

## Chapter 4

# Reproductive Health Care: A Casualty of Hospital Mergers

*Medical decisions must be based on medical and scientific facts, not on ideology.*

*Allan Rosenfield, M. D.  
Dean of Columbia University's School of Public Health, 1995.*

In 1998, a Catholic, married mother of two was planning to deliver her third child at her local hospital, where in the years prior to her third pregnancy, she had been able to get family planning counseling and contraception. It was only after the birth of her child, when she requested her attending physician to have a tubal ligation, that she discovered that her former county-run hospital had recently merged with a Catholic health facility. As a consequence, not only was the hospital no longer performing tubal ligations, but it was also no longer providing birth control or other reproductive health care services<sup>1</sup> to its patients. According to the new hospital's

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<sup>1</sup>For the purpose of this chapter, the reproductive health services discussed are those prohibited by the *Ethical and Religious Directives for Catholic Health Care Services*, – see, *infra*, Section 4.1, 148 – as these have been the focus of controversy in mergers between religious and non-religious hospitals. These services include contraceptive counseling, tubal ligations, vasectomies and other forms of sterilization, whether temporary or permanent, abortion, emergency contraception (EC) for rape victims, and most assisted reproductive methods. Moreover, services commonly banned or restricted at Catholic-affiliated hospitals also include provision of condoms to prevent the spread of HIV/AIDS, end-of-life choices, such as removal of artificial nutrition or hydration, and any medical treatments

administration those services were against Catholic teachings.<sup>2</sup>

Similarly, when in the winter of 1999, Tereza Rodriguez, a low-income woman, living in Sonoma County, California, found out that her fetus had no kidneys and would not survive after delivery, she was in her fifth month of pregnancy, and in urgent need of hospitalization. After learning about the condition of her fetus, Tereza decided to have an abortion. This was not a choice Tereza ever wanted to make. She was devastated, but the idea of carrying the pregnancy to term knowing that her baby would die shortly after delivery was too much to endure.<sup>3</sup> However, Tereza could not go to the Petaluma Valley Hospital in Petaluma, just a few blocks away from her home, to receive the kind of reproductive healthcare that she wanted and needed. Petaluma Valley, which used to perform abortions, had, in fact, recently formed a partnership with Sisters of Saint Joseph of Orange, a Catholic, Church-owned medical center, and the Catholic Church prohibits abortions even in case of rape or when pregnancy could endanger the life of the mother. Consequently, Tereza was forced to travel to San Francisco twice over the next two days to have “seaweed extract inserted to soften her cervix.”<sup>4</sup> Finally, after two more days of waiting, Tereza went back to San Francisco yet a third time “to have her pregnancy terminated.”<sup>5</sup>

These scenarios are only but two examples of what has been happening to women throughout the United States over the last decade, as Catholic and non-Catholic hospitals have been merging at an unprecedented pace. When sectarian and non-sectarian health care facilities merge, doctors’ medical decisions and women’s reproductive health are held hostages of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs),<sup>6</sup> which strongly oppose a whole panoply of reproductive health services including contraception, sterilization procedures, assisted reproduction, and abortion. In other words, when Catholic opposition to reproductive health

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developed through embryonic stem-cells research.

<sup>2</sup>The recount of this true story follows the description of events provided by L. M. Hisel, editor of *Conscience* magazine, a Catholic, pro-choice news journal published by Catholics for a Free Choice (CFFC). See L. M. Hisel, Editor’s Note. “It *Is* Happening Here,” *Conscience* 19 (1998): 1. Catholics for a Free Choice is an independent, not-for-profit organization working in the Catholic social justice tradition, and engaging in research, policy analysis, and advocacy on issues of gender equality and reproductive health. For more information visit the organization’s Web Site at <http://www.catholicsforchoice.org>

<sup>3</sup>The recounts of this true story follows the description of events presented in J. Wells, “The End of Choice?” *Sonoma County Independent*, 25 February – 3 March 1999, p. 10.

<sup>4</sup>Ibid.

<sup>5</sup>Ibid.

<sup>6</sup>See *infra*, Section 4.1, 148.

care is allowed to become more important than the health and well-being of millions of women, the quality of care delivered to them is highly compromised. Moreover, since understanding today's managed health care system<sup>7</sup> can be a very difficult task, many patients are often unable to find out what services they are not entitled to receive until they actually need them. American women every day discover that their local clinics deny them access to reproductive health care services in situations where they need them most. Many of these women are low-income, and possibly uninsured. After they have been refused the reproductive health care services that they need by the facilities they usually rely upon, who can they turn to? In a society whose legislation punishes poor women for becoming pregnant by denying them additional benefits for every new child born to a mother while on welfare, shouldn't these women at least be given a chance to make a personal decision concerning their reproductive destiny?

## 4.1 The Size and Scope of Religious Health Care Systems

Religious health care systems are the largest private, non-profit providers of health care in the United States and, over the last decade, they have been growing "at a pace that outstrips the for-profit system."<sup>8</sup> The years through 1990 to 1997 saw a total of 84 mergers<sup>9</sup> and affiliations<sup>10</sup> between Catholic and non-Catholic hospitals nationwide.<sup>11</sup> By 1996, five of the ten largest health care systems were Catholic,<sup>12</sup> while between 1996 and 1997 Catholic hospitals' net patient revenues nationwide grew 7.7 percent compared to the 5.5 percent of the for-profit systems.<sup>13</sup> Moreover, in 1998, a total of

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<sup>7</sup>See *infra*, Section 4.2, 151.

<sup>8</sup>S. Berke Fogel and L. A. Rivera, *Merger Mania: Religious Hospital Mergers and Access to Reproductive Health Services*, 30 *Journal of Poverty Law* (May-Jun. 1999), 30.

<sup>9</sup>A merger is commonly defined as the establishment of shared assets, liabilities and administrative functions between two entities. See L. Bucar, "When Catholic and Non-Catholic Hospitals Merge," *Conscience* 19 (1998): 3-17, 5.

<sup>10</sup>An affiliation is commonly defined as a cooperative venture that may entail joint purchasing arrangements, apportionment of medical specialties among separately-owned facilities, or the sharing of laboratories and other ancillary services. See Bucar, "When Catholic and Non-Catholic Hospitals Merge," 5.

<sup>11</sup>See Bucar, "When Catholic and Non-Catholic Hospitals Merge," 4.

<sup>12</sup>See Abortion Access Project, *Fact Sheet. The Impact of Catholic Hospital Mergers on Women's Reproductive Health Services*.

Available at <http://www.abortionaccess.org/viewpages.php?id=171>

<sup>13</sup>See Fogel and Rivera, *Merger Mania*, 30.

1,487 hospitals nationwide had been designated as “sole providers” by the Health Care Financing Administration (HCFA),<sup>14</sup> up from 96 in 1994.<sup>15</sup> Sole providers were spread across 26 states and served mainly rural counties where Catholics made up less than one percent of the local population.<sup>16</sup>

The recent increase in the number of Catholic sole providers is directly connected with the larger more general phenomenon of the recent growth of American Catholic health care systems. The reason for this connection is twofold. First, while secular hospitals, in particular in rural areas, have been obliged to close down due to insufficient funding, Catholic facilities supported by ever-stronger Catholic health care networks have survived.<sup>17</sup> Second, in some cases, mergers or acquisitions<sup>18</sup> involving a Catholic and a secular medical center have resulted in one Catholic health care facility.<sup>19</sup> For example, in 1997, the merger of Catholic Care Initiatives and Porter-care Adventist Health Care System in Colorado created one entity, Centura Health, the only health care provider in Fremont County.<sup>20</sup> Similarly, during the same year, the lease of Breville Texas’ Bee County Regional Medical Center to Spohn Health System, a Catholic health care network, resulted in a Catholic facility, renamed Spohn Bee County Hospital, which became the sole provider in Bee County.<sup>21</sup>

According to the Catholic Health Association (CHA), the trade association that represents Catholic health care facilities throughout the United

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<sup>14</sup>In 1996, the Health Care Financing Administration (HCFA) – renamed Centers for Medicare and Medicaid Services (CMS) on July 1, 2001 – granted the designation of sole providers to hospitals across the country for which one of the following conditions existed:

- (1) The facility is located at least 35 miles from the nearest like facility – i.e. another acute-care hospital open to the public;
- (2) The facility is located 25 to 35 road miles from the nearest like hospital, and gets at least 75 percent of its market share from the service area;
- (3) The facility is 15 to 25 road miles from the nearest hospital, which has been inaccessible for at least 30 days in each of the preceding years because of weather, road conditions, etc., or;
- (4) The facility is at least 45 minutes, on the best available roads, from the next hospital.

See Bucar, “When Catholic and Non-Catholic Hospitals Merge,” 5.

<sup>15</sup>Ibid.

<sup>16</sup>Ibid., 4.

<sup>17</sup>Ibid., 7.

<sup>18</sup>The term acquisition refers to the outright purchase of one facility by another. See Bucar, 5.

<sup>19</sup>See Bucar, 5.

<sup>20</sup>Ibid., 7.

<sup>21</sup>Ibid., 8.

States,<sup>22</sup> the total number of Catholic hospitals in the country is currently 611.<sup>23</sup> To date, these facilities represent 12 percent of all medical facilities operating in the country.<sup>24</sup> Data from the 2003 American Hospital Association Survey shows that in 2002 more than 15.4 million patients were checked into emergency rooms at Catholic hospitals and that more than 86 million outpatient visits took place at Catholic-affiliated facilities.<sup>25</sup>

Catholic hospitals operate as non-profit facilities. Their faith-based mission is bound to promote human dignity, care for the poor, and to contribute to the common good.<sup>26</sup> According to Liz Bucar, a policy analyst at Catholics for a Free Choice, “[t]he legacy of this mission has its roots in the Christian tradition of care for the body, mind, and soul, which should be dispensed regardless of the patient’s ability to pay for service. This commitment to indigent care permeates the daily operation of all Catholic hospitals from admission to bill collection[.]”<sup>27</sup> Unfortunately, the faith-based, charitable mission that characterizes Catholic-owned medical facilities is often used to justify denial on the part of religious hospitals of health care services that the Roman Catholic Church regards as controversial, such as euthanasia-related issues arising during the treatment of terminally patients and reproductive health care services.

The Catholic health care system is defined and controlled by its formal affiliation with the Roman Catholic Church. Consequently, the Pope and the local bishops play a key role in the administration of Catholic health facilities. For example, according to canon law, all Catholic-affiliated institutions are property of the Roman Catholic Church, and therefore the Pope, who ranks at the top of the ecclesiastic hierarchy, is entitled to exercise direct control over the administration and daily operations of Catholic health care facilities.<sup>28</sup>

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<sup>22</sup>The Catholic Health Association of the United States of America (CHA) was founded in 1915, and currently unites more than 2,000 Catholic health care sponsors, systems, facilities, and related organizations to advance selected strategic issues. “It also strengthen the Church’s healing ministry, by advocating for a fair health care system, convening leaders to share ideas, and foster collaboration among Catholic health care institutions.” For more information visit the CHA’s Web Site at <http://www.chausa.org>

<sup>23</sup>See Catholics for a Free Choice, *The Facts About Catholic Health Care in the United States* (Washington, D.C.: Catholics for a Free Choice, 2005), 1-7, 1.

<sup>24</sup>Ibid.

<sup>25</sup>American Hospital Association, “AHA Hospital Statistics,” 2003, quoted in Catholics for a Free Choice, *The Facts About Catholic Health Care in the United States* (Washington, D.C.: Catholics for a Free Choice, 2005), 1-2.

<sup>26</sup>See Bucar, 4.

<sup>27</sup>Bucar, 4.

<sup>28</sup>See Bucar, 4, 6.

“As promoters and defenders of the Catholic doctrine,”<sup>29</sup> local bishops also play a key role in the governance of Catholic health care facilities. All principles pertaining to the nature of doctor-patient relationships, business relations between religious and secular health care facilities, as well as employment contracts and the delivery of health care services at Catholic hospitals are determined by the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs), a document first designed and adopted by the National Conference of Catholic Bishops (NCCB) in 1971.<sup>30</sup> Following a 2001 revision, the document is currently comprised of 72 Directives which “address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of [Catholic] health care institutions and services.”<sup>31</sup>

According to the ERDs, a bishop is “pastor, teacher[] and priest”<sup>32</sup> in a Catholic hospital. As pastors, bishops have the duty to foster collaboration among religious and non-religious health care workers, thereby supporting the Church’s main goal of helping the indigent and the sick.<sup>33</sup> As teachers, bishops work to ensure fidelity to the Church’s doctrine among all health care providers delivering services in their dioceses.<sup>34</sup> As priests, bishops are responsible for the spiritual and sacramental care of all patients.<sup>35</sup> Finally, the ERDs give local bishops veto power over any merger or acquisition involving a Catholic and a secular institution located within their dioceses.<sup>36</sup> More specifically, the ERDs require the local bishop’s approval in order for Catholic and non-religious facilities to finalize any business deal they may be involved with.<sup>37</sup>

A Catholic hospital’s sponsor, usually a religious order or a diocese, oversees compliance with the hospital’s statutes and by-laws and is in charge of appointing and removing members of the hospital’s Board of Trustees.<sup>38</sup>

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<sup>29</sup>Bucar, 6.

<sup>30</sup>The National Conference of Catholic Bishops (NCCB) adopted the ERDs for the first time in 1971, and subsequently revised them three times, once in 1975, once on November 17, 1994 during their meeting in Washington D.C. and once in 2001. The 1994 version of the ERDs incorporates major changes and further revises and updates the 1975 document.

<sup>31</sup>“Ethical and Religious Directives for Catholic Health Care Services,” *Origins* 24 (December 15, 1994): 449-462, 449.

<sup>32</sup>*Ibid.*, 452.

<sup>33</sup>See Bucar, 6.

<sup>34</sup>*Ibid.*

<sup>35</sup>*Ibid.*

<sup>36</sup>*Ibid.*

<sup>37</sup>*Ibid.*

<sup>38</sup>*Ibid.* Generally, the sponsors of a Catholic health care facility nominate a Board of Trustees which has the function of monitoring and directing the delivery of medical

The specific powers reserved to sponsors represent the next layer of security measures put in place by the Church to ensure that Catholic doctrine gives essence to day-to-day operations at any given Catholic hospital.<sup>39</sup> According to Liz Bucar, in a small number of cases commonly called “emerging models,” the sponsors may be constituted by a group of lay persons.<sup>40</sup> “In these cases,” Bucar continues, “formal links to the local bishop[s] are secured by contract.”<sup>41</sup>

Contrary to widespread beliefs, only a small portion of a Catholic hospital’s budget comes from its sponsors. A 2004 study of almost 600 religious health care facilities in the United States showed that sectarian hospitals received a total of \$45 billion a year in public funds and that approximately half of these revenues were constituted by Medicaid and Medicare payments.<sup>42</sup>

In addition to payments issued directly by the state and federal governments, Catholic hospitals often enjoy exemption from state and federal

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services at the facility in question. Regardless of whether the Board comprises both laics and members of the clergy its primary goal is to ensure that Catholic teachings inform the hospital’s everyday practice.

<sup>39</sup>Ibid.

<sup>40</sup>Ibid.

<sup>41</sup>Ibid.

<sup>42</sup>See MergerWatch, “Religious Health Restrictions Threaten Women’s Health and Endanger Women’s Lives” (September, 2004), quoted in Catholics for a Free Choice, *The Facts About Catholic Health Care*, 2. Medicaid is a medical assistance program for low-income individuals, jointly funded by the state and federal governments. It was first enacted in 1965, as an Amendment to the Social Security Act of 1935 – *Medicaid Act*, *U.S. Code*, vol. 42, secs. 1396-96v. Medicare is a federally funded health insurance program for people age 65 or older, people under age 65 suffering from specific disabilities and people of all ages with End-Stage Renal Disease, a condition implying permanent kidney failure and requiring dialysis or a kidney transplant. Medicare was signed into law on July 30, 1965 by President Lyndon B. Johnson as an Amendment to the Social Security legislation – *Medicare Act*, *U.S. Code*, vol. 42, secs. 1395-1395b-9. On December 8, 2003, President Bush signed into law the *Medicare Prescription Drug Improvement and Modernization Act* – *Medicare Prescription Drug Improvement and Modernization Act*, Public Law 108-173, 108th Cong. (8 December 2003). This new law revises and updates the 1965 *Medicaid Act*, while creating a new opportunity for Medicare beneficiaries, most of whom did not previously have prescription drug coverage, to purchase drug coverage through a drug insurance coverage plan called Medicare Plan D. Medicaid and Medicare are major welfare programs in the United States, and they are administered at the federal level by the Centers for Medicare and Medicaid Services (CMS). The agency’s new name – see, *supra*, footnote 14, 146 – reflects its mission to serve Medicare and Medicaid beneficiaries by helping consumers to identify the agency that administers their health insurance plan and by developing a more consumer-friendly approach to the two main publicly funded healthcare programs in the nation. For more information visit the agency’s Web Site at <http://cms.hhs.gov>.

income, property, and sales taxes.<sup>43</sup> The Catholic Health Association estimates that tax-exempt bonds represent “the primary source of capital for [Catholic Health Association’s] members.”<sup>44</sup> Also, religious health care facilities are eligible to receive tax-exempt charitable and private contributions and reduced postal rates.<sup>45</sup>

## 4.2 Protecting Access to Reproductive Health Care at Merged Institutions and in Managed-Care Scenarios

The way health care is delivered in the United States has changed dramatically over the past twelve years. In response to skyrocketing health care costs and in the absence of a comprehensive, nationwide health care reform, insurance companies have started reducing their quotas for co-payments, thereby limiting doctors’ and hospitals’ ability to charge for services, while also obliging a substantial number of physicians once in solo-practices to join group practices.<sup>46</sup>

Similarly, a growing number of non-sectarian hospitals have formed partnerships or have been acquired by religious hospitals.<sup>47</sup> The unprecedented increase in the size and influence of religious health care facilities “is among the most significant and least noticed changes”<sup>48</sup> currently taking place in the American health care system. It reflects the ongoing effort made by secular health care facilities to consolidate in order to survive. In fact merged institutions are much more successful than single institutions at cutting down on unnecessary expenses, at eliminating the problem of empty beds, at increasing the efficiency with which they deliver services to the public, and at competing for managed care contracts.<sup>49</sup>

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<sup>43</sup>See Bucar, 6.

<sup>44</sup>Catholic Health Association of the United States of America, *Preserving a Tradition of Service: Reflections on the Tax-Exempt Status of Not-For-Profit Healthcare Institutions* (Saint Louis: Catholic Health Association of the United States of America, 1989), quoted in Bucar, 6.

<sup>45</sup>See Bucar, 6.

<sup>46</sup>Planned Parenthood Federation of America, *Fact Sheet. Opposing Dangerous Hospital Mergers* (1999): 1-7, 1. Available at <http://www.plannedparenthood.org/library/FAMILYPLANNINGISSUES/mergers.html>

<sup>47</sup>Ibid.

<sup>48</sup>Fogel and Rivera, 30.

<sup>49</sup>Planned Parenthood Federation of America, *Fact Sheet. Opposing Dangerous Hospital Mergers*, 1.



In a managed care scenario, a number of health care systems own HMOs – health maintenance organizations – namely, a network of hospitals, medical groups, doctors practices, and various forms of outpatient facilities. Individuals enrolled in a managed care health plan either select or are assigned to a particular HMO, and within the HMO they are required to choose a primary care physician (PCP). In addition to providing basic health care, the PCP authorizes specialty care as needed. The main purpose of the PCP’s authorization system is to prevent unnecessary utilization of health care services on the part of the patient. However, in case of a health problem, a physical examination conducted by a PCP will ensure that suspected medical conditions are properly examined and diagnosed and that, if necessary, the patient is provided with an appropriate referral to see a specialist.

In 1994, the National Conference of Catholic Bishops (NCCB) granted their support to the creation of Catholic health care networks, stating in the Directives that “increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships.”<sup>50</sup> The creation of Catholic health care networks implies not only the acquisition of hospitals, laboratories, doctors’ practices, medical-school campuses, but also an increased buying power that puts Catholic hospitals in a stronger financial position during mergers with non-Catholic facilities.

Hospitals can merge in a variety of ways. “A true merger occurs when two independent hospitals join to form a single cooperation.”<sup>51</sup> By contrast, “an acquisition occurs when one hospital purchases another.”<sup>52</sup> In this chapter, the term merger, unless other specified, will be used to describe all the ways in which religious and secular hospitals decide to work together.

Over the last twelve years, an increasing number of administrators of failing secular hospitals who were desperate to find resources have turned to Catholic hospitals and Catholic health care networks to help them rescue their health care facilities. Financial rescue, however, did not come without a price. Health care delivery at Catholic hospitals is governed by the ERDs. When sectarian and non-sectarian facilities merge, Catholic hospitals often impose religious control on health care delivery, by requiring secular hospitals to follow the Catholic doctrine and therefore to refrain from performing procedures explicitly prohibited by the Church. Because the ERDs are subject to interpretation by every bishop in his diocese, and because the

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<sup>50</sup> “Ethical and Religious Directives for Catholic Health Care Services,” 460.

<sup>51</sup> Planned Parenthood Federation of America, *Fact Sheet. Opposing Dangerous Hospital Mergers*, 1.

<sup>52</sup> *Ibid.*

interpretation of the ERDs can differ from bishop to bishop, the impact that hospital mergers can have on the delivery of all kinds of health services, and of reproductive health services in particular, can be more or less severe.<sup>53</sup> For example, a 1999 survey of the 127 nationwide mergers and affiliations that took place between Catholic and non-Catholic health care providers from 1990 to 1998 shows that nearly half of the surveyed mergers – or 48 percent – lead to the elimination of some or all reproductive health care services.<sup>54</sup>

Mergers between secular and religious providers may also pose a threat to prenatal genetic screening.<sup>55</sup> In fact, the ERDs establish that prenatal screening is not permitted if a pregnancy could be terminated following the diagnosis of serious birth defects, and that genetic counseling may only be provided to educate parents on how to properly take care of a child born with genetic defects.<sup>56</sup>

Finally, in case of a “reversed merger,” i.e., a merger in which a Catholic hospital is purchased by a non-religious institution, the sectarian health care facility may choose to continue to follow the ERDs, although technically speaking the Church no longer controls its operations. Fifteen such mergers took place between 1990 and 1998, and in each one of them the Catholic facility chose to continue to abide by the ERDs.<sup>57</sup>

As mentioned previously in this section, in addition to the troublesome effects that large Catholic health care networks can have on mergers, Catholic health care systems also are much better positioned to play a significant role in the managed-care landscape. Over the last decade, it has become more and more obvious that there is an intrinsic tension between managed care and access to family planning services, especially when enrollees in need of these services are locked into plans that refuse, on moral or religious grounds, to provide reproductive health care to their patients.<sup>58</sup> This alarming trend has forced a disproportionate number of female patients to either shoulder significant health care expenses or to go without

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<sup>53</sup>See Planned Parenthood Federation of America, *Fact Sheet. Opposing Dangerous Hospital Mergers*, 1.

<sup>54</sup>See L. Bucar, *Caution: Catholic Health Care Restrictions May Be Hazardous to Your Health* (Washington, D.C.: Catholics For a Free Choice, 1999), 5.

<sup>55</sup>See Planned Parenthood Federation of America, *Fact Sheet. Opposing Dangerous Hospital Mergers*, 2.

<sup>56</sup>*Ibid.*

<sup>57</sup>See Bucar, *Caution: Catholic Health Care Restrictions May Be Hazardous to Your Health*, 5.

<sup>58</sup>See P. Donovan, “When Plans Opt Out: Family Planning Access in Medicaid Managed Care,” *The Guttmacher Report on Public Policy* 1 (August 1998):8-11, 8.

contraceptive care.<sup>59</sup>

The tension existing between enrollment in managed care plans and access to reproductive care is particularly evident in the case of enrollees who are Medicaid beneficiaries, and who as such are entitled to family planning services by law. Currently, Medicaid serves around 36 million individuals, including children, elderly people, people who are blind or suffer from a physical or mental disability, and people who are eligible to receive federal assisted income benefits.<sup>60</sup> Medicaid covers the costs of in-patient hospital services, out-patient hospital services, laboratory and x-ray services, nursing home services, physician services, physical therapy, hospice care, and rehabilitative services.<sup>61</sup>

Because physicians are not fully reimbursed for services provided to Medicaid patients, many of them tend to limit the number of Medicaid patients they accept to see.<sup>62</sup> At the same time, increased market share by religious health care entities further limits the number of physicians and health care networks with whom state Medicaid agencies can contract to those who do not abide by the ERDs.

The example of New York State can help to illustrate the implications and consequences of this complicated situation. New York is one of 16 states that have adopted statewide mandatory Medicaid managed-care plans.<sup>63</sup> State Medicaid programs began experimenting with managed care beginning in the late 1970s in the hope of cutting costs and improving the delivery of health care services to patients.<sup>64</sup> In the mid-1980s, the U.S. Congress allowed states under specific circumstances to waive Medicaid recipients' freedom to choose their health care providers and to lock them into managed care programs. At the same time, and in an attempt to avoid the same issue from arising again in the future, Congress also proceeded to prohibit states "from abrogating recipients' freedom of choice"<sup>65</sup> in matters related to family planning.

Over the last twelve years, one of the major challenges facing the State of New York has been that of granting all Medicaid beneficiaries with the ability to obtain family planning services from a provider of their choice, even

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<sup>59</sup>See *ibid.*

<sup>60</sup>See Centers for Medicare and Medicaid Services, *Medicaid Information*. Available at <http://cms.hhs.gov/medicaid>

<sup>61</sup>See Legal Information Institute, *Medicaid Law: An Overview*. Available at <http://www.law.cornell.edu/topics/medicaid.html>

<sup>62</sup>*Ibid.*

<sup>63</sup>See Donovan, "When Plans Opt Out," 8.

<sup>64</sup>*Ibid.*

<sup>65</sup>Donovan, 8.

when the beneficiaries are enrollees of Fidelis Care, a Catholic sponsored HMO, serving Medicaid recipients only.<sup>66</sup> Fidelis, which opened its doors in 1993, follows a strict interpretation of the ERDs and therefore refuses to provide family planning services and sterilizations.<sup>67</sup> Furthermore, Fidelis refuses to provide its enrollees with direct referrals to alternative providers that offer birth control, sterilization, and abortion services to Medicaid recipients.<sup>68</sup>

In recent years, New York has engaged in various efforts to make family planning services available to all Medicaid managed care enrollees, and to Fidelis enrollees in particular. In February 1997, the New York Department of Health issued a policy statement concerning access to family planning in managed care plans, which required plans to “assure individuals of childbearing age (including minors [considered to be] sexually active) access to the full range of family planning and reproductive health services from any qualified provider.”<sup>69</sup> This statement, which was sent to all managed care programs, family planning providers, and local social services and health commissioners, explicitly required health plans to inform Medicaid recipients about the existence of this policy – known in New York as the “free access policy” – prior to enrollment, to explain it exhaustively in their member handbooks, and to provide members with a list of local, alternative providers both within and outside the managed care plan.<sup>70</sup> Subsequently, state guidelines were issued requiring Fidelis to inform prospect enrollees and members that family planning services are available from any health care provider accepting Medicaid, that no referral is necessary to obtain these services, and that the services are free of charge to all Fidelis enrollees.<sup>71</sup> The guidelines also required that Fidelis provided all prospective enrollees with a letter from the New York Health Department explaining how to obtain family planning services, along with a list of approved providers compiled by the Department itself.<sup>72</sup> Interestingly enough, the guidelines did not require Fidelis doctors to answer patients’ questions concerning the “free access policy” directly. Instead, the guidelines required that in case of patients’ inquiries concerning the “free access policy” physicians refer patients to the plan’s member

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<sup>66</sup>See Donovan, 8.

<sup>67</sup>Note that sterilization is considered a form of family planning under the *Medicaid Act*.

<sup>68</sup>Ibid.

<sup>69</sup>Donovan, 8.

<sup>70</sup>See Donovan, 8.

<sup>71</sup>Ibid.

<sup>72</sup>Ibid., 9.

service department.<sup>73</sup>

In 1995, two years prior to the New York Health Department's policy statement, Shirley Gordon, director of FAIR: Health Care Reform, a project sponsored by the Center for Law and Social Policy (CLASP), conducted a statewide survey of Medicaid managed care enrollees. She concluded that "confusion and misinformation about the 'free access policy' appear[ed] to be the rule rather than the exception."<sup>74</sup> For example, Gordon found that the majority of Fidelis enrollees who were part of a demonstration project in Brooklyn had not been informed prior to their enrollment with Fidelis that the agency does not provide family planning and reproductive health care services to their members.<sup>75</sup> Gordon also observed that the majority of Fidelis' enrollees had never seen a member handbook, either prior to or following enrollment in the agency's plan.<sup>76</sup>

Another survey of Fidelis doctors conducted by the local Planned Parenthood affiliate in Nassau County, Long Island, in the fall of 1997, i.e. following the New York Health Department's policy statement, revealed that while the majority of Fidelis' physicians knew about their agency's position on family planning services, they were not aware of the possibility for enrollees who were Medicaid beneficiaries to rely on providers outside the Fidelis network to obtain reproductive health care services free of charge.<sup>77</sup> Physicians further declared to have no idea on how to help patients in need of family planning services to find a qualified provider outside the Fidelis network.<sup>78</sup>

Chris Mulnar, director of the Community Service Society's Medicaid Managed Care Education Project, which trains community volunteers to educate Medicaid recipients about their rights, thinks that not only have the efforts undertaken by state authorities to inform managed care plans enrollees about the free access policy been undermined by Fidelis unwillingness to comply with state guidelines, but also by what Mulnar refers to as "limitations of print[ed] communication."<sup>79</sup> As Mulnar notices, "the Medicaid population has, on average, a six grade reading comprehension."<sup>80</sup> In New York City, for example, where an enrollment broker is responsible for

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<sup>73</sup>Ibid.

<sup>74</sup>Ibid.

<sup>75</sup>Ibid.

<sup>76</sup>Ibid.

<sup>77</sup>Ibid.

<sup>78</sup>Ibid.

<sup>79</sup>Ibid.

<sup>80</sup>Ibid., 10.

mailing enrollment packets and process enrollments, there are no face-to-face meetings and therefore prospect enrollees are expected to become familiar with and choose a plan largely on the basis of written materials.<sup>81</sup> Given the level of reading comprehension typical of a Medicaid recipient, “one likely consequence of heavy reliance on written materials”<sup>82</sup> is that many recipients will not fully understand the meaning of the free access policy and the reason for its implementation. Similarly, it is very likely that many recipients will not “realize that they are required to select a plan within 60 days of receiving the enrollment package.”<sup>83</sup> Those who miss the deadline will be assigned a plan.<sup>84</sup> This form of automatic assignment takes on specific significance in New York, where under the state’s 1996 Medicaid Managed Care Act, the first 25 percent of recipients who do not select a plan must be assigned to one such as Fidelis, which has traditionally served the needy population.<sup>85</sup>

Whether the government’s efforts in New York State will be sufficient to overcome the barriers currently limiting the obtainment of family planning and reproductive health services in Catholic Medicaid managed care plans like Fidelis remains to be seen. JoAnn Smith, Executive Director of Family Planning Advocates of New York State, notes that “[right now] [o]nly if a woman asks for further help is the plan obliged to give her or e-mail her, within 48 hours, a list of providers prepared not by Fidelis, but by the Health Department. . . That’s really sloppy health care. We have allowed some institutional needs to dominate public health.”<sup>86</sup>

Family planning providers are especially concerned about the consequences that Fidelis-alike policies may have for teenagers. Providers and advocates both fear that if teens will not be able to obtain birth control methods during a visit to a physician belonging to their health care network, the incidence of adolescent pregnancy and sexually transmitted diseases (STDs) may increase.<sup>87</sup> In addition, advocates are concerned about the fact that many teenagers whose families are enrolled in Fidelis may not know that the plan does not cover contraception or that they can go to any Medicaid provider for free family planning services until they need them, since all managed care-related information is sent to the head of the

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<sup>81</sup>See Donovan, 10.

<sup>82</sup>Donovan, 10.

<sup>83</sup>Ibid.

<sup>84</sup>See Donovan, 10

<sup>85</sup>Ibid.

<sup>86</sup>Donovan, 10.

<sup>87</sup>See Donovan, 10-11.

household.

In 1998 alone, the State of New York began enrollment of 1.4 million Medicaid recipients in managed care plans like Fidelis in the sole New York metropolitan area.<sup>88</sup>

### 4.3 Merger Mania: The End of Choice?

Despite the fact that patients' access to family planning and reproductive health care services is greatly compromised when Medicaid recipients are enrolled in managed care plans like Fidelis, it is at Catholic-affiliated hospitals that the most troublesome effects of the ERDs can be observed.

The ERDs promote prenatal care but prohibit virtually all health care services related to conception, except for natural methods. Consequently, all contraceptive medications and devices are prohibited.<sup>89</sup> The ban posed by the ERDs on the use of birth control methods raises serious concern about the ability of patients to protect themselves from the transmission of sexually transmitted diseases (STDs) and to prevent unwanted pregnancies. The ERDs also prohibit sterilization procedures, such as tubal ligations and vasectomies, from being performed at Catholic-affiliated hospitals.<sup>90</sup> The limitations imposed by the ERDs to sterilization procedures may lead to "frightful consequences."<sup>91</sup> For example, the safety of tubal ligations can be severely compromised by the restrictions laid out by Directive 53.<sup>92</sup> In fact, according to the American College of Obstetricians and Gynecologists, the safest time for a woman to undergo voluntary sterilization is immediately after caesarean delivery. However, in most cases, Directive 53 causes women to undergo a second procedure later in time without taking into consideration the high risk of infection, side effects from anesthesia, additional costs

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<sup>88</sup>Ibid.

<sup>89</sup>See Directive 52: "Catholic institutions may not promote or condone contraceptive practices, but should provide, for married couples and the medical staff who counsel them, instructions both about the church's teaching on responsible parenthood, and in methods of natural family planning," quoted in "Ethical and Religious Directives for Catholic Health Care Services," 458.

<sup>90</sup>See Directive 53: "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution when its sole imminent effect is to prevent conception. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present pathology and a simpler treatment is not available," quoted in "Ethical and Religious Directives for Catholic Health Care Services," 458.

<sup>91</sup>Fogel and Rivera, 33.

<sup>92</sup>See *ibid.*

for hospitalization and treatment, and possibility for the patient to incur an unwanted pregnancy while waiting to have surgery.<sup>93</sup>

According to Susan Berke Fogel, former Legal Director at the California Women's Law Center (CWLC), a non-profit advocacy organization based in Los Angeles, and Lourdes A. Rivera, Staff Attorney at the National Health Law Program (NHeLP),<sup>94</sup> some Catholic hospitals follow protocols that restrict but do not completely prevent physicians from performing sterilizations.<sup>95</sup> Although less limiting in nature, these protocols tend to decrease women's decisional power by allowing physicians to make final decisions concerning their patients' reproductive destiny and by requiring compromising documentation to become part of the patient's medical record.<sup>96</sup> To illustrate the gravity of the situation, Fogel and Rivera cite the example of Saint Joseph Medical Center in Eureka, California, where tubal ligations may be performed only if the "woman's medical records document a 'severe' physical condition or clinical evidence that [additional] pregnanc[ies] will lead to 'severe mental dysfunction'."<sup>97</sup> Unfortunately, one of the most serious and likely consequences of medical records that suggest the existence of a psychological condition is the tendency, on the part of insurance companies, to refuse payment for needed medical services in the future.

Further, Catholic guidelines regulating the delivery of reproductive health care services at religious facilities prohibit all forms of abortions. More specifically, the ERDs define abortion as "[t]he directly intended termination of pregnancy before viability, or the direct intended destruction of a viable fetus."<sup>98</sup> A fetus is generally defined as being viable if it has

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<sup>93</sup>Ibid.

<sup>94</sup>Based in Los Angeles, California, the National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. For more information concerning NHeLP's legal services visit the Program's Web Site at <http://www.healthlaw.org/about.cfm>

<sup>95</sup>Fogel and Rivera, 33.

<sup>96</sup>Ibid.

<sup>97</sup>St. Joseph Health Sys. Humboldt County, *Tubal Ligations Protocol 2* (12 August 1996), quoted in Fogel and Rivera, *Merger Mania*, 33.

<sup>98</sup>See Directive 45: "Abortion, that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus, is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and the implantation of the embryo. Catholic health care institutions are not to provide abortion services even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers," quoted in "Ethical and religious Directives for



the ability to potentially survive outside the mother's womb. In the 1950's, viability was considered to be reached at about 30 weeks after conception. In the 1970's, modern medical technology helped medical doctors determine that a fetus could be considered viable after only 25 weeks of gestation. Currently, viability continues to be pushed further back in the pregnancy and it is now considered to be reached by the fetus after only 19 weeks of gestation.<sup>99</sup> According to the ERDs, abortion procedures may also encompass the use of certain contraceptive devices that allow fertilization of an egg, but prevent implantation: "Every procedure whose sole immediate effect is the termination of pregnancy before viability is abortion, which in its moral context include the interval between conception and implantation of the embryo."<sup>100</sup>

Similarly, even the treatment of an ectopic pregnancy is limited to those medical procedures that are not considered an abortion. The language of Directive 48 is very clear on this matter: "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion,"<sup>101</sup> and translates into a prohibition of all innovative medical treatments that utilize medications instead of surgery to terminate an ectopic pregnancy. Furthermore, Directive 45 prohibits direct abortion also in case of rape or incest, or even if the pregnancy would endanger the life of the mother.<sup>102</sup> Despite their rigidity, the ERDs allow for the use of medications, treatments and even surgery that may lead to the resolution of a serious pathological condition in a pregnant woman, regardless of whether these procedures may incidentally cause the death of the unborn child.<sup>103</sup> Also, the ERDs caution Catholic institutions against affiliation or association with entities that do provide abortions, warning that: "... Catholic healthcare institutions need to be concerned about the danger of scandal in any association with abortion providers."<sup>104</sup>

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Catholic Health Care Services," 457.

<sup>99</sup>See *Abortioninfo.net, Fetal Development*. Available at <http://www.abortioninfo.net/facts/development4.shtml>

<sup>100</sup>See *supra*, footnote 98, 158.

<sup>101</sup>Directive 48, quoted in "Ethical and Religious Directives for Catholic Health Care," 458.

<sup>102</sup>See *supra*, footnote 98, 158.

<sup>103</sup> See Directive 47: "Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot safely be postponed until the unborn child is viable, even if they will result in the death of the unborn child," quoted in "Ethical and Religious Directive for Catholic Health Care," 458.

<sup>104</sup>See *supra*, footnote 98, 158.

Research shows that lack of access to elective abortion services at local hospitals forces women to face a series of unpleasant circumstances, including having to trust physicians they neither choose or know, and having to pay for all additional expenses related to the obtainment of medical care far from where they live.<sup>105</sup> Moreover, according to Fogel and Rivera, some physicians see a direct link between lack of access to abortion services and requests for second trimester abortions, generally viewed as much more dangerous to women's health.<sup>106</sup>

The ERDs also strictly prohibit infertility treatments that include sperm or egg donors or in vitro fertilization.<sup>107</sup> Finally, rape survivors may be given emergency contraception (EC) only if they test negative for conception. Once again, such limitations posed on hospital-based services may have serious consequences for women's health. Fogel and Rivera point out that because of a merger between a religious and a non-sectarian hospital, in one California community rape survivors' advocates were forced to distribute EC in parking lots.<sup>108</sup> Fogel and Rivera also point out that reproductive health care providers and advocates in other states may have to adopt such extreme measures in order to help their clients. In fact, a study published by Catholics for a Free Choice in March of 1999 showed that 82 percent of all Catholic hospitals in the country refused EC to rape survivors.<sup>109</sup>

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<sup>105</sup>See Fogel and Rivera, 34.

<sup>106</sup>Interview by Susan Berke Fogel with medical providers in Orange County, California, March 1999, quoted in Fogel and Rivera, 34.

<sup>107</sup>See Directive 40: "Heterologous fertilization (that is any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to the parents and the child;" and Directive 41: "Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance, e.g., any technique used to achieve extra-corporal conception," quoted in "Ethical and Religious Directive for Catholic Health Care," 457.

<sup>108</sup>Fogel and Rivera, 33.

<sup>109</sup>See *ibid.*

### 4.3.1 Emergency Abortion

Directives 45 to 48,<sup>110</sup> 50 to 51,<sup>111</sup> and 54<sup>112</sup> all reiterate the Church's strict position concerning the inviolability of life.<sup>113</sup> Implied in the language of all above-cited Directives is the Church's view that all medical treatments that may intentionally or unintentionally cause the death of a human being are inconsistent with the "adequate regard"<sup>114</sup> that the dignity of human life deserves, and therefore such treatments will not be tolerated or allowed at Catholic-affiliated hospitals.<sup>115</sup>

The strength of the Church's commitment to the inviolability of life is exposed in Directive 45, which states that no abortion should be performed in a Catholic facility "even based on the principle of material cooperation."<sup>116</sup>

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<sup>110</sup>For the text of Directives 45, 47, and 48, see, *supra*, footnote 98, 158; footnote 103, 159; and Section 4.3, 159 respectively. See also Directive 46: "Catholic health care providers shall be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion," quoted in "Ethical and Religious Directive for Catholic Health Care," 458.

<sup>111</sup>See Directive 50: "Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother, and does not subject them to disproportionate risks, when the diagnosis can provide information to guide preventive care for the mother – or postnatal care for the child – and when the parents or at least the mother give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect;" and Directive 51: "Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents, or if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of the unborn child is permitted with parental consent," quoted in "Ethical and Religious Directive for Catholic Health Care," 458.

<sup>112</sup>See Directive 54: "Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life," quoted in "Ethical and Religious Directive for Catholic Health Care," 458.

<sup>113</sup>See Sr. J. deBlois, CSJ and Rev. K. D. O'Rourke, OP, JCD, "Care for the Beginning of Life. The Revised *Ethical and Religious Directives* Discuss Abortion, Contraception, and Assisted Reproduction," *Health Progress* (September-October 1995):1-6, 4.

Available at <http://www.chausa.org/VALIDATE.ASP>

<sup>114</sup>Sr. J. deBlois, CSJ and Rev. K. D. O'Rourke, OP, JCD, "Care for the Beginning of Life. The Revised *Ethical and Religious Directives* Discuss Abortion, Contraception, and Assisted Reproduction," 4.

<sup>115</sup>*Ibid.*

<sup>116</sup>See *supra*, footnote 98, 158. The principle of material cooperation allows a Catholic health facility to justify tolerance or participation in the delivery of an otherwise forbidden medical service, for example a tubal ligation, if such tolerance or participation can prevent a greater harm, such as the closing down of a much needed medical facility, and if the

Interestingly enough, Directive 47 admits the appropriateness of interventions aimed at treating a serious pathological condition, even when a non-viable fetus would die as a result.<sup>117</sup> The latter circumstance is commonly defined by Catholic scholars as “the double effect.” In order for the double effect to be acceptable and justifiable, the implementation of Directive 47 requires the examination of three key elements, the medical condition of both the mother and the fetus, the methodology of the proposed intervention, and the ways in which the intervention will address the medical condition. According to Sr. Jean deBlois and Rev. O’Rourke,<sup>118</sup> too often misinformed observers claim that all interventions resulting in the death of a fetus constitute a direct termination of pregnancy and are therefore prohibited.<sup>119</sup> This appraisal, they continue, is generally based on an erroneous interpretation of the term “abortion” as one that invariably implies a moral assessment.<sup>120</sup> deBlois and O’Rourke sustain that such an interpretation is an example of lack of understanding of both Catholic teachings and medical terminology, and as a case in point they consider the instance of a 23-year-old woman who is admitted to an emergency room with abdominal cramps and fever.<sup>121</sup> The woman is 19 weeks pregnant, and after a quick assessment of her condition, the physicians establish that heart tones are present, meaning that the fetus is still alive, but that the cervical membranes are bulging and that amniotic fluid is leaking. After appropriate consultation, the physicians make the diagnosis of “probable uterine infection and threatened abortion.”<sup>122</sup> The physicians then decide to try to sustain the pregnancy and treat the infection but with little success.<sup>123</sup> Therefore, they finally opt for artificial rupture of the membranes and drug-induced labor.<sup>124</sup> deBlois and O’Rourke point out that the language of Directive 47 is helpful to justify the nature of the medical intervention performed in this case. In fact, the Directive primarily emphasizes that moral judgment in such a case requires adequate medical

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Catholic institution is not directly involved in the delivery of the medical service at stake.

<sup>117</sup>See *supra*, footnote 103, 159.

<sup>118</sup>Rev. Kevin O’Rourke is Professor Emeritus at the Center for Health Care Ethics at the Saint Louis University, Saint Louis, Missouri. He has provided the interpretation of the Bishops’ ERDs currently followed by the Catholic Health Association (CHA).

<sup>119</sup>See deBlois and O’Rourke, OP, JCD, “Care for the Beginning of Life. The Revised *Ethical and Religious Directives* Discuss Abortion, Contraception, and Assisted Reproduction,” 4.

<sup>120</sup>Ibid.

<sup>121</sup>Ibid.

<sup>122</sup>Ibid.

<sup>123</sup>Ibid.

<sup>124</sup>Ibid.

data.<sup>125</sup> Second, although Directive 47 does not spell out the term of the assessment, it does indicate briefly the manner in which the assessment should be conducted.<sup>126</sup>

In the light of these considerations, deBlois and O'Rourke agree that in dealing with the case of the 23-year-old woman, the attending physicians did opt for a specific course of action, i.e., rupture of the membranes and induction of labor and that the aim of the chosen procedure was threefold, to empty the patient's uterus, to treat the infection, and to complete a labor process that had already begun. In order to complete labor, the physicians also decided to administer a drug that alleviates the patient's uterine infection, while at the same time causing the delivery of a "pre-viable" fetus, an outcome that was completely unintended. deBlois and O'Rourke go as far as arguing that because of the advanced uterine infection, fetal survival was never a plausible outcome. In other words, abortion was inevitable since at the time of hospitalization a fetal body part was already protruding from the patient's uterus. Therefore, de Blois and O'Rourke conclude that fetal death occurred as an indirect effect of a necessary medical intervention. As such, the unfortunate death of a living human being is both justifiable and acceptable.

Unfortunately, the reality of emergency abortion is often very different from the one portrayed in deBlois and O'Rourke's example. Notably, what deBlois and O'Rourke fail to emphasize in their commentary is the fact that no physician at a Catholic hospital would ever perform the medical intervention they describe on a woman displaying the same or similar symptoms encountered in their case study, unless a diagnosis of "uterine infection" was made. In other words, no Catholic hospital would allow for the use of any kind of operations, treatments or medications on pregnant women whose water broke before fetal viability, unless those same women display clear symptoms of acute uterine infection. A uterine infection is a very serious medical condition that may limit a woman's future ability to conceive and bear children, and that, if left untreated, may result in a woman's death.

In May of 1998, when the amniotic sac of 35-year old Kathleen Hutchins ruptured prematurely at 14 weeks, Ms. Hutchins had to endure devastating news. Her physician, Dr. Wayne Goldner, an obstetrician and gynecologist at Elliot Hospital in Manchester, New Hampshire, told her that "her much wanted pregnancy was doomed"<sup>127</sup> and that she needed to undergo an

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<sup>125</sup>Ibid.

<sup>126</sup>Ibid.

<sup>127</sup>MergerWatch, *How Services Were Lost at Merging Hospitals* (May 2001):1-4, 2. Document no longer available online.

emergency abortion as soon as possible to avoid developing a life-threatening uterine infection. But when Dr. Goldner tried to schedule the procedure at Elliot Hospital his request was denied. In 1994, Elliot Hospital, a county-run medical facility had merged with a nearby Catholic medical center and as a result of Elliot's compliance with new Catholic policies, the performance of abortion procedures was currently banned on the hospital premises. Moreover, at the time of hospitalization, Hutchins was not showing signs of uterine infection yet, and the ERDs clearly state that treatments that could result in the death of an unborn child are only allowed when they cannot be safely postponed until after the fetus is viable. Hospital administrators went so far as to threaten to revoke Dr. Goldner's and other members of his staff's licenses if they tried to perform an emergency abortion on Hutchins. At loss for alternatives and worried about wasting precious time trying to convince hospital administrators of the gravity of Hutchins' condition, Dr. Goldner hired a cab, handed \$400 out of his own pocket to his indigent patient, and sent her off to a hospital 80 miles away, where he had made arrangements for her to have an emergency abortion performed. In a letter to Elliot Hospital, a furious Goldner later wrote "I am confronted with a severe ethical and moral dilemma. I am unable to continue my doctor-patient relationship in a safe, professional manner. I feel it deplorable that due to Catholic Church's doctrine, a poor woman of very limited means is being forced to travel to an unfamiliar environment to have a procedure that is readily available from her trusted personal physician. I find it appalling that the only way you will allow me to treat this patient is to wait until she shows signs of infection in her uterus[, since t]his of course will put her at a much greater risk for personal harm, and permanent medical disability, or even death."<sup>128</sup>

### 4.3.2 Extrauterine or Ectopic Pregnancy

An extrauterine pregnancy is often called a "tubal" ectopic pregnancy, because ectopic pregnancies do in fact usually occur in one of the two Fallopian tubes – even though they can also occur in the cervix, ovary or peritoneal cavity. Tubal ectopic pregnancies are the most common type of extrauterine pregnancy in the United States. They constitute about 95 percent of the total ectopic pregnancies occurring in a given year, and can be diagnosed and treated in different ways.<sup>129</sup>

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<sup>128</sup>L. Uttley, "Sorry No Emergency Abortions; We're Part of the Catholic System," *PRO-Choice On-line*: 1-2, 1. Available at [http://www.wcla.org/98\\$-summer/su98\\$-17.html](http://www.wcla.org/98$-summer/su98$-17.html)

<sup>129</sup>See Rev. K. D. O'Rourke, OP, CJD, "Applying the Directives. The *Ethical and Religious Directives* Concerning Three Medical Situations Require Some Elucidation,"

An ectopic pregnancy occurs when the implantation of an embryo and its subsequent development take place in the tubes' inner wall. Although the majority of ectopic pregnancies resolve themselves spontaneously,<sup>130</sup> they can, if left untreated, cause internal bleeding and uterine infections which in turn can endanger the health and life of a pregnant woman. Because the Fallopian tubes are not elastic and therefore cannot stretch to accommodate the developing fetus, the tubal inner walls may eventually rupture, become painful and bleed. Ideally, in case of tubal rupture a gynecologist would remove the embryo from the Fallopian tubes and place it inside the uterus where gestation could then continue normally. However, no surgical intervention currently performed ensures a successful re-implantation of the developing embryo.<sup>131</sup>

When it comes to an ectopic pregnancy, the issue at stake at Catholic-affiliated hospitals concerns the medical procedure with which, following accurate diagnosis, an ectopic pregnancy should be treated. Directive 48 succinctly defines the limits within which treatment of ectopic pregnancies at Catholic hospitals must take place. It reads:

In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.<sup>132</sup>

Apparently, the sole criterion medical intervention should follow is that the treatment must not constitute a direct abortion. Assessments regarding the appropriateness of a proposed intervention seem to be entirely left to the attending physician, who understands both the physiology involved in the condition and the mechanisms of intervention commonly used to address it. According to deBlois and O'Rourke, until fairly recently, in case of an ectopic pregnancy, moral assessments were made by defining the tube itself as "pathological," and thus considering its surgical incision as an acceptable moral intervention, consistent with the principle of double effect.<sup>133</sup> The practical problem that followed from such a moral assessment was that incision of a Fallopian tube seriously limited the woman's ability to conceive and to bear children in the future. deBlois and O'Rourke continue

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*Health Progress* (July-August 1998):1-7, 2. Available at <http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9807&ARTICLE=E>

<sup>130</sup>See C. Beckman et al., *Obstetrics and Gynecology*, 2d ed. (Baltimore: Williams and Wilkins, 1995), 321-331, quoted in O'Rourke, "Applying the Directives. The *Ethical and Religious Directives* Concerning Three Medical Situations Require Some Elucidation," 2.

<sup>131</sup>See O'Rourke, "Applying the Directives," 2.

<sup>132</sup>"Ethical and Religious Directive for Catholic Health Care," 458.

<sup>133</sup>See deBlois and O'Rourke, "Care for the Beginning of Life," 5.

by noting that “[n]ever [can] interventions directly address the pathological condition. . . cure the condition, *and* preserve fertility.”<sup>134</sup>

The Roman Catholic Church currently accepts three types of treatment modalities to address ectopic pregnancy, salpingectomy, salpingostomy, and methotrexate (MTX). Once again, death of a developing embryo caused by one of the three approved treatments is considered an “indirect consequence” and it is therefore accepted by the Church.<sup>135</sup>

Salpingectomy, a procedure in which the obstetrician surgically removes either the pathological segment of the Fallopian tube or the entire tube, is consistent with the principle of double effect.<sup>136</sup> Preserving the life of the mother is the physician’s primary goal, whereas the ensuing death of the developing embryo is a secondary, unindented and unwanted effect.<sup>137</sup> According to O’Rourke, “the rationale justifying salpingectomy is similar to that justifying the removal of a cancerous tumor from a woman who happens to be gravid.”<sup>138</sup>

Contrary to salpingectomy, salpingostomy does not destroy the Fallopian tube. In fact, during a salpingostomy procedure the surgeon makes a small incision in the tube, removes the embedded embryo and then sutures the slit, thereby leaving the tube intact.<sup>139</sup> “The specific focus of this surgical intervention is the removal of the damaged tubal tissue and damaging trophoblastic tissue,<sup>140</sup> not the destruction or death of the embryo, even [if it is possible to foresee] that the death of the [developing embryo] will take place.”<sup>141</sup>

Finally, methotrexate (MTX) is not a procedure but a drug that inhibits cell multiplication.<sup>142</sup> It is often used in very high doses as chemotherapy for the treatment of cancer. Trophoblastic cells are extremely sensitive to the action of MTX. As a consequence, the death of the embryo follow almost immediately upon subministration.<sup>143</sup> The effectiveness of MTX in destroying trophoblastic cells is at the center of an ongoing debate among Catholic

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<sup>134</sup>deBlois and O’Rourke, “Care for the Beginning of Life,” 5.

<sup>135</sup>See O’Rourke, “Applying the Directives,” 2.

<sup>136</sup>Ibid.

<sup>137</sup>Ibid.

<sup>138</sup>O’Rourke, “Applying the Directives,” 2.

<sup>139</sup>See O’Rourke, “Applying the Directives,” 2.

<sup>140</sup>Cells belonging to the embryo embedded on the tube’s wall.

<sup>141</sup>A. Moraczewski, “Managing Tubal Pregnancies I,” *Ethics & Medics* (June 1996): 4, quoted in O’Rourke, “Applying the Directives,” 2.

<sup>142</sup>See *ibid.*

<sup>143</sup>Ibid.



scholars.<sup>144</sup> The debate focuses on the question of whether the principle of double effect can be applied to the use of MTX to treat ectopic pregnancies.<sup>145</sup> On one side, opponents of MTX maintain that since the cells of the embryo and the cells of the future fetus are so intimately connected as to form one entity, MTX as a treatment in case of ectopic pregnancy should be discontinued and banned.<sup>146</sup> On the other side, supporters of MTX use the analogy of normal childbirth, in which the result of the trophoblast, the placenta, is unequivocally separated from the fetus, to argue that MTX should continue to be administered.<sup>147</sup> In their view, the directly intended effect, namely the treatment of a pathological, life-threatening condition by inhibiting the multiplication of the trophoblastic cells, is totally distinct from the unintended effect, the unwanted death of the developing embryo.<sup>148</sup>

### 4.3.3 Hospital Care of Rape Survivors and Dispensation of Emergency Contraception

Emergency contraception (EC) is commonly defined as the use of drugs or devices to prevent pregnancy after intercourse.<sup>149</sup> The most widely available form of EC consists of a combination of different oral contraceptive pills that provide the body with a high concentration of hormones over a short period of time. When taken within 72 hours of unprotected intercourse, EC is estimated to be at least 75 percent effective in reducing the occurrence of an unwanted pregnancy.<sup>150</sup> Alternatively, a copper-T intrauterine device (IUD) can be inserted inside the uterus within five days after unprotected intercourse, thereby reducing the risk of pregnancy by more than 99 percent.<sup>151</sup>

The use of EC has been approved by the Food and Drug Administration (FDA) on February 25, 1997, and defined on that occasion as “remarkably safe and effective.”<sup>152</sup> Similarly, in 1996, the American College of Obste-

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<sup>144</sup>See O’Rourke, “Applying the Directives,” 3.

<sup>145</sup>Ibid.

<sup>146</sup>Ibid.

<sup>147</sup>Ibid.

<sup>148</sup>Ibid.

<sup>149</sup>A. Glasier, “Drug Therapy: Emergency Postcoital Contraception,” *New England J. of Med.* 337 (October 1997).

<sup>150</sup>NOT-2-LATE.com. The Emergency Contraception Web Site. Available at <http://ec.princeton.edu>

<sup>151</sup>Ibid.

<sup>152</sup>Food and Drug Administration, “Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Post-Coital Emergency Contraception,” *Federal Register* 62 (1997): 8610, quoted in S. S. Smugar, MD, B. J. Spina, BA, and J. F. Merz, JD, PhD,

tricians and Gynecologists has declared that “no published studies have reported evidence-based criteria contradicting use of [EC] treatment.”<sup>153</sup>

The dispensation of EC at hospital emergency rooms is currently considered a standard care procedure for rape survivors.<sup>154</sup> However, a growing number of surveys have shown that Catholic hospitals throughout the United States are very likely to have policies in place prohibiting emergency rooms’ physicians from administering EC to women who have been sexually assaulted.<sup>155</sup> For example, findings from a nationwide survey of 589 Catholic hospitals’ emergency rooms conducted by CFFC in 1998 show that an alarming 82 percent of the surveyed emergency rooms did not provide EC to patients who had been raped.<sup>156</sup>

Despite the fact that the interpretation of the position assumed by the Catholic Church on matters concerning the treatment of rape survivors is extremely problematic, the Catholic Health Association likes to define such position as “clear in its intent.”<sup>157</sup> It is Directive 36 that outlines the procedures with which rape survivors should be treated and the circumstances under which EC should be dispensed to patients in need. Interestingly enough, Directive 36 specifies that no EC should be administered to patients whose contraceptive methods have failed during consensual sexual intercourse. In fact, according to the Catholic Church, a woman who has voluntarily engaged in sexual intercourse is expected to bear full responsibility for it and to consider the act itself as “keeping with its intrinsic significance of love and procreation.”<sup>158</sup>

Directive 36 reads:

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“Uninformed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims,” *Am. J. Public Health* 90 (September 2002): 1372-1376, 1372.

<sup>153</sup>American College of Obstetricians and Gynecologists, *ACOG Practice Patterns: Emergency Oral Contraception* (Washington, D.C.: American College of Obstetricians and Gynecologists, 1996), quoted in Smugar et al., “Informed Consent,” 1372.

<sup>154</sup>See M. E. Kobernick, S. Seifert, and A. B. Sanders, “Emergency Department Management of Sexual Assault Victims,” *J. Emerg. Med.* 2, no. 3 (1985): 205-14, quoted in Smugar et al., “Informed Consent,” 2.

<sup>155</sup>See Bucar, *Caution*, 7-10; J. M. Goldenring, “Denial of Antipregnancy Prophylaxis to Rape Victims,” *New England J. Med.* 311 (December 1984): 1637, and J. M. Goldenring, “Inadequate Care of Rape Cases in Emergency Rooms of Hospitals with Religious Affiliation,” *J. Adolesc. Med.* 7 (March 1996): 141-42, quoted in Smugar et al., 1372; NARAL Pro-Choice of New York, *Preventing Pregnancy After Rape: Does Your Hospital Provide Emergency Contraception for Rape Survivors?* (Washington, D.C.: NARAL Pro-Choice America, 1999).

<sup>156</sup>See Bucar, *Caution*, 9, table 2.

<sup>157</sup>O’Rourke, “Applying the Directives,” 3.

<sup>158</sup>*Ibid.*

Compassionate and understanding care should be given to a person who is a victim of sexual assault. Health care providers should cooperate with law enforcement officials, offer the person psychological and medical support, and accurate medical information. A female who has been raped should be able to defend herself against potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation or fertilization. It is not permissible, however, to initiate or recommend treatments that have as their purpose or direct effect, the removal, destruction or interference with the implantation of a fertilized ovum.<sup>159</sup>

Contrary to a woman who has consented to intercourse, a woman who has been victim of rape bears no responsibility for the sexual act she engaged in, and therefore she may decide to try and prevent an unwanted pregnancy by using EC. However, emergency rooms' physicians who work at Catholic-affiliated facilities will not provide rape survivors with EC if ovulation has already occurred. In fact, Directive 36 explicitly prohibits all treatments that have the purpose or effect to remove, destruct, or interfere with the implantation of a fertilized ovum. The Catholic Church considers any medical treatment that interrupts pregnancy after conception to be equivalent to an abortion procedure. Therefore, the Catholic Church holds that when EC prevents pregnancy by interfering with implantation it acts like an abortifacient and as such its use is not permissible.<sup>160</sup> To this respect, Directive 36 strongly recommends in a footnote that "[a] sexually assaulted woman be informed about the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures."<sup>161</sup>

Interestingly enough, Directive 36 is silent on the methods that physicians are allowed to use in order to determine whether conception has occurred, thus leaving Catholic health care providers free to decide under which circumstances they are going to administer EC. Consequently, EC may be offered to a woman in California who has been raped and taken to any of the region's Catholic hospitals for treatment, but it may not be offered to a woman in Illinois who has been sexually assaulted and subsequently taken to Loyola University Medical Center in Maywood.

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<sup>159</sup> "Ethical and Religious Directive for Catholic Health Care," 456.

<sup>160</sup> See "Ethical and Religious Directives for Catholic Health Care Services," 456.

<sup>161</sup> Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810, quoted in "Ethical and Religious Directives for Catholic Health Care," 461.

Alarming situations like the latter fuel the ongoing debate over the laborious procedure set up by Directive 36 for the treatment of rape survivors. Currently, emergency room physicians are required to first perform a pregnancy test on the patient to determine whether conception has occurred.<sup>162</sup> Then, if conception has not occurred, physicians are allowed to initiate a treatment using contraceptive medications.<sup>163</sup> These two steps are regarded by many members of the scientific community as anomalous, because “no pregnancy test will be positive as a result of a recent rape.”<sup>164</sup>

The type of EC most commonly administered to rape survivors is called Ovrал and it has the effect of both suppressing ovulation and rendering the endometrium hostile to the implantation of a fertilized ovum.<sup>165</sup> In the Church’s view, if Ovrал is administered after ovulation has occurred and after a rape survivor has conceived, the medication will have acted as an abortifacient.<sup>166</sup> Therefore, the timing of ovulation becomes critical in avoiding what the Church considers to be “drug-induced abortion.”<sup>167</sup> If ovulation has not yet occurred, Ovrал or Ovrал-like medications can be administered in the hope that they may at least delay the onset of ovulation long enough for the sperm inside the woman’s body to become inactive.<sup>168</sup> However, if ovulation is either under way or has recently taken place, contraceptive medications should not be dispensed.<sup>169</sup>

But is it possible to determine the time of ovulation with the degree of accuracy indirectly required by Directive 36? Recently, two methods have been devised by which the occurrence of ovulation can be tested. The first method, devised by a team of doctors at the Saint Francis Medical Center in Peoria, Illinois, requires a trained obstetrician to perform a progesterone-level test on the patient. The method then calls for the use of a urine “dip-stick” to test for the presence and level of luteinizing hormone (LH) in the patient’s system.<sup>170</sup> If the LH test is negative and if it is also consistent with progesterone-level findings, ovulation is not occurring and EC can be safely administered to the patient.<sup>171</sup> By contrast, if the LH test is positive,

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<sup>162</sup>See O’Rourke, “Applying the Directives,” 3.

<sup>163</sup>Ibid.

<sup>164</sup>O’Rourke, “Applying the Directives,” 3.

<sup>165</sup>See E. F. Diamond, “Ovrал in Rape Protocols,” *Ethics & Medics* 2110 (October 1996): 2, quoted in O’ Rourke, 3.

<sup>166</sup>See O’Rourke, 3.

<sup>167</sup>O’Rourke, 3.

<sup>168</sup>See O’Rourke, 3.

<sup>169</sup>Ibid.

<sup>170</sup>Ibid., 3-4.

<sup>171</sup>Ibid., 4.

ovulation is most probably under way, in which case the dispensation of EC is highly discouraged.<sup>172</sup>

The other method consists of examining the texture of a rape victim's cervical mucus.<sup>173</sup> This test is designed to assess the mucus' ability to facilitate the sperm's upward movement inside a woman's reproductive tract.<sup>174</sup> When the cervical mucus is sticky and cloudy, its ability to conduce sperm is very low. In this case, ovulation is either likely to have already occurred or to be far from occurring any time soon. In contrast, when the cervical mucus is stringy, ovulation is most likely to either be underway or to have recently occurred. In this case, the use of Ovral or Ovral-like medications is banned by the Catholic Church because its dispensation may result in a direct abortion.<sup>175</sup>

In some states, a law currently requires physicians treating rape survivors to fully inform them about the options they have to try and avoid an unwanted pregnancy. In the case of a Catholic hospital, this means that a physician has a legal obligation to inform a rape survivor of the possibility for her to be transferred to a different health care facility if the hospital to which she has been taken does not offer EC to women who have been raped. A physician who fails to notify a rape survivor of her options violates her right to an informed consent to treatment.<sup>176</sup>

Physicians' legal obligation to inform patients about the existence and effects of EC and Ovral-like medications puts Catholic-affiliated hospitals in a very difficult position, mainly because compliance with such an obligation may be regarded by the Church as an act contrary to Catholic principles. In regard to this matter, the Catholic Health Association points out that Directive 36 requires Catholic health care facilities "to cooperate with law enforcement officials [and] offer the person psychological and spiritual support, and accurate medical information".<sup>177</sup> In other words, CHA seems to suggest that "civil law can be followed in such a way that, at most, only mediate[, instead of direct,] material cooperation results."<sup>178</sup> Catholic health care providers may also justify failure to disclose information on EC, by asserting that they have an obligation to care for the health of not one,

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<sup>172</sup>Ibid.

<sup>173</sup>Ibid.

<sup>174</sup>Ibid.

<sup>175</sup>Ibid.

<sup>176</sup>See *Truman v Thomas*, 165 Cal. Rptr. 308 (1980), and *Canterbury v Spence*, 464 F2d 772 (DC Cir 1972), quoted in Smugar et al., 1374.

<sup>177</sup>O'Rourke, 4.

<sup>178</sup>Ibid.

but two patients, the rape survivors and the embryo. However, according to Smugar et al., “the failure to discuss emergency contraception is tantamount to abandonment.”<sup>179</sup> “If a physician discontinues his services before the need for them is at an end,”<sup>180</sup> the authors continues, “he is bound first to give due notice to the patient, and afford the latter ample opportunity to secure other medical attendance of her own choice.”<sup>181</sup> Otherwise, the rape survivor may think that she has been given all medical care available to her.

Between June and August 1998, scientists at the University of Pennsylvania conducted a small pilot study that examined policies and practices related to the provision of information, prescription and pregnancy prophylaxis in emergency rooms.<sup>182</sup> They designed a telephone questionnaire that addressed four areas of interest for their study. First, the researchers were interested in determining whether providers were prevented from discussing or prescribing EC and whether hospital policies concerning this matter were followed. In fact, in some states<sup>183</sup> “conscience clause laws”<sup>184</sup> explicitly

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<sup>179</sup>Smugar et al., 1374. See also, J. D. Bleich and C. A. Tauer, “The Hospital Duty and Rape Victims,” *Hastings Cent Rep* 10 (April 1980): 25-27, E. H. Loewy, “Institutional Morality, Authority, and Ethics Committees: How Far Should Respect for Institutional Morality Go?,” *Camb Q Healthc Ethics* 3 (Fall 1994): 578-84, and P. B. Hoffman, “Response to ‘Institutional Morality, Authority and Ethics Committed: How Far Should Respect for Institutional Morality Go?’,” *Camb Q Healthc Ethics* 4 (Winter 1995): 98-99, quoted in Smugar et al., 1374.

<sup>180</sup>See *An Act to Amend the Public Health Law in Relation to Emergency Contraception in Cases of Rape*, New York Assembly Bill no. 9359 (2000), quoted in Smugar et al., 1374.

<sup>181</sup>Ibid.

<sup>182</sup>See Smugar et al., 1372.

<sup>183</sup>Illinois, Louisiana, Maryland, Missouri, Montana, Oregon, Pennsylvania, and South Carolina.

<sup>184</sup>In the days following the *Roe v Wade* decision, with which the American Supreme Court legalized abortion during the first trimester of pregnancy, there was great concern among sectarian health care providers – both physicians and facilities – that they would be forced to perform abortion procedures. Because of this widespread concern, many so called “conscience clauses” were passed into law “with the intent of protecting the rights of individuals and institutional religious providers to refuse to perform this newly legalized medical procedure on moral or religious grounds.” A. Bonavaglia, “Co-Opting Conscience. The Dangerous Evolution of Conscience Clauses in American Health Policy,” *ProChoice* (January 1999): 1-16, 1. Over the 29 years that have followed the *Roe* decision, religious providers have been playing an increasingly dominant role in the national health care delivery. As a consequence, conscience clauses have become increasingly far-reaching. Currently, conscience clauses are responsible for a number of “troubling trends”:

- “They exempt individuals, health care facilities and health insurance plans and employers from paying for care or providing coverage for care they consider to be immoral, unethical, or against their religious beliefs.
- They permit a provider or health plan to opt out of offering and covering any service

exonerates providers and institutions from their legal obligation to “suggest,”<sup>185</sup> “counsel,”<sup>186</sup> “recommend,”<sup>187</sup> “advise,”<sup>188</sup> “refer for,”<sup>189</sup> or “aid, abet, or facilitate abortion.”<sup>190</sup> Although state conscience laws do not necessarily apply to EC, the authors of the questionnaire assumed that those same laws may be used in conservative environments to justify withholding of information.<sup>191</sup> The second issue addressed in the questionnaire was the researchers’ interest in determining whether the hospital’s pharmacy was dispensing EC. Finally, questions grouped under the third and fourth areas of interest were designed to determine whether or not referrals to alternative providers were given to patients, and the total, annual volume of rape cases treated at a given hospital.

The results of this study revealed that 12 of the 27 Catholic hospitals contacted by the authors reported to have specific policies in place prohibiting the discussion of EC with rape survivors. Of the 12 hospitals with restrictive policies in place, eight indicated that relevant information was still likely to be provided to the victims. For example, in four hospitals, providers would discuss EC despite the policy; in two hospitals the victims would be transferred to the gynecology department or to another provider, where information on EC was made readily available to them. In other two hospitals, rape counselors coming to the emergency room would inform rape survivors about the existence and availability of EC. The study also

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at all, instead of opting out of specific services, such as abortion.

- They permit a health insurance plan not only to opt out of offering or covering a service but also to withhold information about it and to refuse referral.
- They guarantee a health plan a legal right to receive public funds and contracts, regardless of what kind of services the plan refuses to provide.
- They focus on the ‘entity’s exemption,’ while refusing to preserve the patient’s right to legal, safe and medically necessary services.”

Bonavaglia, “Co-Opting Conscience. The Dangerous Evolution of Conscience Clauses in American Health Policy,” 1-2.

<sup>185</sup>Illinois *Compiled Statutes*, sec. 70/6, quoted in Smugar et al., 1372.

<sup>186</sup>Ibid. See also, Louisiana *Revised Statutes*, sec. 40:1299.31, quoted in Smugar et al., 1372.

<sup>187</sup>Ibid. See also, Missouri *Revised Statutes*, sec. 197.032.2, quoted in Smugar et al., 1372.

<sup>188</sup>Ibid. See also, Montana *Code Annotated*, sec. 50-20-111, and Oregon *Revised Statutes*, sec. 435.485, quoted in Smugar et al., 1372.

<sup>189</sup>See *supra*, footnote 188, 173, and *infra*, footnote 190, 173, and footnote 191, 173. See also, Maryland *Annotated Code Health General*, sec. 20-214 (a), quoted in Smugar et al., 1372.

<sup>190</sup>Pennsylvania *Pennsylvania Statutes*, title 18, sec. 3213, quoted in Smugar et al., 1372.

<sup>191</sup>Smugar et al., 1372.

revealed that three of the eight hospitals that reported to disclose some information concerning EC to patients would also inform rape survivors that rules governing health care delivery at the facility prohibited medical staff from fully discussing EC with patients. Finally, at the remaining four hospitals with conscience policies in place, patients would find out about EC only if they asked the staff and medical personnel about it.<sup>192</sup> The authors of the study commented that these policies and practices seriously undermined a survivor's right to be fully informed about her treatment's options, and did "jeopardize physicians' fiduciary responsibility to act in their patients' best interest."<sup>193</sup>

Similarly, in 1999, Catholics for a Free Choice (CFFC) conducted a nationwide survey of emergency rooms at Catholic hospitals to determine whether EC was being administered to women who requested it, regardless of hospital's policies concerning the issue. Between December 23, 1999 and January 6, 2000, a total of 589 emergency rooms at Catholic-affiliated hospitals were contacted by phone by a woman asking anonymously whether "the morning after pill was available."<sup>194</sup> If the answer was "maybe" or "sometimes," the caller would ask for further explanations concerning the circumstances under which EC would be provided.<sup>195</sup> If the answer was "no" the caller would ask for a referral.<sup>196</sup> Unfortunately, when a hospital was willing to provide either EC or a referral, the survey was unable to determine whether hospital staff would have administered contraceptive medications or provided the patient with information regarding EC without first being asked by the patient about them.<sup>197</sup> In other words, the survey was not able to determine if and to what extent Catholic hospitals abide by state laws requiring health care facilities to inform rape survivors about the existence, availability and effectiveness of EC.<sup>198</sup> As already mentioned earlier in this section, of the 589 hospitals surveyed, 482 – or 82 percent – reported to provide EC under no circumstances.<sup>199</sup> Only 22 percent of the hospitals' emergency rooms at which zero tolerance policies against EC were in place reported to provide patients in need with referrals.<sup>200</sup> The survey

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<sup>192</sup>For a more detailed description of the survey's methodology and findings, see Smugar et al., 1372-73, table 2.

<sup>193</sup>Smugar et al., 1372.

<sup>194</sup>Bucar, *Caution*, 9.

<sup>195</sup>Ibid.

<sup>196</sup>Ibid.

<sup>197</sup>See Bucar, *Caution*, 9-10.

<sup>198</sup>See *ibid.*, 10.

<sup>199</sup>Ibid.

<sup>200</sup>Ibid.



found that 40 percent of the referrals provided were “minimal,” or “not terribly helpful” – namely something like “call the Health Department[,]”<sup>201</sup> while a total of 149 surveyed emergency rooms reported not to provide the caller with any referrals at all.<sup>202</sup> At 20 of these emergency rooms, members of the staff who answered the phone hang up before the caller could even ask for a referral, while staff at other 53 facilities was downright rude to the caller.<sup>203</sup> For example, an employee of Bon Secours DePaul Medical Center in Norfolk, Virginia told the caller that “this is an emergency room and [yours] is not an emergency” before the caller was able to state the reason for her call.<sup>204</sup> In Texas, six hospitals – Saint Elizabeth Hospital in Beaumont, Burleson Saint Joseph Health Center in Caldwell, Saint Paul Medical Center in Dallas, Saint Joseph Hospital in Houston, Villa Rosa Hospital in San Antonio, and Providence Health Center in Waco – told the caller that EC was not available anywhere in the city.<sup>205</sup> In Dillon, South Carolina, Saint Eugene Community Hospital explained to the caller that the only way for her to get EC was to travel to North Carolina.<sup>206</sup>

After having reported a rape, women are often taken to a Catholic hospital by the police, because there is no other medical facility available in the area. In a previous, nationwide survey dated 1998, CFFC had identified 91 Catholic institutions as being sole providers in the area that they served. Furthermore, the 1998 survey further revealed that 68 of the sole providers – or 75 percent – did not offer EC even in case of rape.<sup>207</sup> For example, the emergency room at Burleson Saint Joseph Regional Health Center, sole provider for the city of Caldwell, Texas, informed the caller that “no one in town offers [EC or] provide referral[s].”<sup>208</sup> This means that, in cities like Caldwell, women who had been raped, women who engaged in voluntary unprotected intercourse and women whose contraceptive method failed could not prevent unwanted pregnancies.

In 1993, the diocese of Peoria, Illinois, and prior to this institution, the archdiocese of Chicago in 1986, directed local Catholic hospitals to cease the provision EC to rape survivors.<sup>209</sup> In Chicago, the archdiocese went even further and instructed all Catholic health providers under their su-

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<sup>201</sup>Ibid.

<sup>202</sup>Ibid.

<sup>203</sup>Ibid.

<sup>204</sup>Ibid.

<sup>205</sup>Ibid.

<sup>206</sup>Ibid.

<sup>207</sup>Ibid.

<sup>208</sup>Ibid.

<sup>209</sup>Ibid., 9.

pervision to place a sticker on the brochures that they distributed to rape survivors bearing the warning, “Drugs to prevent pregnancy are prescribed at some non-Catholic facilities. Our hospital does not supply these drugs, since in good conscience we will not cooperate in what may be an abortion.”<sup>210</sup> CFFC estimate that as a result of this policy, 14 Catholic hospitals in Chicago denied around 1,004 victims of sexual assault access to EC in 1992 alone.<sup>211</sup>

As many as 700,000 American women are raped each year.<sup>212</sup> Of these women, an estimated 25,000 become pregnant as the result of the rape.<sup>213</sup> As many as 23,000 of these pregnancies could be prevented each year by timely dispensation of EC.<sup>214</sup>

#### 4.3.4 Permanent Planning: Sterilization Procedures<sup>215</sup>

In 2000, a review of health care statistics funded by the National Institute of Child and Human Development (NICHD) revealed that sterilization is the new, most common contraceptive method among married couples in the United States.<sup>216</sup> According to the review, while an estimated ten million women were using the birth control pill in order to avoid an unwanted pregnancy, sterilization had become the family planning method of choice for 15 million of American men and women.<sup>217</sup> Sterilization for women means undergoing a tubal ligation procedure. Tubal ligations block the Fallopian tubes, otherwise responsible for carrying fertilized eggs to the uterus for implantation.<sup>218</sup> For men, sterilization means undergoing a vasectomy, a surgical procedure that shears the tubes responsible for carrying the sperm.<sup>219</sup> The raising popularity of sterilization procedures is largely due to three main

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<sup>210</sup>Ibid.

<sup>211</sup>Ibid.

<sup>212</sup> See MergerWatch, *Emergency Contraception in Emergency Rooms*. Available at [http://www.mergerwatch.org/ec/ec\\_er.html](http://www.mergerwatch.org/ec/ec_er.html). MergerWatch is an initiative created by the Family Planning Advocates of New York State in 1996, with the intent of monitoring threats to reproductive health care, resulting from mergers or other health care industry transactions, through which restrictive religious health care doctrine will be imposed on secular health care providers. For more information visit the initiative’s Web Site at [http://www.mergerwatch.org/mergerwatch/about\\_mw.html](http://www.mergerwatch.org/mergerwatch/about_mw.html)

<sup>213</sup>Ibid.

<sup>214</sup>Ibid.

<sup>215</sup>L. Liang, “Permanent Planning: More Couples Pick Sterilization as a Method of Birth Control,” *Chicago Tribune*, 13 September 2000.

<sup>216</sup>See *ibid.*, 1.

<sup>217</sup>Ibid.

<sup>218</sup>Ibid.

<sup>219</sup>Ibid.

factors, better technology, widespread concern about the long-term effects of hormone-based birth control methods, and possibility to have the costs of the procedure covered by health insurance.<sup>220</sup> In fact, most insurance plans currently cover sterilization, while only one-third to half of them cover other methods of birth control.<sup>221</sup>

Despite the fact that permanent sterilization has become America's most popular family planning method, sterilization procedures are far more common among women than among men.<sup>222</sup> The total number of tubal ligations in the United States is 1.5 times higher than the number of vasectomies, even though tubal ligations are more invasive and more expensive procedures.<sup>223</sup> The review sponsored by the NICHD also showed that in 2000, as many as 11 million American women relied on tubal ligations to avoid conception, while only about 4.20 million women relied on their partners' willingness to have a vasectomy performed.<sup>224</sup> The difference in numbers may be due to both lack of information concerning the procedure and to the fact that men think that a vasectomy will compromise their virility by causing impotence. By contrast, medical research shows that a vasectomy has no negative or permanent effect on a man's sexual function and performance.<sup>225</sup> A second study – the National Survey of Family Growth – also conducted in 2000, confirmed that between 1995 and 2000, 28 percent of female contraceptive users of childbearing age chose tubal ligations.<sup>226</sup> This second survey also showed that between 1995 and 2000, the percentage of women who chose sterilization was even higher among indigent women – 41 percent – thus making tubal ligations the most popular method of birth control among America's single mothers.<sup>227</sup>

But to what extent does a woman's decision to undergo a tubal ligation truly depend on her own will? When Catholic health care institutions acquire non-sectarian hospitals, tubal ligations are often discontinued, thereby making a woman's decision to undergo a sterilization procedure almost entirely dependent on the policy followed by the newly Catholic-affiliated health care facility. Zina Campos knows this kind of situation

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<sup>220</sup>Ibid.

<sup>221</sup>Ibid., 2.

<sup>222</sup>Ibid.

<sup>223</sup>Ibid.

<sup>224</sup>Ibid.

<sup>225</sup>Ibid.

<sup>226</sup>See A. Pile, "A Collision of Medicine and Faith," *Los Angeles Times*, Monday, 3 January 2000, 1A, 16A.

<sup>227</sup>Ibid.

firsthand.<sup>228</sup> In the winter of 1999, when Campos became pregnant for the ninth time she decided that following her baby's birth she would undergo a tubal ligation. Despite the fact that her obstetrician, Taki N. Anagnostou, is not an advocate for the women's reproductive rights movement, he agreed with Campos' decision. In fact, Anagnostou declared that "one more pregnancy would drastically increase the chance of life-threatening complications."<sup>229</sup> For Campos, who was 34 years old in 2000, the decision to get her Fallopian tubes tied was "a sort of personal epiphany"<sup>230</sup> – a tangible proof of the fact that getting off welfare in the spring of 1999 had been for good. In fact, in 2000 Campos, a resident of Gilroy, the poorest farming community in central California, was no longer a welfare recipient but a proud part-time county health worker. When asked about the reasons leading to her decision to undergo a sterilization procedure, Campos declared: "My body can't take [pregnancy] anymore – not only my body, but economically. How am I going to get these kids to college? How can I give them what I did not get?"<sup>231</sup> What Campos had not taken into account when deciding to undergo a tubal ligation was the fact that in the fall of 1999, Catholic Healthcare West (CHW)<sup>232</sup> – California's largest hospital owner – purchased Gilroy's only hospital, South Valley Community, and renamed it Saint Louis Regional Medical Center. Within a week from the acquisition, the local newspaper reported that tubal ligations would be discontinued at Saint Louis.<sup>233</sup>

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<sup>228</sup>The facts cited in this rendering of Zina Campos' life story are borrowed from L. Laurence, "The Hidden Threat that Puts Every Woman at Risk," in comp. California Women's Law Center, *California Women's Law Center in the News. The ARCH Project* (Los Angeles: California Women's Law Center, 2001).

<sup>229</sup>Ibid.

<sup>230</sup>Ibid.

<sup>231</sup>Ibid.

<sup>232</sup>Headquartered in San Francisco, Catholic Healthcare West (CHW) is a corporation formed by nine orders of Roman Catholic nuns. Founded in 1986, CHW is the eighth largest hospital system in the nation and the largest not-for-profit hospital provider in California. As of June 30, 2005, CHW owned a total of 41 medical centers in California, Arizona and Nevada and a total of 6,782 acute care beds. For more information concerning CHW, visit the organization's Web Site at <http://www.chwhealth.org>

<sup>233</sup>See *Saint Louise Regional Hospital Policy Regarding Sterilization Requests in Singular Perplexed Cases*.

"Saint Louise Regional Hospital's mission is accomplished in accordance with the teachings of the Roman Catholic Church... and is specifically guided by the Ethical and Religious Directives for Catholic Healthcare Services... In accordance with Church teachings, direct sterilizations are not performed at Saint Louise General Hospital... [However,] [c]ertain procedures that induce sterility are permitted by the Church, as discussed in the [Directives]. These

In the light of this sudden change in hospital policies at Saint Louis, Dr. Anagnostou had to inform Campos that she would not be able to undergo her sterilization procedure in Gilroy but that he could arrange for her to have the same procedure performed by a different physician at Hazel Hawkins Memorial Hospital, in Hollister, a medical facility about 20 miles away from Gilroy. For a woman of modest financial means like Campos, who does not own a car, the task of traveling 45 miles away from Gilroy in order to reach the next health care facility was arduous at best. Public transportation was too expensive for Campos to afford, while finding someone who would look after her eight children while Campos was gone was an impossible feat. Moreover, Dr. Anagnostou also told Campos that her insurance plan would not cover the costs for a tubal ligation at the hospital in Hollister and that the nearest hospital belonging to her plan at which she could have the procedure done was over 90 miles away from home.<sup>234</sup> Dr. Anagnostou was strongly opposed to the idea of Campos traveling near or at the time of delivery. Her previous child had arrived so suddenly that Campos had barely made it to the hospital in time to receive medical care.<sup>235</sup> Campos herself felt that she was not granted the right to decide on her own reproductive destiny. She said: “I am not saying [Catholic Healthcare West] should change their values, and morals and beliefs. I am saying that if they won’t take care of

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procedures ‘are permitted when their direct effect is cure or alleviation of a present pathology, and simpler treatment is not available.’ [Dir. 53] [Similarly,] material cooperation in certain cases may be admissible. . . in accord with the norms of ethics and moral theology governing this dilemma. . . This resolution will arise when a determination has been made in consultation with representatives appointed by the Diocese Bishop of San Jose’ that material cooperation in some procedures that include sterility may be admissible in certain particular circumstances, attendant upon some singular cases. The reason excluding material cooperation must be ones that are distinct and in addition to, the medical indications in favor of the sterilization procedure. For a tubal ligation to be admissible at Saint Louise Regional Hospital, the material cooperation must be excused by reasons that are in accord with the accepted norms of ethics and moral theology that govern material cooperation. The indispensable element of medical necessity together with the Excusing Causes which admit material cooperation [need to be present]. Medical reasons. . . do not justify the [sterilization] procedure or cooperation in the procedure. [ ] For a case to be considered there must be social, geographic, and /or financial factors that prevent the patients from obtaining the initial or primary procedure at an alternative facility.”

<sup>234</sup>Laurence, “The Hidden Threat.”

<sup>235</sup>Ibid.

us, they should make sure we have some place that does.”<sup>236</sup>

Obstetricians and gynecologists agree on the fact that denying a mother the right to undergo a tubal ligation following delivery is not just deplorable, it is bad medicine. In fact, performing the surgery post-partum is not only easier but also much less risky for the patient. Immediately following delivery both the uterus and the Fallopian tubes sit lower in the abdomen, making it simpler for the physician performing the surgery to reach them. Also, performing post-partum sterilization is far less costly than performing the same procedure later in time and “as a stand-alone surgery[.]”<sup>237</sup>

Before 2001, and thanks to the rules set forth by the principle of cooperation, a small number of non-sectarian facilities had been able to continue to provide their patients with sterilization services, even following a merger or acquisition involving a Catholic institution.<sup>238</sup> In fact, with respect to the principle of cooperation, prior to 2001 the ERDs clearly stated that a Catholic hospital is allowed to merge with a secular hospital that provides reproductive health services as long as the Catholic facility carefully avoids its direct involvement in the provision of services that the Church considers morally objectionable.<sup>239</sup> The fact that the NCCB and other leading Catholic organizations had so far kept silent as to the appropriateness of invoking the principle of cooperation to justify the provision of sterilization procedures had led to a variety of so called “creative solutions,” i.e. arrangements through which a Catholic hospital purchasing a secular institution was allowed to continue the provision of tubal ligations and other sterilization treatments, by contracting the services out to a group of physicians or to other independent health care providers.<sup>240</sup> Also, lack of further guidance concerning the proper use of the principle of cooperation had allowed sterilization procedures to be preserved at non-religious facilities when Catholic and non-Catholic institutions had merged together to create larger health care networks.<sup>241</sup>

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<sup>236</sup>Ibid.

<sup>237</sup>Ibid.

<sup>238</sup>See *Bishops to Revise Directives, Sterilization Loophole to be Closed*, 23 October 2001, 1-4, 2.

Available at [http://www.catholicsforchoice.org/new/pressrelease/102300CHA\\_Advisory.htm](http://www.catholicsforchoice.org/new/pressrelease/102300CHA_Advisory.htm)

<sup>239</sup>See Bucar, *Caution*. See also, L. Lagnado, “Their Role Growing, Catholic Hospitals Juggle Doctrine and Medicine,” *Wall Street Journal*, 4 February 1999, A2. Please note that the NCCB had established that the use of the principle of cooperation was strictly prohibited in situations involving abortion procedures.

<sup>240</sup>Ibid.

<sup>241</sup>Ibid.

However, starting with 1996, the Vatican started to become “directly involved in some of the accommodations being crafted,”<sup>242</sup> and to push for the elimination of sterilization services at Catholic-owned facilities.<sup>243</sup> As a result of the pressure exerted by the Vatican in matters concerning the principle of cooperation, “the Congregation for the Doctrine of the Faith instructed the NCCB to revise Part Six of the Directives,<sup>244</sup> and its appendix sections<sup>245</sup> that seemed to contribute to the misapplication of the principle of cooperation in association with other-than-Catholic organizations. . . .”<sup>246</sup> Revisions to the ERDs were drafted by a small working group at the NCCB held in Washington D.C. in November of 2000. The main goal of the revisions was to eliminate the ability of Catholic hospitals and health care systems to utilize the principle of cooperation to allow non-Catholic hospitals to perform sterilizations. Consequently, a new line was added to Directive 53 – previously stating that direct sterilization was not permitted at Catholic health facilities<sup>247</sup> – specifying that: “Catholic healthcare institutions are not to provide direct sterilization, even based upon the principle of cooperation.”<sup>248</sup> Directive 70 was also changed to read: “The principle governing cooperation cannot justify Catholic healthcare institutions engaging in immediate material cooperation in intrinsically evil actions, such as abortion, direct sterilization and euthanasia.”<sup>249</sup> Moreover, a new Directive, Directive 73 was added. It reads: “Because of the changing environment in healthcare, cooperative ventures should be re-evaluated periodically to ensure ongoing consistency with Catholic teaching.”<sup>250</sup> Finally, the Appendix to Part Six of the Directives was revised in order to “clarify and simplify the

<sup>242</sup>R. Benson Gold, “Hierarchy Crackdown Clouds Future of Sterilization, EC Provision at Catholic Hospitals,” *The Alan Guttmacher Report on Public Policy* 5 (May 2002): 11-13, 12.

<sup>243</sup>See *Bishops to Revise Directives*, 2.

<sup>244</sup>See *Ethical and Religious Directives for Catholic Healthcare Services*, Part 6: Forming New Partnerships with Health Organizations and Providers. See also, “Ethical and Religious Directive for Catholic Health Care,” 459.

<sup>245</sup>See *Ethical and Religious Directives for Catholic Health Care Services*, Appendix: Principles Governing Cooperation.

<sup>246</sup>See *Bishops to Revise Directives*, 2.

<sup>247</sup>See *supra*, footnote 90, 157.

<sup>248</sup>*Bishops to Revise Directives*, 2.

<sup>249</sup>In its previous version, Directive 70 read: The possibility of scandal, e.g. generation of confusion about Catholic moral teaching, is an important factor that should be considered when applying the principles governing cooperation. Cooperation, which is all other respects is morally appropriate, may be refused because of the scandal that would be caused in the circumstances. See “Ethical and Religious Directives for Catholic Health Care Services,” 460.

<sup>250</sup>*Bishops to Revise Directives*, 2.

articulation of the principle of cooperation.”<sup>251</sup> Currently, the Appendix to Part Six establishes that immediate material cooperation is “permissible in rare cases, but only for individuals and not for corporate entities.”<sup>252</sup>

On June 15, 2001, the 285 U.S. Bishops voted in Atlanta to approve the Vatican-directed revisions of the ERDs. The approval granted by the Bishops to all of the proposed changes rendered sterilization equal to abortion and euthanasia, defining it as “an intrinsically evil service, and completely forbidding its provision at any non-Catholic affiliated hospital.”<sup>253</sup> Susan Berke Fogel, former legal director of the California Women’s Law Center, a non-profit, advocacy organization based in Los Angeles, California, commented the Bishops’ revisions to the ERDs by saying: “With today’s vote to ban sterilization, the bishops have imposed a terrible hardship on millions of women, [and poor women in particular,] seeking services at Catholic-affiliated hospitals throughout the United States. It is appalling to have one of our basic healthcare services described as ‘evil’.”<sup>254</sup>

#### 4.3.5 Brackenridge Hospital: A Case Study

The “travails”<sup>255</sup> of Brackenridge Hospital in Austin, Texas, can be considered “a microcosm of the multifaceted ongoing debate over the involvement of Catholic hospitals in the provision of reproductive health care”<sup>256</sup> services. The seven-year long controversy involving Brackenridge features all the issues fueling the national debate, from an attempt to craft a so-called “creative solution” to the direct involvement of the Vatican to stop the provision of sterilization procedures at the facility to a fierce public dispute over the dispensation of EC.<sup>257</sup>

In 1995, Seton Healthcare Network, a Catholic chain, signed an agreement with the City of Austin to lease Brackenridge hospital, a public facility.<sup>258</sup> The original agreement between the City and Seton allowed re-

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<sup>251</sup>Ibid.

<sup>252</sup>Ibid.

<sup>253</sup>California Women’s Law Center, *California Women’s Law Center Condemns Vote by the National Conference of Bishops to Ban Sterilization at All Catholic-Controlled Hospitals*, 15 June 2000, press release.

<sup>254</sup>Ibid.

<sup>255</sup>Benson Gold, “Hierarchy Crackdown,” 13.

<sup>256</sup>Ibid.

<sup>257</sup>See Benson Gold, 13.

<sup>258</sup>The following recounting of the seven-year controversy involving Brackenridge Hospital is modeled after R. Benson Gold, “Hierarchy Crackdown Clouds Future of Sterilization, EC Provision at Catholic Hospitals.” *The Guttmacher Report on Public Policy* 5 (May 2002): 11-13.



productive health services, except for abortion, to continue at Brackenridge Hospital, even after Seton formally assumed control of the facility. However, between 1996 and 1997, i.e. shortly after the agreement was signed, the Vatican sent three letters to the Austin's Bishop John McCarty, questioning the lease agreement. The Vatican was particularly concerned about the provision of sterilization procedures as was allowed by the terms of the lease. To address the Vatican's concerns, the hospital's agreement was amended, and its new version ensured that city employees, rather than hospital staff, would provide sterilizations in the facility, and that the city would be financially responsible for the delivery of these services. A total number of about 450 sterilizations per year were provided under the revised agreement.<sup>259</sup> The compromise remained effective until June 2001, when the NCCB voted on the revised version of the ERDs. In fact, approval of the revisions seemed to target exactly the kind of creative solution crafted by Seton and the City of Austin. At the end of June 2001, shortly after the Bishops' vote, Seton announced that Brackenridge would discontinue sterilizations, even if the procedures were performed by city employees.

In response to this new development the City of Austin then proposed to create what they called "a hospital within the hospital[,]"<sup>260</sup> i.e., a separately licensed hospital on the fifth floor at Brackenridge, entirely financed and operated by the City Administration. In this way, deliveries and postpartum sterilizations would continue to be available. Seton agreed to the City's proposal, at least in principle, and advised its staff at Brackenridge to refer patients to the fifth floor when asked about reproductive health care services. Despite the initial success of the fifth-floor clinic, when the City Council prepared to vote on the proposal, Seton announced that it would allow the provision of EC both in its own emergency room and at the clinic on the fifth floor only after an ovulation test had established that a woman was not ovulating at the time of treatment. Seton went so far as to declare that it could not even provide "support services,"<sup>261</sup> such as water or electricity, to the whole facility if EC was provided in the absence of an ovulation test. "Thrown off guard by this last-minute request, the City Council withdrew the plan from consideration."<sup>262</sup>

In February of 2002, the City of Austin and Seton finally struck a new compromise which allowed EC to be provided only on the fifth floor and only to women who had been raped. As a result of this compromise, Seton

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<sup>259</sup>See Benson Gold, "Hierarchy Crackdown," 12.

<sup>260</sup>Ibid.

<sup>261</sup>Ibid.

<sup>262</sup>Ibid.

relented on its own request for ovulation testing. Although the compromise seemed to partially solve a very complicated situation, many women's advocates were unhappy with it. For example, Peggy Romberg former Executive Director of the Women's Health and Family Planning Association of Texas, a non-profit advocacy organization based in Austin, commented: "Because of Seton's insistence that the city-owned and operated fifth floor be governed in part by the Catholic Directives, the residents of Austin will not have access to the reproductive health care services available in other public, tax-supported hospitals in Texas."<sup>263</sup>

#### **4.4 Safeguarding Access: Advocacy Efforts to Preserve Reproductive Health Care Services**

For many years, the American Civil Liberties Union (ACLU) and other U.S. advocacy organizations have been working very hard to preserve both availability and access to reproductive health care services to all women in need. As part of their efforts, these organizations have been monitoring hospital mergers nationwide, and in some cases they have intervened to help activists protect reproductive health care at their local medical facilities. Starting with 1996, state reproductive health care advocates have begun to launch campaigns to increase public awareness of the risks posed by hospital mergers. One of the most alarming aspects of these merger transactions, state advocates noticed, is that "they typically occur in a stealth fashion[,] behind closed doors[,] and often are considered private deals."<sup>264</sup> Over the last six years, following the pattern initiated by different organizations at the federal level, women's health supporters all over the United States have engaged in community-based advocacy efforts with the intent of helping citizens to preserve access to reproductive health care services at their local hospitals. In June of 1996, for example, the Family Planning Advocates of New York State launched the MergerWatch Project,<sup>265</sup> an initiative aimed at monitoring mergers in and outside of New York State and at educating community activists, policymakers, and advocates on how to best organize and oppose mergers that threaten the provision of essential health care services at their local hospitals. MergerWatch is currently responsible for constantly updating a series of reference materials, including fact sheets, tool-kits, talking points, and presentation tools all aimed at assisting activists and advocates

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<sup>263</sup>Ibid.

<sup>264</sup>Fogel and Rivera, 36.

<sup>265</sup>See *supra*, footnote 212, 176.

with the task of promoting positive change in their communities. For this purpose, the MergerWatch materials carefully describe a variety of steps that can be taken by activists both before and after mergers and acquisitions involving religious and secular hospital have been announced. These proposed steps have the goal of reducing the likelihood that access to reproductive health care be eliminated after a merger agreement has been reached. Strategies identified by the MergerWatch resources include learning which hospitals are financially vulnerable, and therefore more inclined to become merger participants, identifying local community leaders willing to speak out in favor of reproductive health services at Catholic-affiliated hospitals, using the media to raise public awareness on how lack of reproductive health services will affect the entire community, and educating hospitals' Board Members about the many ways in which mergers can negatively impact a community.<sup>266</sup>

Similarly, in 1996, the California Women's Law Center (CWLC) and the National Health Law Program (NHeLP) jointly launched the Advocates for Reproductive Choice in Healthcare (ARCH) Project. ARCH is described by its founders as "an education, organizing, advocacy, and policy effort to ensure that reproductive health and family planning services are available and accessible in communities where religiously-affiliated health care systems are taking over local health resources."<sup>267</sup> According to both the CWLC and NHeLP, as religious systems merge with secular hospitals, low-income women, men, and adolescents are losing access to a whole range of legal and medically necessary reproductive health services. The ARCH Project, they continue, can provide assistance to advocates and local communities by providing them with community organizing experience and education strategies, by producing necessary information concerning given merger plans between religious and non-sectarian hospitals, by tailoring legal advocacy to ensure access to reproductive health services, and by negotiating directly with

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<sup>266</sup>The MergerWatch Project reference materials discussed in this section of the chapter can be found at

<http://www.mergerwatch.org/resources.html>

<sup>267</sup>California Women's Law Center and National Health Law Project, Inc., *The ARCH Project* (Los Angeles: California Women's Law Center, 1999), 1.

health care systems and government agencies.<sup>268</sup> Currently, the ARCH National Advisory Board encompasses a total of 44 organizations, foundations, universities, law firms, and Medical Doctors located in California, Connecticut, Florida, Maryland, Massachusetts, New York, Oklahoma, Texas, and Washington, D.C.

Following are two examples of the kind of advocacy efforts that the ARCH Project has engaged in between early 1996 and June 2001. Queen of Angels-Hollywood Presbyterian Medical Center is a Catholic hospital located in East Hollywood, Los Angeles. It mostly serves patients belonging to low-income minority communities residing both in North Hollywood and in Central Los Angeles. In 1998, about 55 percent of the individuals served by Queen of Angels were Latinos,<sup>269</sup> 33 percent of them were recently immigrated Armenians,<sup>270</sup> at least 16 percent of them were Asian American, in particular Los Angeles born Filipino-Americans,<sup>271</sup> and seven percent were African Americans.<sup>272</sup> The percentage of Queen of Angels' service popula-

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<sup>268</sup>The activities of the ARCH project are governed by seven leading principles:

- “The presence of a religious health system in a community must never prevent women, men and adolescents from receiving the full range of health care services they need.
- Women’s health services, including all legal methods of contraception, assisted reproduction, sterilization, and abortion, may neither be marginalized or denied.
- Health systems that do not perform abortions, or refuse to provide other reproductive health care services, must facilitate timely, appropriate, and accessible referrals to qualified providers.
- All victims of sexual assault must have appropriate access to emergency contraception.
- Health insurance plans must cover the full range of reproductive health services.
- Community members and health systems employees must be educated about the range of services that should be available in any particular health facility.
- Health practitioners must never be prevented from giving their patients full and accurate information about the full range of health options, or from discussing these options confidentially.”

California Women’s Law Center and National Health Law Project, Inc., *The ARCH Project*, 1.

<sup>269</sup>S. Goldberg, A. R. Villaraigosa, and S. Wildman, “Protect the Sick at the Economic Bottom,” *Los Angeles Times*, Sunday, 1 March 1998.

<sup>270</sup>Tenet Healthcare Corporation, *News Release: Tenet Reaches Definitive Agreement to Acquire Queen of Angels – Hollywood Presbyterian Medical Center* (Hollywood: Tenet Healthcare Corporation, 1997), 8.

<sup>271</sup>Ibid.

<sup>272</sup>Ibid.

tion represented by the Latino community was and still is the most likely to comprise indigent and uninsured individuals. In fact, research shows that Latino children and minors residing in Los Angeles are three times more likely to have no health insurance than non-Hispanic white children – 29 and ten percent respectively.<sup>273</sup> Similarly, in 1995 alone, 45 percent of the Los Angeles Latino adult population ages 14 to 44 lacked health insurance coverage.<sup>274</sup>

In 1997, Queen of Angels spent about six to seven percent of its \$150 million annual budget on care for patients who could not pay – more than twice the national average for non-profit health care institutions.<sup>275</sup> During the same year, almost two-thirds of Queen of Angels' 75,000 annual patients were enrolled in Medi-Cal,<sup>276</sup> and 30 percent were on Medicare.<sup>277</sup>

In mid-March 1997, California State Attorney General Daniel E. Lungren formally announced that Tenet Healthcare Corporation, the nation's second largest for-profit hospital chain, had bid \$86 million to buy the 122 beds available at Queen of Angels Hospital. Following the announcement of the possible acquisition, Robert Steward, Queen of Angels' Vice-President of Public Affairs, commented: "We have to sell the hospital. . . [It] cannot afford to remain a free-standing facility when other medical centers are joining chains so rapidly. . . For [its] long-term survival [ ] this hospital needs to be in a large system. Attracting managed care contracts and utilizing economies of scale is the only way to remain competitive."<sup>278</sup>

After the intention of Tenet to buy Queen of Angels became public, community activists launched a campaign to block the sale. Opponents were mainly concerned with the terms of the proposed agreement pertaining to four issues. First, the agreement allowed Tenet to drastically reduce the volume of charity care at Queen of Angels. In 1996 alone, Queen of Angels "invit[ed] a steady stream of poor people through its door for free treat-

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<sup>273</sup>See R. Brown at al. (Los Angeles: Center for Health Policy Research, 1997), quoted in L. Rivera, "Testimony of Lourdes Rivera: Public Hearing on Sale of Queen of Angels-Hollywood Presbyterian to Tenet," Los Angeles, Calif., 28 February 1997, photocopy, 1.

<sup>274</sup>Ibid.

<sup>275</sup>D. Cogan, "Assault on a Queen," *New Times Los Angeles*, Thursday, 13 November 1997, 6-8, 7.

<sup>276</sup>Medi-Cal is the California Medicaid State Program.

<sup>277</sup>See Cogan, "Assault on a Queen," 7. Medicare is a federal assistance program, which covers medical care expenses for low-income people ages 65, or older, and people living with disabilities.

<sup>278</sup>Cogan, "Assault on a Queen," 6.

ment,”<sup>279</sup> and spent about \$13 million of its \$140 million budget on charity care.<sup>280</sup> Second, Tenet had only committed to maintain basic emergency services – a fundamental source of care for the indigent and the uninsured – and to maintain the obstetrics and perinatal services at Queen of Angels for only five years after acquiring the hospital, provided that Medi-Cal revenues would not decrease during that time.<sup>281</sup> Third, nothing in the agreement seemed to protect the jobs of the 1,200 Queen of Angels employees. Finally, some consumers’ advocates – such as CWLC and NHeLP – protested Tenet’s pledge to honor Catholic policies concerning the provision of reproductive health care services at Queen of Angels.<sup>282</sup>

At the time of the sale agreement, Queen of Angels denied legal and medically necessary reproductive health care services to men and women in the community, and claimed to do so based on conscience. Tenet, a non-sectarian health care system, decided to abide by the ERDs, and therefore to continue denying the delivery of reproductive health care services at Queen of Angels for at least 20 years following the sale. As a non-sectarian institution, Tenet bears no obligation to conscience. Lourdes Rivera, Staff Attorney with NHeLP, commented: “The only positive aspect of Tenet purchasing Queen of Angels is that [Tenet is a non-sectarian institution] and could have expanded access to reproductive health services to those in need. Instead of expanding services, however, it will continue to deny women, men, and adolescents access [to it]... These restrictions [ ] Tenet will continue to impose raise serious concerns about the ability of patients to prevent unwanted pregnancies or sexually transmitted diseases, including HIV/AIDS.”<sup>283</sup> Despite the concerted efforts of the ARCH Project and the Los Angeles County Coalition for Quality Healthcare, a coalition formed by the local Union, California Attorney General Daniel Lungren approved the agreement, thereby causing an extremely needy community to lose access to basic health care services.

Similarly, in December 1995, Merced County, a rural community of the California Central Coast, started looking for a health care network to run

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<sup>279</sup>Ibid.

<sup>280</sup>Ibid.

<sup>281</sup>Medi-Cal is California’s state Medicaid program

<sup>282</sup>As specified earlier in the chapter, the ERDs prohibit the delivery of virtually all health services related to conception, except for natural methods, all forms of birth control and all contraceptive devices, tubal ligations, vasectomies, and all forms of abortion. Tenet’s pledge to honor Catholic policies concerning the provision of reproductive health care services implied that all the above cited medical services will continue to be banned at Queen of Angels.

<sup>283</sup>Rivera, “Testimony of Lourdes Rivera,” 3.

its Merced Community Medical Center in Merced.<sup>284</sup> At the time, about 75 percent of the hospital's patients load was made up by both Medi-Cal and Medicare recipients.<sup>285</sup> In their search for a buyer, the County decided to hire a private consulting firm based in Los Angeles to go through the proposals submitted by three health care groups – Sutter Health, California Health System and Mercy, owned by CHW.<sup>286</sup> In July of 1996, the firm announced that it had selected Sutter Health to take over Merced Community Medical.<sup>287</sup> In 1996, Sutter Health, a for-profit health care system based in Sacramento, owned a total of 25 leases nationwide and operated 25 hospitals in California and Hawaii alone.<sup>288</sup> According to the consulting firm, the Sutter Health proposal – a 20-year lease proposal for a net value of \$13 million – satisfied, among others, one stated priority of Merced Community Medical, to ensure that indigent people will continue to have their medical needs taken care of, regardless of their ability to pay.

After the Board of Supervisors at Merced Community Medical voted in favor of the Sutter Health's proposal, Sutter took over the Merced facility on January 1, 1997, and renamed it Sutter Merced Medical Center.<sup>289</sup> In the spring of 2000, Mercy Hospital, a health care facility situated in Merced, and belonging to Catholic Healthcare West, and Sutter Merced Medical Center began negotiations with the purpose of turning Merced into a “one-hospital town.”<sup>290</sup>

The sudden decision made by Sutter Health to let Mercy take over their lease alarmed statewide reproductive health advocates. In a letter written by Susan Berke Fogel, Legal Director of CWLC, to the Board of Supervisors at Sutter Merced, and dated October 2000, Fogel expressed her concerns and urged the Board to ensure that, in case of a merger agreement with CHW, “the contract terms specifically require that CHW provide full access to reproductive health services, in particular tubal ligations, and all forms of contraception. . .”<sup>291</sup> Fogel also pointed out that: “it is critical that the contract with CHW is specific as to: The extent to which the Eth-

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<sup>284</sup>D. Birch, “Sutter Hospital Lease Bid Goes to Merced Board,” *Modesto Bee Online*, Friday, 19 July 1996, photocopy.

<sup>285</sup>*Ibid.*

<sup>286</sup>*Ibid.*

<sup>287</sup>*Ibid.*

<sup>288</sup>*Ibid.*

<sup>289</sup>*Ibid.*

<sup>290</sup>M. Conway, “Sutter Merced, Mercy May Join Forces,” *Modesto Bee Online*, Thursday, 16 April 2000, photocopy.

<sup>291</sup>S. Berke Fogel, “Letter to Sutter Merced Board of Supervisors,” Los Angeles, Calif., 30 October 2000, photocopy.

ical Directives will be enforced at the facility, and under the terms of the contract, and the obligation of CHW to provide both inpatient, and outpatient tubal ligations, and all forms of contraception without restrictions other than standardized eligibility for county health services.”<sup>292</sup> On October 31, 2000, Fogel re-enforced her position during a testimony that she gave at the Beilesen Hearing in Merced County.

CHW took over Sutter Merced in the winter of 2001. As a result of the advocacy efforts made by the ARCH Project, and by other reproductive health supporters in the local community, some medically necessary reproductive health services, discontinued at Sutter Merced after the merger with Mercy went into effect, were allowed to be further provided at alternative health care facilities in Merced County. In fact, CHW agreed to run the Merced facilities in accordance to the so called “community model.” Under this model, although a hospital is owned by a religious health care system, it is not officially considered a Catholic medical facility, and therefore *some* reproductive health care services will continue to be provided at the facility – while *other* reproductive health care services will be provided to patients in need at alternative facilities. Because of CHW’s support of the “community model,” Mercy Hospital ceased to offer family planning services to its patients and instead agreed to rely on a separate state-run provider in Livingston for the dispensation of birth control methods. The Family Planning Services facility in Livingston offered contraceptive counseling, contraceptive medications, obstetrics and gynecological services, male sterilization, and EC. However, neither tubal ligations or abortion procedures were offered at this facility. Also, under the “community model,” the Maternity Services Department at Mercy continued to provide delivery services, childbirth and breastfeeding classes, and C-sections, while post-partum counseling was provided to mothers indirectly in the form of a videotape. Finally, Mercy’s Emergency Department examined rape survivors and agreed to administer EC upon request. Under no circumstances were abortions performed at Mercy.

Sutter Merced Medical Center, for its part, was allowed to continue providing contraceptive counseling, birth control, pre-labor and delivery services, post-partum counseling, and tubal ligations. However, no abortion procedures were allowed to be performed under any circumstances. Finally, women residing in Merced County and in need of reproductive health care services, could also rely on the Merced Planned Parenthood affiliate. The Planned Parenthood clinic offered obstetrical and gynecological services,

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<sup>292</sup>Ibid.



contraceptive counseling, birth control, and tubal ligations to all women in need. Once again, no abortion procedures were performed at this facility.

Despite CHW's willingness to run the merged medical facility in Merced according to the community model, in the eyes of local activists and women's health advocates the use of the community model represented only a partial victory. In fact, not only does the merged medical facility in Merced currently provide EC only upon patients' request, but also the two closest clinics that women residing in Merced County can rely on to terminate their pregnancies are located in Modesto and in Fresno, some 30 miles away from the Merced area.

#### **4.4.1 When Community Action Works: Blocked Mergers and Creative Compromises**

Despite the occasional defeat, in recent years community activists have been successful at both stopping hospital mergers that threatened the provision of essential health care in their community and at crafting original compromises that guarantee access to reproductive health care services to all patients in need.

For example, in 1997, Christiana Care, a non-religious health system, and St. Francis Hospital, which is part of the Catholic Health Initiative Network, submitted a Certificate of Need (CON) to the State of Delaware to build an outpatient surgery center in downtown Wilmington.<sup>293</sup> Because St. Francis Hospital is a Catholic institution, it abides by the ERDs. As a consequence, contraceptive services, dispensation of EC in case of sexual assault, tubal ligations and vasectomies, all types of abortion, as well as fertilization services and certain types of end of life choices are all prohibited at St. Francis.

The terms of the joint venture between the two hospitals set forth that daily operations at the new outpatient surgery center would also be regulated by the ERDs. Wilmington residents were outraged by the news and decided to organize to oppose the planned joint-venture. With the assistance of MergerWatch, Planned Parenthood of Delaware, and other advocacy organizations, Wilmington residents worked to educate other members of their community about the negative impact that a collaboration between St. Francis and Christiana Care would bring about.

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<sup>293</sup>The facts reported in the following section of the chapter are borrowed from MergerWatch, *Proposed Hospital Mergers Blocked by Community Action* (December 2005): 1-9. Available at [http://www.mergerwatch.org/pdfs/ch\\_proposal\\_blocked.pdf](http://www.mergerwatch.org/pdfs/ch_proposal_blocked.pdf)

As part of their community action efforts, Wilmington residents wrote letters and op-eds in local newspapers and testified against the building of the new outpatient center at the state CON hearing in September 1997. At the CON hearing, community activists came forth with creative suggestions for the state officials in charge of reviewing the venture application on how Christiana Care and St. Francis could collaborate without endangering the provision of vital health care services in Wilmington.

On September 11, 1997, just a week after the CON hearing, Christiana Care announced that it had blocked off the agreement. A Christiana Care spokesperson explained that “in the internal review and approval process of the Christiana Care Board it was determined that a joint-venture with St. Francis would create problems that would outweigh the benefits.”<sup>294</sup>

Similarly, in March 1999, after a year-long protest led by The Oklahoma Coalition for Quality in Women’s Health Care and by a coalition of local physicians, St. Mary’s Mercy Hospital and Integris Bass Baptist Hospital “scrapped their plans”<sup>295</sup> to form a venture and to jointly operate a women’s health center in Enid, Oklahoma. Had the venture become a reality, the newly created women’s health center in Enid would not have been able to provide patients with any reproductive health care service.

Integris Bass Hospital and St. Mary’s Mercy announced their plan for a joint-venture in 1998 after a local private business company had made public its intention to open a women’s health center in Enid. If this center had become a reality, it would have drawn patients away from Integris and St. Mary’s Mercy, the two main hospitals in the area. From the very beginning, executives at St. Mary’s demanded that the jointly-owned women’s health center abide by the ERDs and therefore not provide patients with tubal ligations following delivery.

Following the public announcement concerning the joint-venture plan, Enid residents started to organize against what they considered a threat against women’s health. Community activists included politicians and health care providers. In fact, more than 70 percent of the physicians working and residing in Enid had signed a petition opposing the terms under which the proposed health center would operate.

In response to the wave of public outcry, executives at St. Mary’s tried to strike a compromise with the community activists, by presenting them with an alternative plan. The new plan allowed patients who had requested to undergo a tubal ligation following delivery to be transported to Integris Bass

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<sup>294</sup>MergerWatch, *Proposed Hospital Mergers Blocked by Community Action*, 2.

<sup>295</sup>See *Proposed Hospital Mergers Blocked by Community Action*, 2.

Hospital the day after delivery in order for them to undergo the procedure. The community activists were outraged by this proposal. In their opinion, not only did the proposed plan “fragment women’s health”<sup>296</sup> but it also increased the risks inherent to a sterilization procedure while forcing the mother to leave her newborn behind at the health center for a couple of days.

In March 1999, St. Mary’s Mercy and Integris canceled their \$12 million project. The CEOs of both hospitals declared that concerns expressed by both local physicians and Enid’s residents had played a crucial role in the decision to abort the project. One of the community activist expressed her position regarding the failed joint-venture plans with these words: “It was never my intent to stop [St. Mary’s Mercy and Integris] from building the center... [my intent was] to make sure that physicians’ concerns were addressed and patients’ rights were preserved.”<sup>297</sup>

In early 2003, West Suburban Hospital, a non-sectarian medical center located in Oak Park, Illinois, publicly announced its intention to be acquired by Catholic-owned Resurrection Health Care System.<sup>298</sup> West Suburban listed its precarious financial position as the main reason for its decision to accept the terms of the planned acquisition. Resurrection Health Care, like other Catholic-owned health care systems, abides by the ERDs and requires institutions that become part of their network to do the same.

Following the public announcement in the winter of 2003, a broad coalition composed of community members, local physicians, and national organizations, such as MergerWatch and the National Women’s Law Center (NWLC),<sup>299</sup> started to organize in Oak Park. The coalition was especially concerned with the fact that the acquisition threatened the provision of crucial reproductive health services at West Suburban. Moreover, the coalition was concerned with the impact of the acquisition on the availability of charity care at West Suburban. In fact, Resurrection “had a poor record of

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<sup>296</sup> *Proposed Hospital Mergers Blocked by Community Action*, 6.

<sup>297</sup> *Ibid.*

<sup>298</sup> The facts reported in the following section of this chapter are borrowed from MergerWatch, *Working with the Community: Hospital Merger Compromises that Protect Patients*. (December 2005): 1-6.

Available at <http://www.mergerwatch.org/pdfs/ch.compromises.pdf>

<sup>299</sup> The National Women’s Law Center (NWLC) is a non-partisan, non-profit organization that uses the law to expand the possibilities for women and girls in this country. Since its foundation in 1972, NWLC has been particularly interested in defending the rights and addressing the needs of low-income women and young adults, and their dependent families. For more information concerning NWLC, visit the Center’s Web Site at <http://www.nwlc.org>

providing free care”<sup>300</sup> to the indigent and the uninsured.

In its efforts to avoid the West Suburban acquisition, the coalition was faced with a serious obstacle. A new state law recently enacted in Illinois had greatly decreased the state’s power to oversee hospital mergers and acquisitions. In fact, the law introduced a so called “certificate of exemption” process. This process allows state hospitals to change ownership without incurring the state’s assessment of how the change in ownership will impact the delivery of health care services in a given community. The “certificate of exemption” process also prevents the State of Illinois from investigating allegations of financial hardship. Such allegations were at the very core of the West Suburban’s acquisition. Unfortunately for the Oak park resident, the portion of the law dealing with allegations of financial hardship applied despite the fact that community activists had been successful in showing that “[West Suburban] predictions of financial disaster were unfounded.”<sup>301</sup>

The coalition therefore decided to reach out to state legislators, the County Health Department, the State Health Facility Planning Board (HFPPB) – the authority in charge of overseeing the exemption process – and the State Attorney General for support. This strategy paid off and the West Suburban coalition was able to obtain a series of “legally binding protections”<sup>302</sup> for its community. First, prior to West Suburban’s acquisition, three minor clinics previously affiliated with West Suburban became independent and therefore immune from Resurrection’s request to abide by the ERDs. As a result, family planning services and HIV/AIDS prevention counseling mentioning the importance and effectiveness of condom use continued to be offered at these three clinics. Second, following the acquisition, a new protocol regulating the dispensation of EC to rape survivors was introduced at West Suburban. According to this protocol, rape survivors who tested positive to an ovulation test are allowed to be promptly provided with EC at one of the independent clinics. Finally, Resurrection agreed to continue honoring the charity care policy that was already in place at West Suburban before the acquisition agreement went into effect.

In 2000, Pro Choice Washington (PCW), a coalition of state pro-choice women’s organizations negotiated a creative compromise to preserve abortion services at Swedish Medical Center in Seattle. Earlier that year, Swedish Medical initiated a business venture with Catholic-owned Providence Health System. As part of the venture, both entities agreed that

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<sup>300</sup>MergerWatch, *Working with the Community: Hospital Merger Compromises that Protect Patients*. (December 2005), 2.

<sup>301</sup>Ibid.

<sup>302</sup>Ibid.

Swedish medical would stop “[performing] non-therapeutic/elective abortions”<sup>303</sup> at both its facilities, located on First Hill and on Ballard in Seattle. In 2005, as a result of PCW’s ongoing efforts, Swedish Executives agreed to create an independent Reproductive Health Services Center within both its facilities, thereby allowing abortion services to continue to be provided. However, the two Centers will not be allowed to provide any other kind of reproductive health care services and they will be considered as “separate legal entit[ies] outside of the Providence/Swedish alliance.”<sup>304</sup> The Centers will have independent Board of Directors and they will contract with Swedish to provide abortion services to the community. Providence, for its part, will have no contact or business relationship with the Centers, while Swedish has agreed to continue to provide all reproductive health care services it provided before the merger with Providence took place, until construction of the two Reproductive Health Services Centers will be completed.

## 4.5 Impact of Mergers on Local Communities: A Summary

As shown throughout the chapter, the presence of a religiously sponsored hospital or health system in a community often defines the extent to which men, women, and adolescents are able to access reproductive health services. In the case of Catholic hospitals, decisions concerning what services are available to patients in need are too often made by the hospital’s Board of Supervisors in consultation with the local Bishop, without taking into account the actual health care needs of the communities they serve. And while the ERDs clearly prohibit contraception, sterilization, EC, and abortion procedures, there is little or no consistency from community to community as to what reproductive services are made available. Some Catholic hospitals, like Queen of Angels in Los Angeles, prohibit all reproductive health services, whereas others, like Brackenridge Hospital in Austin, Texas and Swedish Medical in Seattle, have crafted creative compromises with Catholic-owned health care system and currently run independent hospitals within the hospital. Finally, some others, like the Sutter Merced Medical Center in Merced, California prohibit abortion procedures under all circumstances and offer EC only upon patients’ request.

Changes in hospitals’ ownership, and the subsequent loss of control over

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<sup>303</sup>Ibid., 5.

<sup>304</sup>Ibid.

health care delivery, are always a concern for local communities.<sup>305</sup> Even more dangerous to local communities are mergers and acquisitions, because far too often “community members and advocates are unable to have a seat at the table when the deals are negotiated.”<sup>306</sup> In some states, there is a public process that notifies community members of ongoing mergers’ negotiations, supplies them with precious information, or allows for community input on the matter.<sup>307</sup> Yet, while some states have enacted laws that help the public to get involved in merger negotiations when for-profit hospitals buy non-profit hospitals, legalized public involvement is almost non-existent when a non-profit hospital acquires another non-profit health care facility.<sup>308</sup>

According to Fogel and Rivera, the threat to health care delivery posed by the rising number of religiously-sponsored hospitals is highest in rural communities, like Gilroy, California, where following a merger between a Catholic and a secular medical facility, no alternative sources of reproductive health care are made available to both affluent and needy women, like Zina Campos. In fact, mergers and acquisitions involving sectarian and non-sectarian health care facilities affect every person’s ability to access reproductive health care services. Low-income women, however, are the ones who pay the highest price. Often, low-income women may be unable to find affordable child care for their children while they have to travel to a distant clinic in order to receive services. They may lack the financial resources necessary to either pay out-of-pocket for medical services or to cover travel expenses. Finally, traveling to an alternative clinic and be absent from work for a couple of days may cause poor women to lose their already precarious jobs.

When a hospital controlled by a religious institution denies women access to reproductive health, the responsibility to provide those services to indigent women falls on other providers in the community. In these situations, family planning clinics like Planned Parenthood or county-run health facilities become the only viable source of care to needy women. However, those clinics may lack the capacity to meet the sudden increased demand for free medical care. In 1998, for example, the Health Care Financing Administration (HCFA), the federal agency in charge of administering the Medicaid and Medicare programs, declared that “[s]exual assault response

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<sup>305</sup>See Fogel and Rivera, 32.

<sup>306</sup>Fogel and Rivera, 32.

<sup>307</sup>General Accounting Office, *Not-for-profit Hospitals: Conversion Issues Prompt Increased State Overnight* (Washington, D.C.: General Accounting Office, 1997), quoted in Fogel and Rivera, 32.

<sup>308</sup>See Fogel and Rivera, 32.

teams run by count[ies] health departments have difficulties meeting the needs of [rape survivors] when local hospitals refuse [to provide them with] emergency contracepti[ve] medications.”<sup>309</sup>

Measured by enrollment, Medicaid is the “largest health insurer in the country.”<sup>310</sup> As such, Medicaid is one of the major financiers of reproductive health care services to low-income women of childbearing age. Increased health market control by religious institutions substantially limits the number of health care facilities that do not abide by the ERDs with whom state Medicaid programs can contract to ensure access to reproductive health care. The situation is even more alarming for Medicaid beneficiaries enrolled in managed care plans.<sup>311</sup> The Balanced Budget Act of 1997 (BBA)<sup>312</sup> granted states ample discretion over the mandatory enrollment of Medicaid beneficiaries in managed care plans. Medicaid managed care enrollees are restricted to a limited network of providers.<sup>313</sup> Although Medicaid beneficiaries have the right to seek family planning services from any qualified provider even when enrolled in managed care plans, they cannot exercise this right if they are unable to find alternative, non-religious providers in their community. Similarly, this right becomes illusory if Medicaid managed care enrollees are not informed about the possibility for them to rely on “out-of-plan services,”<sup>314</sup> or if they do not receive help identifying and locating alternative providers.

Over the last eight years, a number of communities have witnessed a variety of advocacy efforts, brought about by community members, organizations defending reproductive rights, and state institutions, aimed at preserving reproductive health care services, at least to some extent. The events that took place in Troy, New York, between the spring of 1994 and the summer of 1996, are an example of how negatively a merger can impact access to comprehensive reproductive health care “when a community does not demand continuation of services, and when the state fails to ensure their availability.”<sup>315</sup> Furthermore, the Troy merger features many of the issues,

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<sup>309</sup>Fogel and Rivera, 36.

<sup>310</sup>A. Schneider et al., *Medicaid Eligibility for Families and Children* (Menlo Park: Kaiser Commission on Medicaid and the Uninsured, 1998), 1.

<sup>311</sup>In 1997, over 32 million people, about 48 percent of the Medicaid population, were enrolled in Medicaid managed care plans. See Health Care Financing Administration, *National Summary of Medicaid Managed Care Programs and Enrollment* (Washington, D.C.: Health Care Financing Administration, 1998), quoted in Fogel and Rivera, 36.

<sup>312</sup>*Balanced Budget Act*, Public Law 105-33, (1997).

<sup>313</sup>See Fogel and Rivera, 36.

<sup>314</sup>Fogel and Rivera, 36.

<sup>315</sup>The facts cited in the recounting of the Troy merger are borrowed from P. Dono-

negotiations and battles that have characterized and still characterize advocacy efforts to stop hospital mergers and acquisitions across the country.

The Troy merger involved Leonard Hospital, a small non-sectarian community hospital that also operated a network of primary care clinics, and St. Mary's Hospital, a slightly larger Catholic facility. These two hospitals served "a financially and medically needy population in a three-counties, largely rural area. Leonard hospital provided contraception, vasectomies and referred women who requested abortion procedures or tubal ligations to other facilities delivering those services."<sup>316</sup> By contrast, St. Mary offered no reproductive health care services, and no referrals for sterilization or abortion procedures.

In April 1994, Seton Health Systems applied to the Public Health Council of the New York Health Department for permission to merge Leonard and Saint Mary, and to operate the newly formed medical center. Seton, a Catholic health care system, made it clear from the very beginning that it would abide by the ERDs on matters pertaining to the provision of reproductive health care. On August 4, 1994, the Public Health Council voted in favor of Seton's proposal without even touching on Seton's decision not to provide reproductive health care services to the community. Moreover, the Council acted before Seton's proposal had been examined by the State Hospital Review and Planning Council, an institution responsible of examining hospital mergers' proposals and to issue recommendations as to whether proposed mergers should be approved. However, the Planning Council approved Seton's proposal on the condition that Seton agreed to refer patients in need of reproductive health care to alternative providers directly. To this end, the Public Council gave Seton four options to handle a patient's request for reproductive health care services. Seton could choose to either offer the requested service, refer the patients to providers that offered that service, give patients a list compiled by the State Health Department, or refer the patients to state, county, or local government agencies that can supply a list of reproductive health care providers. Unfortunately, the Council established that all the above requirements and options were to apply only in case patients specifically requested to be provided with reproductive health services.

In January of 1995, shortly after Seton began operating the new medical center, a lawsuit was filed. The plaintiffs, two young women who relied on

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van, "Hospital Mergers and Reproductive Health Care," *Family Planning Perspectives* 28 (November/December, 1996): 1-4.

<sup>316</sup>Donovan, "Hospital Mergers and Reproductive Health Care," 1.



Leonard Hospital for their health care needs, Family Planning Advocates of New York City, and two local Planned Parenthood affiliates sought to set the merger aside. They contended that “the state violated accepted standards of care by failing to require direct referrals for family planning.”<sup>317</sup> Further, they argued that Seton’s simple act of giving patients a list of providers “. . . will force many patients to maneuver through a complex and burdensome process, often requiring two or more trips, in order to find a qualified health care practitioner to meet their needs.”<sup>318</sup> The plaintiffs also sustained that the state’s approval of the merger violated informed consent laws, because it did not require Seton to give out referrals unless explicitly asked by the patients.<sup>319</sup> Moreover, the state seemed not to have considered “public need” as carefully as state laws require prior to approval of mergers negotiations.<sup>320</sup> The merger, the plaintiffs argued, was in fact blatantly detrimental to poor and underinsured women, because only very few private physicians in the area offered services to Medicaid beneficiaries, and none provided treatment on a sliding-fee scale.<sup>321</sup> In fact, as the plaintiffs pointed out, if indigent women who did not own a car lost access to reproductive services at Leonard Hospital, they would experience serious difficulties reaching an alternative provider, considering that public transportation is very scarce in the Troy area.<sup>322</sup>

After about a year of fervent negotiations between Seton’s representatives and Eve Gartner, former Senior Staff Attorney at Planned Parenthood Federation of America, the non-profit organization that represented the plaintiffs, a settlement was reached. Seton agreed to give patients who required an initial referral a detailed list of qualified reproductive health care providers. It was also agreed that, if a Seton’s physician believed that it was in the patient’s best interest to avoid a pregnancy, the physician would inform the woman about the risks inherent in bringing the pregnancy to term. At the same time, the physician would also inform the patient that Seton only approves of natural family planning methods but that a list of family planning clinics providing more comprehensive reproductive services was available to patients. Furthermore, under the terms of the settlement,

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<sup>317</sup>Donovan, 2.

<sup>318</sup>Brief of Petitioners, *In the Matter of the Application of Amelia E. v Public Health Council et al.*, NY Sup. Ct., Albany Cty, Index no. 7062-94 (Jan. 20, 1995), 12, quoted in Donovan, 2.

<sup>319</sup>See *ibid.*

<sup>320</sup>*Ibid.*

<sup>321</sup>*Ibid.*

<sup>322</sup>*Ibid.*

the State Health Department was to compile referral lists and to update them every six months. The lists were to include the providers' name, address, telephone number, hours of operation, and information explaining whether listed providers would accept Medicaid or other third-party coverage, or serve low-income patients on a sliding or reduced fee-scale. Also, the list should specify whether the providers could be reached using public transportation.

Despite all the positive changes brought about by the law suit, the agreement stated that Seton was not required to “arrange for appointments, make phone calls, or engage in any other contact with the [listed] providers.”<sup>323</sup> Eve Gartner defined the settlement “a crucial step towards guaranteeing that patients who rely on sectarian institutions for their health care obtain [the reproductive health services] they need. . . .”<sup>324</sup> However, continued Gartner, “[the agreement] is definitely a compromise,”<sup>325</sup> since it does not require Seton to offer such services itself or to give out referrals to alternative providers in the absence of a patient's request. Nonetheless, when considering that the State of New York had already approved the merger without requiring Seton to provide direct referrals, the settlement agreement, Gartner added, “. . . is probably the best that could be achieved[.]”<sup>326</sup>

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<sup>323</sup>*Memorandum of Understanding Between Seton Health Care System, Inc., and the New York State Department of Health*, signed by the parties on 9 May 1996, and approved by the New York Supreme Court on 14 May 1996, quoted in Donovan, 2.

<sup>324</sup>E. Gartner, conversation with Patricia Donovan, Center for Reproductive Law and Policy, New York, Ny., 1996, quoted in Donovan, 2.

<sup>325</sup>*Ibid.*

<sup>326</sup>*Ibid.*