Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, & 15-191

In The Supreme Court of the United States

DAVID A. ZUBIK, ET AL.,

Petitioners,

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Writs Of Certiorari To The United States Courts Of Appeals For The Third, Fifth, Tenth, And District Of Columbia Circuits

BRIEF OF AMICUS CURIAE COMPASSION & CHOICES IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICUS CURIAE COMPASSION & CHOICES[1]

Compassion & Choices, with more than 450,000 supporters, is the nation's oldest, largest, and most active nonprofit organization committed to improving care and expanding choice at the end of life. For over thirty years, Compassion & Choices has envisioned a society where people receive state-of-the-art healthcare and a full range of choices for dying in comfort, dignity, and control. Compassion & Choices aims to ensure that individuals understand the benefits and burdens of all feasible treatment options, that treatment decisions are fully respected, and that healthcare reflects a person's values and priorities for life's final chapter. Compassion & Choices offers free consultation, planning resources, referrals, assistance with advance directives, and support anywhere in the country through its End of Life Consultation Program. Advocating at the state and federal levels, Compassion & Choices pursues policies that empower consumers to be in charge of their own healthcare decisions and litigates to achieve better medical care and access to a full range of end-of-life options.

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[1] In accordance with Rule 37.6, amicus curiae certifies that no counsel for any party authored this brief in whole or in part, and no person or entity other than the named amicus curiae made a monetary contribution for the preparation and submission of this brief. Letters of consent to the filing of amicus curiae briefs have been filed with the Clerk.

Compassion & Choices is concerned that a decision for the petitioners in these consolidated cases addressing insurance coverage for contraceptives could, inadvertently, substantially impair the implementation of people's end-of-life healthcare choices.

SUMMARY OF ARGUMENT

In challenging the regulations at issue, petitioners argue that the regulations substantially burden petitioners' religious exercise by requiring them to cooperate in the immoral acts of others – specifically, by requiring them to give notice in order to opt out of providing healthcare insurance coverage of contraceptives, which petitioners find morally objectionable.

Compassion & Choices is concerned that a similar argument could be made by a healthcare provider who morally objects to a medically sound healthcare decision by a patient or surrogate, or to a provision in an advance directive such as a do-not-resuscitate order or a prohibition against the use of a ventilator or feeding tube. Such an argument would upend statutory mandates in forty-seven states requiring the objecting provider to cooperate in the patient's transfer to someone who will comply with the decision or directive. If this Court were to embrace petitioners' position as they articulate it, the Court's decision would impair the exercise of the constitutional right to refuse unwanted medical treatment by undermining those statutory mandates. Amicus curiae

urges this Court to keep in mind, when crafting its decision, that it may affect the efficacy of millions of Americans' healthcare decisions and advance directives and determine the fate of statutory transfer mandates nationwide.

ARGUMENT

I. STATUTORY MANDATES IN FORTY-SEVEN STATES BALANCE COMPETING CONSTITUTIONAL INTERESTS BY REQUIRING A HEALTHCARE PROVIDER WHO MORALLY OBJECTS TO A HEALTHCARE DECISION OR ADVANCE DIRECTIVE TO COOPERATE IN THE PATIENT'S TRANSFER TO A PROVIDER WHO WILL COMPLY.

Petitioners seek to evade compliance with the regulations implementing the women's preventive care provision of the Patient Protection and Affordable Care Act of 2010 on the ground the regulations would force petitioners to violate Catholic teachings regarding cooperation in the immoral act of another. *See* Brief for Petitioners in Nos. 14-1418, 14-1453 & 14-1505 at 17. Nothing in the regulations forces petitioners to fund or otherwise participate in the acts they find morally objectionable – specifically, the use of contraceptives. The regulations merely require petitioners to give notice of their religious objections in order to opt out of providing healthcare insurance coverage of contraceptives. In this way, however, they contend the regulation requires them, variously, to

"assist," "effect," "cooperate" in, or "facilitate" the conduct they find morally objectionable, thus substantially burdening their religious exercise. *See* Brief for Petitioners in Nos. 14-1418, 14-1453 & 14-1505 at 10, 17, 20, 23, 32, 44, 47, 51; Brief for Petitioners in Nos. 15-35, 15-105, 15-119 & 15-191 at 2, 43, 45, 48, 49, 50, 51, 53, 56.

It is an alarmingly short step, however, from petitioners' arguments to statutory mandates regarding healthcare providers who have moral objections to a medically sound healthcare decision by a patient or surrogate, or to a provision in an advance directive such as a do-not-resuscitate order or a prohibition against the use of a ventilator or feeding tube. In such instances, nearly every state in the Nation requires the objecting provider to cooperate in the patient's transfer to another healthcare provider who will comply with the decision or directive.

In describing the healthcare provider's duty of cooperation, some state statutes use the very same words that petitioners use in objecting to the regulations at issue here:

- Fourteen states require healthcare providers to "assist" in such transfers.[2]

[2] Ala. Code § 22-8A-8(a) (2015) ("reasonably cooperate to assist"); Cal. Prob. Code § 4736(b) (West 2015) ("all reasonable efforts to assist"); Haw. Rev. Stat. § 327E-7(g)(3) (2015) ("all reasonable efforts to assist"); Idaho Code § 39-4513(2) (2015) ("good faith effort to assist"); Ill. Comp. Stat. ch. 755, § 40/35 (2015)

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- Eight states require healthcare providers to "effect" or "effectuate" such transfers.[3]
- Four states require healthcare providers to "cooperate" in such transfers.[4]

("assist . . . in effectuating"); Me. Stat. tit. 18a, § 5-807(g)(3) (2015) ("all reasonable efforts to assist"); Miss. Code Ann. § 41-41-215(7)(c) (2015) ("all reasonable efforts to assist"); N.M. Stat. Ann. § 24-7A-7(G)(3) (2015) ("all reasonable efforts to assist"); 20 Pa. Cons. Stat. § 5424(b) (2015) ("every reasonable effort to assist"); Tenn. Code Ann. § 68-11-1808(f)(3) (2015) ("all reasonable efforts to assist"); Tex. Health & Safety Code Ann. § 166.046(d) (West 2015) ("assist the physician in arranging the transfer"); Utah Code Ann. § 75-2a-115(4)(e)(v) (West 2015) ("all reasonable efforts to assist"); Vt. Stat. Ann. tit. 18, § 9707(b)(3)(B) (2015) ("assist the principal, agent, or guardian in the transfer"); Wyo. Stat. Ann. § 35-22-408(g)(iii) (2015) ("all reasonable efforts to assist").

[3] Ill. Comp. Stat. ch. 755, § 40/35 ("assist the patient or surrogate in effectuating the timely transfer"); Iowa Code § 144A.8(1) & (2) (2015) ("take all reasonable steps to effect the transfer"); Kan. Stat. Ann. § 65-28,107(a) (2015) ("effect the transfer"); Mo. Rev. Stat. § 459.030(1) (2015) ("take all reasonable steps to effect the transfer"); N.H. Rev. Stat. Ann. § 137-J:7(II) (2015) ("make the necessary arrangements to effect the transfer"); N.J. Stat. Ann. § 26:2H-62(b) (West 2015) ("effect an appropriate, respectful and timely transfer"); 23 R.I. Gen. Laws § 23-4.11-7 (2015) ("make the necessary arrangements to effect the transfer"); S.C. Code Ann. § 44-77-100 (2015) ("make reasonable efforts to effect the transfer").

[4] Ala. Code § 22-8A-8(a) ("reasonably cooperate to assist"); Alaska Stat. § 13.52.060(g)(3) (2015) ("cooperate and comply with a decision . . . to transfer"); N.J. Stat. Ann. § 26:2H-62(c) (West 2015) ("cooperate in effecting an appropriate, respectful and timely transfer"); W. Va. Code § 16-30-12(b)(2) (2015) ("cooperate in facilitating such transfer").

- One state requires healthcare providers to "facilitate" such transfers.[5]

Statutes in other states describe the duty of cooperation in similar ways:

- Twelve states require healthcare providers to "transfer" such patients.[6]
- Ten states require healthcare providers to "take all reasonable steps" to transfer, effect such transfers, or arrange care by another.[7]

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[5] W. Va. Code § 16-30-12(b)(2).

[6] Ariz. Rev. Stat. Ann. § 36-3205(C)(1) (2015) ("transfers the responsibility for the patient's care"); Colo. Rev. Stat. § 15-18-113(5) (2015) ("transfer the care"); Fla. Stat. § 765.1105(2)(a) (2015) ("reasonable efforts to transfer the patient"); Ind. Code § 16-36-4-13(e) (2015) ("transfer the qualified patient"); La. Stat. Ann. § 40:1151.6(B) (2015) ("reasonable effort to transfer the patient"); Md. Code Ann., Health-Gen. § 5-613(a)(1)(iii) (West 2015) ("reasonable effort to transfer the patient"); Mass. Gen. Laws ch. 201D, § 15(b) (2015) ("the patient is transferred"); Or. Rev. Stat. § 127.625(2)(c) (2015) ("reasonable effort to transfer the principal"); S.D. Codified Laws § 34-12D-11 (2015) ("reasonable effort to . . . transfer the declarant"); Tex. Health & Safety Code Ann. § 166.046(d) ("reasonable effort to transfer the patient"); Va. Code Ann. § 54.1-2987 (2015) ("reasonable effort to transfer the patient"); Wis. Stat. § 154.07(1)(a)(3) (2015) ("good faith attempt to transfer the qualified patient").

[7] Ark. Code Ann. § 20-17-207 (2015) ("take all reasonable steps to transfer"); Conn. Gen. Stat. § 19a-580a (2015) ("take all reasonable steps to transfer"); Iowa Code § 144A.8(1) ("take all reasonable steps to effect the transfer"); Minn. Stat. § 145B.06(1)(b) (2015) ("take all reasonable steps to transfer"); Mo. Rev. Stat. § 459.030(1) ("take all reasonable steps to effect the transfer"); Mont. Code Ann. § 50-9-203 (2015) ("take all reasonable steps as

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- Four states require healthcare providers to "arrange" such transfers.[8]
- Three states require healthcare providers to make an "investigation" or a "reasonable effort" to find another physician.[9]
- Three states prohibit healthcare providers to "impede," "prevent," or "unreasonably delay" such transfers.[10]

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promptly as practicable to transfer"); Neb. Rev. Stat. § 20-409 (2015) ("take all reasonable steps as promptly as practicable to transfer"); Nev. Rev. Stat. § 449.628 (2015) ("take all reasonable steps as promptly as practicable to transfer"); N.D. Cent. Code § 23-06.5-09(2) (2015) ("take all reasonable steps to transfer"); Okla. Stat. tit. 63, § 3101.9 (2015) ("take all reasonable steps to arrange care of the declarant by another physician or health care provider").

[8] Ill. Comp. Stat. ch. 755, § 40/35 ("arrange for the patient's transfer"); N.Y. Pub. Health Law § 2994-f(1) (McKinney 2015) ("make all reasonable efforts to arrange for the transfer"); Okla. Stat. tit. 63, § 3101.9 ("take all reasonable steps to arrange care of the declarant by another physician or health care provider"); Tex. Health & Safety Code Ann. § 166.046(d) ("the facility's personnel shall assist the physician in arranging the patient's transfer").

[9] Ind. Code § 16-36-4-13(f) (2015) ("reasonable investigation" to find "other physician willing to honor the patient's declaration"); S.C. Code Ann. § 44-77-100 ("reasonable effort to locate a physician or health care facility that will effectuate the declaration"); S.D. Codified Laws § 34-12D-11 ("reasonable effort to locate and to transfer the declarant to a physician or health care provider willing to honor the declaration").

[10] Del. Code Ann. tit. 16, § 2508(g)(3) (2015) ("Not impede the transfer"); Ky. Rev. Stat. Ann. § 311.633(2) (2015) ("No physician or health care facility . . . shall impede the transfer"); Ohio Rev. Code Ann. § 2133.10(A) (West 2015) ("shall not

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- One state requires healthcare providers to "provide reasonably necessary consultation and care in connection with" such transfers.[11]

Federal law bolsters these statutory mandates by requiring healthcare providers who receive Medicare or Medicaid funds to "ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization." Patient Self Determination Act, 42 U.S.C. § 1395cc(f)(1)(D) (2012).[12]

II. ADOPTING PETITIONERS' POSITION WOULD UNDERMINE THESE STATUTORY MANDATES AND IMPAIR THE EXERCISE OF THE CONSTITUTIONAL RIGHT TO REFUSE UNWANTED MEDICAL TREATMENT.

The point of this survey is to demonstrate the extraordinarily broad reach of petitioners' position as

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prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer").

[11] Ga. Code Ann. § 31-32-8(2) (2015).

[12] Three states (Michigan, North Carolina, and Washington) lack statutes addressing the issue of transfer, leaving the issue to be governed by the applicable standard of medical care. The number of states surveyed here adds up to more than fifty because some state statutes include multiple descriptions of healthcare providers' duties in connection with such transfers.

they articulate it. If accepted, it would substantially impair end-of-life decision-making by millions of Americans who – whether directly, through surrogates, or by executing advance directives – have exercised the constitutional right to refuse unwanted medical treatment. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). Recent surveys estimate that advance directives have been executed by 26% of the overall adult population, 47% of adults over the age of forty, and 72% of adults over the age of sixty who died during the preceding decade. U.S. Gov't Accountability Office, *Advance Directives: Information on Federal Oversight, Provider Implementation, and Prevalence* 21, 24-25 (2015). For people who are admitted to a hospital that refuses, for reasons of religious conviction, either to comply with a medically sound healthcare decision or valid advance directive or to cooperate in transfer to another facility, statutory mandates for transfer would become toothless and the constitutional right to refuse unwanted medical treatment would be impaired.

This adverse impact on constitutionally guaranteed choice in healthcare is undeniable, given the enormous contribution of Catholic hospitals to the provision of healthcare in America. As of January 2016, a total of 639 Catholic hospitals nationwide – 34% of which were located in rural areas – accounted for some five million yearly hospital admissions and some twenty million yearly emergency room visits. *See* Catholic Health Association of the United States,

Facts & Statistics, Catholic Health Care in the United States (Feb. 9, 2016), https://www.chausa.org/about/about/facts-statistics. Catholic hospitals in rural areas are commonly "sole community providers," meaning no nearby hospitals provide similar services. *See* 42 C.F.R. § 412.92(a) (2016) (classifying hospital as sole community provider if it is "located more than 35 miles from other like hospitals" or is "located in a rural area" and meets other criteria); Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 Mercer L. Rev. 1087, 1092 (1996) ("The Health Care Financing Administration has designated forty-six Catholic hospitals as 'sole community providers.' "). A substantial number of Americans, many of whom are not Catholic, are treated at Catholic hospitals not by choice but by circumstance – for example, because no similar facility is nearby or because a medical emergency has rendered the patient unconscious and unable to choose among available hospitals.

Issues of conscience will inevitably arise in situations where patients' healthcare decisions and advance directives are at odds with the Ethical and Religious Directives for Catholic Health Care Services (ERDs) to which Catholic hospitals adhere. For example, advance directives commonly provide for refusal of artificial nutrition and hydration, but Directive Number 58 of the ERDs imposes on Catholic hospitals an obligation to provide "medically assisted nutrition and hydration for those who cannot take food orally," which "extends to patients in chronic and presumably irreversible conditions (e.g., the

'persistent vegetative state') who can reasonably be expected to live indefinitely if given such care." United States Conference of Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 31 (5th ed. 2009); *see also id.* at 30 ("Introduction" to "Issues in Care for the Seriously Ill and Dying") (artificial nutrition and hydration "should in principle be provided to all patients who need them, including patients diagnosed as being in a 'persistent vegetative state' (PVS)"). Or a patient might decide to refuse or disable a pacemaker in contravention of Directive Number 56 of the ERDs, which imposes on all patients (Catholic or non-Catholic) a "moral obligation to use ordinary or proportionate means of preserving his or her life" and explains that "[p]roportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community." *Id.* at 31.

Petitioners' arguments bring into plain view the "flood of religious objections regarding a wide variety of medical procedures and drugs" that the majority in *Hobby Lobby* said the government had "made no effort to substantiate." *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2783 (2014). If this flood was not yet predictable then, it surely is now. The short step from petitioners' arguments to healthcare decisions and advance directives demonstrates that *Hobby Lobby* truly "ventured into a minefield" by an "immoderate reading" of the Religious Freedom Restoration Act. *Id.* at 2805 (Ginsburg, J., dissenting).

The time has come for a return to moderation in defining the contours of conscientious objection in a pluralistic society.

CONCLUSION

For the foregoing reasons, amicus curiae urges this Court to keep in mind, when deciding these consolidated cases, that the efficacy of millions of Americans' healthcare decisions and advance directives, and the fate of statutory transfer mandates in forty-seven states, hang in the balance.

Respectfully submitted,

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