Abstract. Evidence suggests that the nurse’s role as an advocate for patients and for the professional right to conscience is being eroded because of a lack of conscience protections in the Patient Affordable Care Act and because of a faulty understanding in general of the separation of church and state. While the main task of the principle of separation of church and state is to secure religious liberty, the principle is increasingly interpreted in a secularist way to mean that religion must be confined to the home and church and that people of conscience may not object to immoral practices in the workplace or public square. If nurses must risk their jobs to advocate for their patients, patient care will suffer. National Catholic Bioethics Quarterly 14.1 (Spring 2014): 47–52.

The Patient Protection and Affordable Care Act is a social policy that has the potential to significantly affect the autonomy of nurses and their obligations to those they serve. This will be particularly true for those of us who consider our nursing career to be both a vocation and a ministry. It is undeniable that the history of organized health care closely follows the history of the Catholic Church, and for many of us nursing is a ministry to those we serve, not just Christians or Catholics but all those in need. It is a response to the parable of the Good Samaritan (Luke 10:30–37), by which Jesus answers the question, “Who is my neighbor, whom I must love as I love myself?”

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In telling the story of the robbed and beaten man who was ignored by the temple priest and Levite but offered healing help by the despised Samaritan, Jesus asks a rhetorical question: “Which of these three, in your opinion, was neighbor to the robbers’ victim?” Of course it was the Samaritan, the outsider, who helped the non-Samaritan man when others passed him by. Jesus admonishes us to “go and do likewise.” And thus Catholic health care began, with its commitment to serve all in need, turning no one away regardless of faith or national origin or ability to pay.

Secular history textbooks tell us that one of the first organized nursing efforts was that of Saint Benedict’s order, founded in the sixth century, and the first organized system of health care delivery was that of the Hospitallers, whose order was founded in the twelfth century to assist pilgrims during the Crusades. In the United States, hospitals began as the great corporal works of mercy of the heroic women religious developed into the Catholic health care systems that currently serve over 88 million patients annually, providing more health care than any entity other than the government. In fact, “Sisters Hospital,” the first hospital west of the Mississippi River, was founded by Saint Elizabeth Ann Seton’s Sisters of Charity in Saint Louis, Missouri, in 1830.

Yet public policies have been continually redefining Catholic ministries as licensed agencies of the government, with no claim to the rights protected by the US Constitution and its First Amendment. The first two clauses of that amendment state simply, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.” The first clause, a basis for the legal principle of the separation of church and state, is known as the establishment clause; it is currently being misapplied to trample on rights that are guaranteed protection in the second clause, the free exercise clause. As Yale University constitutional law professor Stephen Carter states, “The most significant aspect of the separation of church and state is not, as some seem to think, the shielding of the secular world from too strong a religious influence; the principal task of the separation of church and state is to secure religious liberty.”

The evidence of attacks on religious freedom is growing, negatively affecting not only health care agencies but, even more dangerously, nurses and the patients they care for. Specifically, when nurses experience coercion of conscience, they cannot fulfill their obligations as patient advocates. Significant cases include that

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of Toni Lemly, a nurse at Tammany Parish Hospital in Louisiana, who in 2004 lost her full-time position there for refusing to administer emergency contraception. The hospital refused to grant a reasonable accommodation for Lemly’s religious beliefs. It took five years for Lemly to receive justice.6

In 2009, Cathy Cenzon-DeCarlo, a surgical nurse at Mount Sinai Hospital in New York City, was forced to assist at an abortion even though she had provided appropriate notice of her conscientious objection when she was hired in 2004. Only after DeCarlo sued the hospital did the federal government investigate, and in 2013 the hospital revised its policy.7

In 2010, eight nurses were disciplined by Nassau University Medical Center, in East Meadow, NY, for refusing to assist with abortions. Fortunately, their labor union supported the nurses, and the decision was reversed.8 A similar action by twelve nurses against the University of Medicine and Dentistry of New Jersey was also reversed after legal recourse was threatened.9

Unfortunately, there is little evidence that professional associations support the rights of conscience of health care professionals. In fact, the evidence points to the opposite. The American College of Obstetricians and Gynecologists, for example, recently reaffirmed a statement titled “The Limits of Conscientious Refusal in Reproductive Medicine,” which requires physicians who object to abortion and who practice in resource-poor areas to cooperate in abortions through referral or locate their practices near abortion providers and, in an emergency, perform abortions.10

Even more egregious is a statement by the Religious Coalition for Reproductive Choice, In Good Conscience: Guidelines for the Ethical Provision of Health Care in a Pluralistic Society, which admonishes readers that the law should not be overridden by positions of conscience based on religious beliefs.11 Most disconcerting to nurses is the statement pertaining to conscientious objection in the American Nurses Association’s Code of Ethics for Nurses with Interpretive Statements:

6 Lemly v. St. Tammany Parish Hospital, District No. 1, 8 So. 3d 588 (La. 2009).
Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Such grounds exclude personal preference, prejudice, convenience, or arbitrariness. Conscientious objection may not insulate the nurse against formal or informal penalty.12

What is morally objectionable is often open to debate between those who claim a conscience right and those who reject that claim, and a nurse facing penalties for conscientious objection is left with little recourse.

Into this scenario enters the Patient Protection and Affordable Care Act. The ACA has many wonderful provisions: it provides benefits to those with pre-existing conditions, prohibits lifetime caps on reimbursement for care, allows adult children to remain on their parents’ insurance policies until they are twenty-six years old, and provides community-based care for Medicaid enrollees with disabilities; it also fixes the coverage gap for prescription medications in Medicare part D, provides free well-baby care, and extends Medicaid coverage to persons with incomes up to 138 percent of the poverty level.

We have seen, however, that the implementation of the ACA has not been without its problems. A major concern is that a number of persons who will be enrolling in Medicaid could find themselves without providers, since almost one-third of surveyed family physicians are unwilling to accept new Medicaid patients.13 The average reimbursement rate for Medicaid is 58 cents on the dollar. And while the federal government has increased reimbursement for those caring for new Medicaid enrollees, the number of new enrollees is expected to exceed twenty-one million by 2022.14 Combining this with the planned Medicare cuts to hospitals of $155 billion by 2020, the anticipated growth of the elderly population to 20 percent of the general population by 2030, and the growing number of physicians who intend to retire in the next five years, we have to ask, who will care for our patients, and how will hospitals absorb the increased number of patients on Medicaid and Medicare who have no other provider?15 Already the fiscal effect on hospitals is being felt in forecasts.

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of significant employee layoffs. How can nurses be patient advocates, especially for the poor and vulnerable who need their care, when their own jobs are threatened?

Never before has our advocacy been more needed. Some fear that there will be a general disincentive for hospitals to treat patients under the ACA for a number of reasons: the act provides for penalties for hospital readmissions within thirty days for the same diagnosis and for payment rate-setting by an independent payment advisory board; it also establishes a physician quality-reporting system that rewards both quality and cost containment, and it calls for temporarily reduced and then prorated funding for hospitals that provide a disproportionate percentage of uncompensated care.\(^{16}\) Research has shown that only 27 percent of readmissions are preventable, and safety-net hospitals serving the uninsured are most vulnerable to these penalties.\(^{17}\) Based on community-needs surveys that these hospitals are now required to conduct, the hospitals could be penalized or could even lose their tax-exempt status if the uninsured rates in their communities drop by 45 percent.\(^{18}\)

Nursing is a vocation that is mission driven, not money driven. Moving the focus from beneficent care to the bottom line erodes the role of the nurse as patient advocate. The nurse also becomes subject to a belief that all ethics are reduced to what is legal, rather than what is moral. And while the ACA has language to protect nurses from having to directly assist in abortion or assisted suicide procedures, clear definitions of what this entails are missing. Furthermore, the Church amendments (42 USC § 300a-7), which state that no entity receiving certain federal funds may discriminate against personnel for refusing to participate in any lawful health service, are not included in the ACA. And since the ACA does support programs that provide abortion on demand, the Church amendment or a similar provision is clearly needed. There is also no protection for nurses who cannot in good conscience provide abortifacients and contraceptives or counseling for their use, even though part of


the contraceptive mandate issued by the Department of Health and Human Services requires coverage of “all FDA-approved contraceptive methods [and] sterilization procedures” as well as counseling for their use.19

Blind obedience has consequences for nurses, but it also affects their patients. Think of the atrocities committed by Nazi medical researchers who were tried at Nuremberg.20 What is legal is not necessarily ethical. Nurses must be free to exercise their consciences if they are to fulfill their roles as patient advocates, especially for the poor and vulnerable who need their care.

What is at stake is the right of nurses, especially Catholic nurses, to exercise their First Amendment right to the free exercise of religion as provided for by the free exercise clause. Yet when such attempts have been made by nurses, they have been wrongly accused of violating the principle of separation of church and state, specifically, the establishment clause of the First Amendment.

Nothing could be further from the truth. The establishment clause states that there will be no state religion. There is increasing evidence, however, that we have a state religion, called secular relativism. And the threat from such a misunderstanding of the legal principle of the separation of church and state is real.

One is left to ask, Will nurses, in such an environment, report instances of denial of care, non-admission for care, or other refusals of beneficent care based on economics if in doing so they will be accused of introducing into their nursing practice values based on their faith? Will nurses continue to have to risk their jobs if they speak up for professional practice that respects all human life, when in doing so they will be accused of violating the separation of church and state?

The evidence suggests that in all of these scenarios, the role of the nurse as patient advocate and as an advocate for the professional right to conscience is being eroded because of the faulty understanding of separation of church and state. While the establishment clause affirms that there is to be no state religion, the free exercise clause is equally important, for it prohibits violations of religious freedom by the government, not just in places of worship but in the public square. The misunderstanding is having dismal consequences not only on value-based nursing practice but also on recipients of nursing care. In fact, misunderstanding of the provisions of the First Amendment is having a widespread effect on society. As Carter states, “The potential transformation of the Establishment Clause from a guardian of religious freedom into a guarantor of public secularism raises prospects at once dismal and dreadful.”21

21 Carter, Culture of Disbelief, 122–123.