*, not increase, access to tubal ligations by forcing the Catholic Hospitals to prohibit all tubal ligations. And there is clearly no compelling state interest whatsoever in preventing the Catholic Hospitals from permitting the procedures when the hospitals conclude that they can be performed in a Catholic hospital.

d. The Catholic Hospitals' Purported Binary Choice to Either Allow Tubal Ligations on Demand or Prohibit Them Altogether Does Not Make Petitioners' Application of Section 1258 Constitutional.

Petitioners have argued their interpretation of Section 1258 survives constitutional scrutiny because the Catholic Hospitals may comply with the law by "refusing entirely to provide tubal ligations to anyone." (MSJ Opp. at 19:21-22.). As discussed in Section VI, *supra*, that means of complying with the law would impose a burden on the Catholic Hospitals because it would require them to ignore other, competing religious directives, regulations, and accreditation standards. In *Catholic Charities*, the Court considered a somewhat similar argument. albeit not one that related to a Catholic hospital's provision of health care services to patients consistent with the religious directives that controlled the provision of such care: that Catholic Charities could avoid the law requiring provision of health coverage for contraception by simply not providing prescription drug coverage altogether; therefore, the WCEA did not substantially burden Catholic Charities' religious beliefs. *Catholic Charities*, 32 Cal.4th at 562; *compare Trinity Lutheran*, 137 S. Ct. at 2022 ("To condition the availability of benefits ... upon [a recipient's] willingness to ... surrender[ ] his religiously impelled [status] effectively penalizes the free exercise of his constitutional liberties") (citation and quotations omitted). The Court noted that Catholic Charities contended that providing prescription drug benefits to employees was part of its religious mission and that putting it to the choice of discontinuing such benefits still burdened its free exercise of religion.

The Supreme Court did not treat Catholic Charities with the "special solicitude" required for religious freedom claims of religious organizations, and it ignored the important fact that Catholic Charities is a part of the Catholic Church. *Hosanna-Tabor*, 565 U.S. at 189. That approach is now in serious question based on *Guadalupe* and the forthcoming decision in *Fulton*

v City of Philadelphia, discussed in Section VI(B)(2), *infra*. Instead, the Court evinced hostility to religion by openly questioning whether provision of employee benefits actually was part of Catholic Charities' religious mission, as opposed to merely reflecting a secular "philosophical choice." *Catholic Charities*, 32 Cal. 4th at 563. Nevertheless, the Court accepted Catholic Charities' contention for purposes of argument, and did not decide that the case on that basis. *Id*. at 564.

As discussed above, the *Catholic Charities* Court did not purport to decide the case on the ground that the law did not substantially burden Catholic Charities' exercise of religious freedoms, but rather based upon the compelling state interest and least restrictive alternative tests. *Id*. at 564-65. Thus, *Catholic Charities* does not support Petitioners' argument that Section 1258 does not substantially burden the Catholic Hospitals' free exercise rights. Moreover, any interpretation of Section 1258 that would force the Catholic Hospitals into a binary choice between (i) violating Catholic doctrine by allowing tubal ligations on demand or (ii) prohibiting tubal ligations even when the procedure would properly be performed as part of the hospitals' healing ministry would obviously substantially burden the Catholic Hospitals' free exercise of religion.

This burden on free exercise rights is massively magnified by the ACLU's request, as counsel for Petitioners in this case, that the Attorney General require Dignity Health to maintain the current level of women's reproductive services at the Catholic Hospitals (and other hospitals), including those such as tubal ligations that are and must be provided, in the ACLU's words, as "exceptions" to the ERDs. (Strumwasser Decl., ¶ 24, Ex. 9 (Public Hearing Tr.), 165:19-166:8 (emphasis added)). As Dignity Health is prohibited from reducing the current level of women's reproductive services at the Catholic Hospitals, Petitioners' claim that Section 1258 should survive judicial scrutiny because the hospitals may make the choice to "refus[e] entirely to provide tubal ligations to anyone" is plainly false and Petitioners and their counsel know it. If the Catholic Hospitals made that choice, Dignity Health would violate the Attorney General's condition, and Dignity Health would be at risk of being sued by the Attorney General for specific performance. Thus, the only way to comply with Petitioners' requested enforcement of Section

1258 would be the other side of the binary choice they proposed – allowing tubal ligations on demand, which would mean that the Catholic Hospitals would cease to be Catholic hospitals and would likely be defrocked and removed from the Dignity Health system, and possibly closed altogether, a point which Petitioners and their counsel also recognize.[105] Putting the Catholic Hospitals between such a rock and a hard place poses an obvious and substantial burden on their rights to free exercise of religion that cannot withstand any level of constitutional scrutiny.

2. The U.S. Constitution Also Prohibits the State From Compelling the Catholic Hospitals to Perform Tubal Ligation Procedures Prohibited by Religious Doctrine and From Prohibiting Tubal Ligations When the Procedures Are Permitted by Religious Doctrine.

The Catholic Hospitals also are entitled to protection of their religious freedoms under the U.S. Constitution. The U.S. Constitution's protection for religious freedom has followed a complicated and uneven path for a generation, and it has never been more complicated than at present. In 1990, the United States Supreme Court overruled existing precedent applying strict scrutiny to free exercise claims asserted by plaintiffs complaining of burdens imposed by a state criminal statute regulating narcotics that was a "valid and neutral law of general applicability." *Smith*, 494 U.S. at 879 (1990) (religious beliefs protected under the Free Exercise Clause of the U.S. Constitution do not exempt an individual from complying with a neutral state law of general applicability that does not target religion).[106] Congress responded to *Smith* by explicitly repudiating it in RFRA which provides that "laws 'neutral' toward religion may burden religious exercise as surely as laws intended to interfere with religious exercise." 42 U.S.C. § 2000bb(a)(2);[107] *see also Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 694 (2014) (noting RFRA was enacted in response to *Smith*). RFRA provides "very broad protection for religious

[105] "[F]acilities that run afoul of the ERDs could simply be cut loose from the broader health system—which could mean sudden death for a facility." McGrath Decl., ¶ 4, Ex. 24 (https://healthlaw.org/wp-content/uploads/2018/11/Coalition-Letter-Dignity-CHI-Merger-Sept.-2018.pdf).

[106] *Smith* was decided 6-3. Justice O'Connor, who concurred in the result, wrote a dissent joined by the dissenters, noting that the majority opinion "dramatically departs from well-settled First Amendment jurisprudence, appears unnecessary to resolve the question presented, and is incompatible with our Nation's fundamental commitment to individual religious liberty." *Smith*, 494 U.S. at 891 (O'Connor, J., concurring and dissenting).

[107] Under RFRA, the federal "Government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000bb-1.

liberty." *Id.* (applying RFRA to protect free exercise rights of owners of for-profit company to not provide abortion coverage). In 1997, the Supreme Court overruled RFRA as applied to the states arguably resulting in the patchwork application of different standards depending on whether a state or a federal law was at issue.[108] *See City of Boerne v. Flores*, 521 U.S. 507, 511 (1997).

The bizarre imbalance caused by *Smith* and RFRA–which together permit state laws to interfere with federal constitutional rights in ways that even federal laws cannot–appears ready to topple. On February 24, 2019, the Supreme Court granted certioari in *Fulton v. City of Philadelphia*, Supreme Court Case No. 19-123. One of the specific issues for review is whether *Smith* should be overruled.[109] At least four justices have already signaled their desire to overrule *Smith* in favor of stronger protections for the exercise of religious freedom.[110]

The Supreme Court had already moved away from an absolutist application and towards a more nuanced and flexible view of *Smith* in recent years. *See Trinity Lutheran*, 137 S.Ct. at 2021 n. 2 (explaining that *Smith* did not say "that any application of a valid and neutral law of general applicability is necessarily constitutional under the Free Exercise Clause"). Rather, whether *Smith* will require in any particular case that the asserted religious freedom must yield to a neutral

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[108] In other words, if the federal government passed a law identical to Section 1258, the Court would be required to apply RFRA's strictest scrutiny test to a claim based on the U.S. Constitution.

[109] The Court will recall that Dignity Health, in its pending certiorari petition in *Minton*, expressly requested the Supreme Court to "hold" the *Minton* case until it decides *Fulton*, as both cases pose the identical First Amendment issue regarding the continued viability of *Smith*. We will report to this Court very soon regarding whether the Supreme Court has elected to hold the *Minton* case pending its decision in *Fulton*, in lieu of an outright grant or denial of certiorari.

[110] *Kennedy v. Bremerton Sch. Dist.*, 139 S.Ct. 634, 637 (2019) (Alito *et al.*, JJ., concurring regarding denial of certiorari; *see also Morris Cty. Bd. of Chosen Freeholders v. Freedom From Religion Found*., 139 S. Ct. 909, 911 (2019) (distinguishing *Hobby Lobby* and *Smith* as cases involving exemptions from generally applicable laws, which cases "can pose difficult questions) (statement of Kavanaugh *et al.*, JJ., regarding a denial of certiorari). Justice Roberts, who did not join in *Bremerton* or *Morris County* statements, made his willingness to depart from *Smith* clear in *Trinity Lutheran*, a case that involved whether a religious entity could be prohibited from participating in a program to subsidize rubber playground mats. *Trinity Lutheran*, 137 S. Ct. at 2021, n.2 ("This is not to say that any application of a valid and neutral law of general applicability is necessarily constitutional under the Free Exercise Clause"). PRH is expressly opposed to nomination of Judge Amy Coney Barrett to the Supreme Court. https://secure.everyaction.com/R_rmPjaxQkCZzmlKrvTe6A2a. Judge Barrett finds a "weak presumption of stare decisis in [the Supreme Court's] constitutional cases, noting that reversal is reflective of mere "jurisprudential disagreement." Amy C. Barrett, Precedent and Jurisprudential Disagreement, 91 Tex. L. Rev. 1711, 1728 (2012-2013) ("I tend to agree with those who say that a justice's duty is to the Constitution and that it is thus more legitimate for her to enforce her best understanding of the Constitution rather than a precedent she thinks clearly in conflict with it."), *available at* https://scholarship.law.nd.edu/law_faculty_scholarship/293.

state law presents "difficult" and "delicate" questions. *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719, 1723-24 (2018). While the *Masterpiece* Court did not need to resolve those questions,[111] its opinion spoke of "reconciliation" of the state's right to protect persons from discrimination with the right to exercise freedom of religion (*id.* at 1723); "determin[ing]" a "balance" between free exercise of religion and "an otherwise valid exercise of state power" (*id.* at 1723-24); "weigh[ing]" the state's interest against the baker's "sincere religious objections" (*id.* at 1732); and placing "sufficient[] constrain[ts]" on any decision favoring free exercise of religion over antidiscrimination law (*id.* at 1728-29). The Court clearly did not consider the application of *Smith* to be cut and dried. Instead, the Court said "[t]he outcome of cases like this in other circumstances must await further elaboration in the courts, all in the context of recognizing that these disputes must be resolved with tolerance, without undue disrespect to sincere religious beliefs, and without subjecting gay persons to indignities when they seek goods and services in an open market." *Id.* at 1732.

An approach that is fully consistent with *Smith* yet affords "constitutionally protected space for religious organizations" is to recognize that *Smith* constrained the ability of *individuals* to practice their religion in a manner that would violate generally applicable state law. Nothing in *Smith*, which involved affirmative religious practices of *individuals* and a state criminal statute, purported to reach the fundamental religious tenets of a religious organization itself. *EEOC v. The Catholic U.*, 83 F.3d 455, 462 (D.C. Cir. 1996) (noting *Smith*'s focus on individuals, not religious organizations); *Gellington v. Christian Methodist Episcopal Church*, 203 F.3d 1299, 1303-04 (11th Cir. 2000) (same); *Combs v. Central Texas Annual Conf. of the United Methodist Church*, 173 F.3d 343, 348-49 (5th Cir. 1999) (same). Indeed, the principal motivation for the decision in *Smith* was the potential for each individual to become a law unto him or herself by defining his/her religious beliefs to prohibit conduct required by the law at issue. *Smith*, 494 U.S. at 885. This concern is far less applicable to formally religious entities that must conform to long-held religious doctrine. Indeed, it is their First Amendment right. *Amos*, 483 U.S. 327, 342

[111] These questions were not answered because the Court concluded that Colorado had not applied its law in a neutral manner. *Masterpiece*, 138 S. Ct. at 1732.

(1987) (Brennan, J., concurring) ("Determining that certain activities are in furtherance of an organization's religious mission . . . is thus a means by which a religious community defines itself").

For good reason, *Smith* has never been applied to require a religious hospital to perform a procedure prohibited by religious doctrine. *See* Section IV(A), *supra*. The First Amendment "gives special solicitude to the rights of religious organizations." *Hosanna-Tabor*, 565 U.S. at 189. The *Smith* Court may have had this solicitude in mind when it stated it had "never held that an *individual's* religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate" and that it has "consistently held that the right of free exercise does not relieve an *individual* of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)." *Smith*, 494 U.S. at 878-79 (emphasis added). Again, that is the rule of the ministerial exception cases – certain laws of general applicability plainly do not apply to religious institutions. Thus, "[i]t does not follow [from *Smith*] that a *church* may never be relieved from such an obligation." *EEOC v. The Catholic U.*, 83 F.3d at 462 (citations omitted; emphasis in original); *see also Catholic Charities*, 32 Cal.4th at 572 (Brown, J., dissenting) (recognizing *Smith*'s references to the religious practices of individuals and noting that "[i]t is ... far from self-evident, if or how, *Smith* applies to laws that directly contravene the religious conduct of religious organizations").

Protecting Catholic hospitals, by permitting them to apply a pastoral application of Catholic religious doctrine when deciding whether to permit a tubal ligation when a physician presents sufficient evidence that there is an increased medical risk to the patient if she were to become pregnant in the future, is much closer to *Masterpiece*'s respect for the inability of members of the clergy to perform marriage ceremonies at odds with their faith. Petitioners can "recognize and accept [Catholic health care providers' adherence to the ERDs] without serious diminishment to their own dignity and worth." *Masterpiece*, 138 S. Ct. at 1727. And there is no danger of a slippery slope in the narrowly constrained and well-defined context of religious hospitals subject to established doctrinal prohibitions on certain activities. Allowing Catholic

hospitals to consider sterilization operations in the context of the ERDs does not implicate the concern expressed in *Smith*—allowing an individual, "by virtue of his beliefs, 'to become a law unto himself.'" *Smith*, 494 U.S. at 885 (citations omitted). Accordingly, application of Section 1258 to the Catholic Hospitals need not and should not be based on the inapplicable analysis enunciated in *Smith*, but based upon the application of strict scrutiny and in the same manner the claim is analyzed under the California Constitution. *See* Section VI, *supra*.

3. Courts Traditionally Respect the Rights of Religious Organizations Not to Be Compelled to Violate Their Faith.

The U.S. Supreme Court has repeatedly reaffirmed the notion that courts will not compel churches, or institutions that carry out the church's mission, to engage in acts prohibited by the church's fundamental tenets even where those acts would otherwise be required by generally applicable state law. In *Hosanna-Tabor*, the Court noted that even the plaintiff and the EEOC "acknowledge[d] that employment discrimination laws would be unconstitutional as applied to religious groups in certain circumstances. They grant, for example, that it would violate the First Amendment for courts to apply such laws to compel the ordination of women by the Catholic Church or by an Orthodox Jewish seminary." *Hosanna-Tabor*, 565 U.S. at 189.

And it is well established that the state cannot compel a faith-based hospital to perform procedures that are contrary to its faith or require a physician to act contrary to his or her conscience. In *Masterpiece Cakeshop*, the Court considered the proposition that "a member of the clergy who objects to gay marriage on moral and religious grounds could not be compelled to perform [a same-sex wedding] ceremony without denial of his or her right to free exercise of religion" so self-evident that it could merely be "assumed." *Id.*, 138 S. Ct. at 1727. That outcome "would be well understood in our constitutional order as an exercise of religion, an exercise that gay persons could recognize and accept without serious diminishment to their own dignity and worth."[112] *Ibid.*

It is fully consistent with the Supreme Court's statements above to recognize a protection for Catholic hospitals to apply a pastoral application of Catholic religious doctrine when deciding

[112] In addition to its free exercise rights, a church or other religious institution could not be compelled to perform a same-sex marriage based upon the under *Guadalupe's* enunciation of the church autonomy doctrine too.

whether to permit a tubal ligation when a physician presents sufficient evidence that there is an increased risk to the patient if she were to become pregnant in the future is no different. Catholic religious doctrine, including the ERDs, is the culmination of centuries of efforts of Catholic health care practitioners to minister in accord with the Church's teaching, and the ERDs were adopted to provide uniform instructions to Catholic health care providers on ethical medical practices.[113] The ERDs are well established and an entrenched part of health care at Catholic hospitals nationwide.

VII. THE RELIEF PETITIONERS SEEK IS NOT IN THE PUBLIC INTEREST.

Where a party seeks a writ under Code of Civil Procedure section 1085, "issuance of the writ is not a matter of right, but involves a consideration of its effect in promoting justice; likely public detriment warrants denial of relief." *Rivera v. Div. of Indus. Welfare*, 265 Cal. App. 2d 576, 592 (1968); *Ferenz v. Sup. Ct.*, 53 Cal. App. 2d 639, 643 (1942) (same).[114]

> The writ of mandamus is not wholly a writ of right, but lies, to a considerable extent, within the sound judicial discretion of the court where the application is made; . . . and no court should allow a writ of mandamus to compel a technical compliance with the letter of the law, where such compliance will violate the spirit of the law.

Sutro Heights Land Co. v. Merced Irr. Dist., 211 Cal. 670, 705 (1931); *San Diego Cty. Dep't of Pub. Welfare v. Sup. Ct.*, 7 Cal. 3d 1, 9 (1972) ("Although mandamus is 'generally classed as a legal remedy, the question of whether it should be applied is largely controlled by equitable considerations'"). "The necessity of issuing the writ must be clearly established. It will not issue in doubtful cases. It will not issue if the writ would result in grievous public or private wrong in conflict with the spirit of the statute, even though it be in compliance with the technical letter of the law." *El Camino Land Corp. v. Bd. of Sup'rs of Tehama County*, 43 Cal. App. 2d 351, 355, 110 P.2d 1076, 1079 (1941).

The Petition prays vaguely that the Court should issue an order requiring Dignity Health

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[113] McGrath Decl., ¶ 30, Ex. 50 (O'Rourke et al., *A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services* (Dec. 2001) Health Progress), p. 18.

[114] In its April 30, 2020 order, the Court found that Petitioners have standing and a sufficient beneficial interest in the writ. The Court also found Petitioners had public interest standing. Dignity Health continues to assert that Petitioners lack beneficial interest or public interest standing, and incorporate by reference their prior argument without repeating it verbatim here.

to "adopt[] a compliant policy regarding granting tubal ligation to its patients." (Petition, Prayer ¶ B.) Such writ relief is unnecessary because, as shown, the Catholic Hospitals have adopted compliant policies. But even if Petitioners had identified a technical violation of a particular interpretation of Section 1258 with respect to the Catholic Hospitals' application of their policies, the law was never intended to interfere with a religious hospital's mission.

Nor was this case ever about stopping tubal ligations. This case has *always* been about Chamorro's desire to *obtain* a tubal ligation, PRH's desire to perform *more* tubal ligations, and Petitioners' claim that Dignity Health *could not prohibit* such procedures for religious reasons.[115] (McGrath Decl., ¶ 41, Ex. 61 (Chamorro Depo.), 48:4-50:17; TRO 2:25-26; 5:12-13; 15:10-13.) It is true that Petitioners continued to litigate this case even after they conceded that Section 1258 cannot compel Catholic hospitals to forsake the ERDs. However, they cannot so quickly disclaim their verified pleading in this action. There is literally a heading in the Petition that says "Patients are Harmed When Their Doctors Are Prevented from Performing Postpartum Tubal Ligation." (Petition, ¶ 10-11;) McGrath Decl., ¶ 76, Ex. 96 (Declaration of Samuel Van Kirk, M.D. in Support of TRO, ¶ 28).)

Petitioners' counsel admits that stopping the sterilization review process would be worse than allowing the Catholic Hospitals to continue providing the level of elective sterilizations that they provide pursuant to their policies and process. On behalf of the ACLU, Ms. Dawson identified herself as Petitioners' counsel, and lobbied the Attorney General to compel the Catholic Hospitals as a condition of consent to continue to continue providing, under the ERDS as "exceptions", the very services that she knew Petitioners and the ACLU sought to enjoin. Ms. Dawson and PRH followed with a letter again requesting that to serve the community interest, at a minimum, the Catholic Hospitals be required to provide these services at their existing levels.[116]

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[115] As for PRH, its mission is "to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients" —goals that will be thwarted through the relief sought here. McGrath Decl., ¶ 44, Ex. 64 (https://prh.org/mission-and-history/).

[116] The ACLU said this on its websites: "Ideally, the Attorney General would require all Dignity Health hospitals in California to expand their women's health services to include those prohibited by the ERDs. This is unlikely to happen, but more plausible requirements might be … that Dignity Health commit to not diminishing or eliminating any currently-offered reproductive health services for a long period of time." McGrath Decl., ¶ 71, Ex. 91 (https://www.aclusocal.org/sites/default/files/aclu_socal_dhchi2018_faq.pdf, p. 4.).

Both results cannot be in the public interest, and the Court should take Ms. Dawson's testimony at her word. *Crestlawn Mem'l Park Ass'n v. Sobieski*, 210 Cal. App. 2d 43, 51 (1962) (writ relief barred by unclean hands); *San Diego Dept.*, 7 Cal.3d at 9 (same).[117]

VIII. THE COURT SHOULD DENY THE RELIEF PETITIONERS SEEK BECAUSE IT WOULD INTERFERE WITH THE CALIFORNIA ATTORNEY GENERAL'S PLENARY REGULATORY AUTHORITY.

Petitioners ask this Court to issue a writ directing MMCR to take action that would be prohibited outright by the conditions the California Attorney General placed upon his consent to the change in control and governance effected by the Ministry Alignment Agreement ("MAA") between Dignity Health and Catholic Health Initiatives. This Court should refrain from making any such order, which would effectively collaterally attack the AG's consent to the transaction in an area over which he is vested with plenary regulatory authority. This Court should not use the rubric of enforcing a hospital licensing statute (Section 1258) to make an order impacting the obligations the AG imposed on MMCR.

Transactions involving the governance of non-profit hospitals, specifically including review of the level of women's reproductive services to be provided after a proposed transaction affecting such hospitals, are the domain of the AG. The AG is vested with the authority and responsibility to approve transactions involving nonprofit health care entities to ensure they serve the public interest. Corp. Code §§ 5914, 5920; 5 Cal. Transactions Forms--Bus. Entities § 23:4 ("Because the intended beneficiaries of a charitable enterprise are members of the general public . . . , the Attorney General's office is given broad supervisory authority to assure that this

[117] Nor may the Court interfere with the Catholic Hospitals' exercise of discretion. *Unnamed Physician*, 93 Cal. App. 4th at 618. Because Section 1258 does not require a health facility to perform any "sterilization operations for contraceptive purposes," Section 1258 gives health facilities at least some discretion regarding how they comply with the statute. Thus, the Court cannot issue an order requiring the Hospitals to comply with Section 1258 in a particular way. *See Ridgecrest Charter Sch. v. Sierra Sands Unified Sch. Dist*., 130 Cal. App. 4th 986, 1003 (2005) ("the District was obligated to follow the law . . . but how it did that was largely a matter committed to its discretion"); *Ellena v. Dep't of Ins.*, 230 Cal. App. 4th 198, 205 (2014) ("a party may not invoke mandamus to force a public entity to exercise discretionary powers in any particular manner"); *California Water Impact Network v. Newhall Cty. Water Dist*., 161 Cal. App. 4th 1464, 1483–84 (2008) (same); *Cary v. Long*, 181 Cal. 443, 451 (1919). At most, the Court may prohibit the Hospitals from considering a factor prohibited by Section 1258. But the Hospitals may lawfully elect to permit *no* such procedures, or to employ a compliant review process. Honoring the uniqueness of each patient requires acknowledging the innumerable permutations of medical factors that may require consideration.

'charitable trust' is carried out."). The AG can identify and address all public health concerns related to changes of ownership or governance of nonprofit health facilities through the notice and review process set forth in Corporations Code section 5914 *et seq*. and in the accompanying regulation, Cal. Code Regs., tit. 11, § 999.5 et seq. Specifically, all of the transaction documents and extensive supporting materials must be provided to the AG and made public; a health impact report must be prepared by the AG, and made public, addressing the transaction's effects on the availability and accessibility of health care services in the affected community; and a public meeting is held at which members of the public may raise any concerns that they have with respect to the proposed transaction. Cal. Code Regs., tit. 11, § 999.5(c)-(e). The AG may approve transactions subject to particular conditions. Corp. Code § 5921. He is vested with discretion to evaluate numerous factors in determining whether to grant approval and whether to impose conditions. Corp. Code § 5923. And he is vested with enforcement powers over the conditions he imposes "to the fullest extent provided by law," including, that, among other things, he is "entitled" to "specific performance, injunctive relief, and other equitable remedies a court deems appropriate for breach of any of the conditions . . . ." Corp. Code § 5926; Cal. Code Regs., tit. 11, § 999.5(g)(6). The AG "shall monitor compliance with any terms or conditions of any agreement or transaction for which the Attorney General has given written consent or conditional consent . . . ." Cal. Code Regs. tit. 11, § 999.5; *see also* Corp. Code § 5250 (public benefit corporation "is subject at all times to examination by the Attorney General, on behalf of the state, to ascertain the condition of its affairs and to what extent, if at all, it fails to comply with trusts which it has assumed or has departed from the purposes for which it is formed").

The order Petitioners ask this Court to make would undermine and threaten the stability of a complex transaction that has been expressly sanctioned by the AG under a statutory scheme designed to protect and further the public interest. "Except for judicial review of executive branch decisions . . . , a court is not empowered to interfere with core executive functions." California Practice Guide: Administrative Law Ch. 2-F 2:301; *Steen v. Appellate Division, Superior Court*, 59 Cal. 4th 1045, 1053 (2014) ("the doctrine [of separation of powers] is violated when the actions of one branch defeat or materially impair the inherent functions of

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another") (citation omitted); *In re Lira*, 58 Cal. 4th 573, 584 (2014) (holding that a court's general authority to craft just and equitable remedies does not permit it to interfere with executive branch control over a particular area in the absence of specific statutory authorization to do so). Writ relief is equitable and discretionary, *TransparentGov Novato v. City of Novato*, 34 Cal. App. 5th 140, 148 (2019), and courts have discretion to refrain from embroiling themselves in areas over which another branch of government has—and is exercising—plenary regulatory authority "when granting the requested relief would require a trial court to assume the functions of an administrative agency, or to interfere with the functions of an administrative agency." *Alvarado v. Selma Convalescent Hospital*, 153 Cal. App. 4th 1292, 1298 (2007); *Center for Biological Diversity, Inc. v. FPL Grp., Inc.*, 166 Cal. App. 4th 1349, 1371-72 (2008).

The order Petitioners ask this Court to make here would implicate all of these concerns. The AG has specifically exercised his authority with regard to the reproductive services provided at MMCR following the MAA transaction—the precise subject of the order Petitioners seek from this Court. The AG's November 21, 2018 consent was made expressly conditional on the requirement that MMCR, for at least the next five years, "*maintain and provide women's healthcare services including women's reproductive services* at current licensure and designation with *the current types and/or levels of services*." (Strumwasser Decl., ¶ 23, Ex. 8 (emphasis added).) As of the date of the AG's consent, "the current types and/or levels" of women's reproductive services offered by MMCR included that tubal ligations for the purpose of contraception were prohibited by the ERDs and not permissible, but that MMCR might permit tubal ligations on a case-by-case basis if medically necessary to cure or alleviate a present pathology. MMCR *cannot* change its current policy regarding tubal ligations without violating the AG's condition of consent. To do so could subject Mercy (and Dignity Health and the entire Dignity Health/CHI entity) to the full range of the AG's enforcement powers, which could result, in theory, in a revocation of the approval and a forced unwinding of the entire transaction. This would not be in the public interest and would benefit no one.

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IX. CONCLUSION.

Dignity Health does not violate Section 1258. Moreover, its review process is protected by the First Amendment. Even if the Court found a violation of Section 1258, the relief Petitioners seek is not in the public interest. Therefore, the Court should deny the Petition, as well as any requested relief.

Dated: October 7, 2020

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