When a Hospital Becomes Catholic

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I. INTRODUCTION

Mention of this topic—the potential elimination of health services resulting from a merger or affiliation between Catholic and non-Catholic hospitals—rarely triggers discussions about "community health." It does trigger comments about abortion1 and First Amendment Free Exercise and Establishment concerns.2 Some have characterized the issues arising out of these alliances as "women's reproductive health" issues,3 but few have described the issues in terms of community health. Perhaps the phrase, "women's reproductive health," suggests why. Women's health is often understood to be reproductive health, or as the narrower issue, abortion. Unfortunately, it seems to go without saying, that women's reproductive health is generally understood to be different and separate from "health." So under patriarchal logic, it stands to

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1. Media stories about Catholic/non-Catholic hospital alliances often identify the crux of the issue as one of abortion or reproductive services. See, e.g., Dena Bunis, Doctrine Rules in Hospitals, NEWSDAY, Mar. 9, 1995, at A56 ("Those doctors [at a Catholic-affiliated hospital] follow church teachings and do not perform abortions or other reproductive services forbidden by the church.").

2. The few legal scholars who have addressed the topic have focused on First Amendment analysis. For an excellent analysis of the role of sectarian hospitals in health care, see Kathleen M. Boozang, Deciding the Fate of Religious Hospitals in the Emerging Health Care Market, 31 Hous. L. Rev. 1429 (1995).

3. Organizations, such as the California Women's Law Center and the Center for Reproductive Law & Policy (New York), that have attempted to intervene to prevent the elimination of services are those identified with, and long active in, protecting women's reproductive health.
reason that we fail to discuss the elimination of services—many of which are known as women's reproductive health services—as a community health problem.

It is also interesting that abortion so clearly shapes the discussion of this topic. That probably reflects the level of political controversy surrounding the legality of abortion and the Catholic Church's role in the controversy, as well as the conflation of women's health with abortion. In fact, a merger or affiliation between Catholic and non-Catholic hospitals may result in the elimination of certain end-of-life choices, counseling for persons who are Human Immune Deficiency ("HIV") positive about the use of condoms to prevent HIV transmission, clinical trials for women, vasectomies, tubal ligations, contraceptive advice and distribution, the morning-after pill for rape victims, many types of assisted procreation technologies, as well as abortion. For some, the potential impact of a Catholic/non-Catholic hospital alliance on health care choices of men transforms the issue into one of community health as opposed to women's health. Yet, why should it take direct impact on men (or the middle class, or whites, or American citizens) to gain recognition of a problem as one affecting community?

Prior mergers and affiliations show that abortion and women's reproductive health services are significantly more vulnerable to elimination than those services also offered to men. The fact that women's choices are most vulnerable shows that while we have acquired some ability to lay claim to and authority over health issues that directly affect our lives, particularly reproductive health issues, women's health is still considered to be separate from and outside of community health. Impact on women (and/or persons of color, the disabled, the poor, the elderly, the immigrant) should be sufficient to trigger concerns about community health. So, while we work to claim abortion and other reproductive health services as women's issues, we must simultaneously work to create community that includes women and other marginalized persons. We must resist moves to define community health priorities by majoritarian efficiency concerns.

The failure of this topic to trigger concerns about community health may also result from the assumption that mergers and affiliations are corporate acts. This assumption limits the way we think and talk about the issues—we accept that corporate acts have primarily fiscal implications for our lives. I have found that when the deals are being made, "community" interests in creating a fiscally viable hospital are used to justify the elimination of women's health choices. These explanations tend to run along the lines of Star Trek's Vulcan credo: "The needs of the many outweigh the needs of the few." This both segregates and diminishes women's health needs. At the same time, the needs of the
many rationale obscures the interests being protected, and it privileges a fiscal efficiency discourse over one that could reveal how patriarchy, class, race, and other interests might weight the needs being balanced.

When the Catholic/non-Catholic merger or affiliation takes place in a rural area, geographical as well as socio-political distances become significant. The elimination of health care services at a hospital often has more acute effects in a rural area because no other health facilities may be located nearby. Other factors particular to rural areas—lower income levels, a larger percentage of uninsured patients, lack of public transportation, smaller social service networks, and fewer information sources—exacerbate the barriers to finding alternative facilities. Those whose health needs have been marginalized in these communities may be in different, and sometimes worse, situations than those in more populated areas. On the other hand, there are many similarities between the potential responses by, for example, African-American women with low incomes in an urban neighborhood, and white women in a rural area where the nearest hospital is negotiating an alliance with a Catholic institution. Although this article highlights the particularities of deals made in rural areas, much of the discussion also applies to deals made in urban and non-metropolitan areas.

In the discussion that follows, I describe the role of Catholic hospitals in health care both on a national level, and with respect to rural areas. In that section, Part II, I also sketch the relations between business and doctrine in Catholic/non-Catholic hospital alliances. In Part III, I try to expose the mechanisms that define the needs of the many and devalue the needs of the few. Among other things, I describe the Ethical and Religious Directives that shape Catholic healthcare, the justifications for trading women’s health choices for the other benefits of a hospital alliance, the socio-economic factors particular to health care in rural areas, and some of the legal rules that enable the needs of the many standard of decisionmaking. Part IV represents my efforts to collect strategies and ideas that others have developed. My goal is largely to help distribute information. In the process, I hope to promote the use of means that foster community dialogue and open the negotiating process to the community. While the mechanisms I describe are legal, and therefore adversarial in nature, I look to the work of activist scholars who have developed community-constructing methods of lawyering for the principles that guide the use of these legal mechanisms.

I hope this information may prove useful to activists who are, and work on behalf of, women, poor people, and people of color. The primary intersections of subordination that affect health care in Catholic/non-Catholic hospital deals occur among these groups, and I believe that
collaboration among these activists will best effect an inclusive understanding of health care needs. I speak of inclusion, and hope to simultaneously affirm that prioritizing the needs of those identified as the few over those of the many is often the most appropriate way to achieve inclusion.

II. DOLLARS, DEALS, AND DIRECTIVES

Many of us are somewhat aware that Catholic health care facilities are prevalent and well established in our communities. We know of local hospitals named for patron saints or hospitals with names that contain the words “Mercy,” “Charity,” or “Good Samaritan.” But few of us have thought about the business side of the Catholic health ministry or the links between church leaders, religious doctrine, and hospital care. In this section, I briefly lay out some facts and figures to illustrate the extent to which the Catholic health ministry has taken on responsibility for health care in the United States, particularly in rural areas. I also sketch the current impetus toward mergers and affiliations between Catholic and non-Catholic hospitals and the church-side decisionmaking structure involved in those deals.

A. Facts and Figures about the Catholic Health Care Network

The Catholic health care network delivers the largest portion of private sector health care in the United States. Sixteen percent of the national hospital admissions are in Catholic hospitals. In some areas, Catholic hospitals provide a much greater percentage of health care. For example, Catholic hospitals account for thirty-one percent of all licensed hospital beds and admissions in Illinois. Many of these facilities are concentrated in the Chicago area, where there are twenty Catholic hospitals. In a more extreme example, Sacred Heart Hospital in Lane County, Oregon supplies approximately seventy percent of the area's

4. In a March 1995 poll, only 27% of women surveyed knew that “belonging to a Catholic-controlled health plan means that access to routine medical procedures can be restricted.” EDK ASSOCIATES, INC., FOR CATHOLICS FOR A FREE CHOICE, HEALTH CARE REFORM CROSSROADS: THE GAP BETWEEN CATHOLIC CHURCH MANDATES AND WOMEN'S NEEDS 3 (March 1995). Eighty-eight percent of the women surveyed “do not want their health care restricted by the dictates of Catholic teachings simply because health care providers in their area undergo... a merger.” Id. at 4.


7. Arsenio Oloroso, Jr., Cardinal Rules, as Errant Catholic Hospital Learns, CRAIN'S CHICAGO BUS., Feb. 26, 1996 (v. 19, no. 9).
In total, the Catholic health care network includes 57 multi-institutional systems, 247 health care centers, and 1556 specialized care facilities in addition to just over 600 hospitals. Catholic hospitals are run as private non-profit institutions. They are tax exempt under section 501(c)(3) of the Internal Revenue Code and usually enjoy state tax exempt status as well. In addition, Catholic hospitals accept Medicare and Medicaid patients. In translation, this means that Catholic hospitals are providing a significant amount of government-insured care to elderly, disabled, and low-income patients. Catholic hospitals also admit privately insured, and some indigent patients. In fact, the Catholic health ministry has expressed a strong commitment to providing care and advocacy for "the poor, the uninsured and the underinsured." Catholic health care facilities and organizations also support and give hands-on health care to immigrants, Acquired Immune Deficiency Syndrome ("AIDS") patients, the mentally ill, the disabled, and the elderly.
Catholic hospitals are big business, as well as non-profit. A Catholics for a Free Choice publication reports that “in 1990, 561 Catholic short-stay hospitals generated more than $48 billion in gross patient revenue, $32 billion in net patient revenue, and $1.6 billion in net income. They also managed more than $38 billion in assets.” A significant majority of Catholic hospitals—nearly seventy-one percent in 1993—are affiliated with a Catholic system. The systems range from two to thirty-six hospitals owned, leased, sponsored, or managed by a system. The American Hospital Association reported that there were sixty-six Catholic systems in 1993. However, that number may be lower now due to the trend toward merger among health care systems.

While Catholic hospitals are located throughout the United States, nearly half are in the Midwest. Close to twenty-five percent of Catholic hospitals are in the 100 largest cities in the United States; forty-six percent are in smaller urban areas, and twenty-nine percent of Catholic hospitals are in rural areas. The Health Care Financing Administration has designated forty-six Catholic hospitals as “sole community providers.” Hospitals that are sole community providers are geographically isolated from other hospitals; they are entitled to receive greater Medicare reimbursements than other hospitals. A sole

17. Catholics For a Free Choice is an organization of Catholics that does public policy, education and advocacy work. The mission statement says that “Catholics for a Free Choice shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women's well-being, and respect and affirm the moral capacity of women and men to make sound and responsible decisions about their lives.” See HEALTHCARE LIMITED, supra note 5, back cover page.
18. HEALTHCARE LIMITED, supra note 5, at 7.
20. Id. For a complete list, see HEALTHCARE LIMITED, supra note 5, at 33-35.
21. Id.
24. HEALTHCARE LIMITED, supra note 5, at 7.
26. 42 C.F.R. § 412.92(a) lists criteria for classifying a sole community hospital. According to the criteria, a sole community hospital is located more than 35 miles from
community provider is the only hospital in the area, and most, if not all, of these hospitals are in rural areas.\textsuperscript{27}

B. Mergers and Affiliations

The hospitals mergers and acquisitions boom began in the 1980s. A 1986 survey of hospitals showed that more than forty percent of hospitals responding to the survey had merged or were considering a merger.\textsuperscript{28} During this period, Catholic hospitals participated in the trend by merging with other Catholic hospitals.\textsuperscript{29} Because Catholic-with-Catholic hospital mergers raised little or no concern about impact on the type of health care services being made available, these mergers caused little controversy.

The trend toward merging, forming other types of alliances, and building health care systems has continued in the 1990s.\textsuperscript{30} In part, the Clinton Administration's initial push for health care reform spurred health care organizations into mergers and other types of alliances to protect themselves from anticipated economic shifts.\textsuperscript{31} Despite the apparent failure of national health care, health care organizations have continued consolidation activity.\textsuperscript{32} One result of this activity is that the

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\item other like hospitals, or it is located in a rural area and meets one of three sets of additional criteria. The additional criteria for rurally-located hospitals allow for shorter distances from other hospitals if weather, topography and other conditions impede travel.
\item 42 C.F.R. § 412.92(b)(2)(iv) and § 412.92(d) set out the rule and the formula for calculating the enhanced Medicare reimbursement rates for sole community hospitals.
\item 27. Most designated sole community hospitals are located in the West. U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, HEALTH CARE IN RURAL AMERICA 150 (Sept. 1990).
\item 29. For an overview of these developments, see Mary Kathryn Grant & Margaret Mary Modde, The Evolution of Catholic Multiinstitutional Systems, 18 TOPICS IN HEALTH CARE FINANCING 24 (June 22, 1992); see also Mary A. Grayson, Catholics Consolidate, 59 HOSPITALS 9 (Oct. 1, 1985).
\item 30. Note that during the 1980s, most of the consolidation took place horizontally, with hospitals merging or affiliating solely with other hospitals, like facility joining with like facility. In the 1990s, the push has been toward vertical integration or the development of "integrated development systems." The goal of vertical integration is "one-stop shopping," with hospital suppliers, short-stay primary care hospitals, long term facilities, physician groups, and insurers all linked in one system. Grant & Modde, supra note 29.
\item 32. One story on these trends reported that "business needs will continue to propel such changes, regardless of what happens to legislation in Washington, D.C." Stephen K. Murata, Merger Mania: This is the Year It Will Reach You, 71 MEDICAL ECONOMICS 29 (Mar. 7, 1994). The pressure for consolidation comes in part from the excess number of hospital beds in many areas that resulted from pre-1980s health care economics. The introduction of managed care in the 1980s has exacerbated this overbedding problem by
number of hospitals nationwide has decreased. Catholic hospitals have participated in this trend.

The key change in the consolidation trend is that Catholic hospitals have been willing to merge or affiliate with non-Catholic hospitals to remain competitive in the 1990s. In fact, in 1994, the National Conference of Catholic Bishops revised the Ethical and Religious Directives for Catholic Health Care Services to include a section on "Forming New Partnerships with Health Care Organizations and Providers." This section expressly acknowledges and provides guidance for the possibilities of Catholic/non-Catholic collaborations in terms of both economics and social commitments. The National Conference of Catholic Bishops also set up the Ad Hoc Committee on Health Care Issues and the Church to provide assistance and guidance in these deals.

Fifty-seven mergers or affiliations between Catholic and non-Catholic hospitals took place between 1990 and 1995. Within this trend, the tendency has been for Catholic hospitals to ally with non-Catholic non-profits. But more recently, Catholic hospitals have been making deals with private for-profit hospitals and health systems. A major player in this development has been Columbia/HCA Healthcare Corporation,

34. Id.
36. Id.
37. Id. at 26.
38. CATHOLICS FOR A FREE CHOICE, REPRODUCTIVE HEALTH AT RISK: A REPORT ON MERGERS AND AFFILIATIONS IN THE CATHOLIC HEALTH CARE SYSTEM (1995) [hereinafter REPRODUCTIVE HEALTH AT RISK]. Vertical alliances between Catholic institutions and between Catholic and non-Catholic institutions are also being made at a high rate. "More than 90 percent of Catholic hospital CEOs responding to a 1995 CHA survey indicated they are discussing integration with another facility or are already participating in integrated delivery." Catholic Hospitals Struggle to Keep Identity, 5 HEALTH CARE PR AND MARKETING NEWS, Mar. 7, 1996.
39. A twist in this trend occurred in 1994, when "[t]he Roman Catholic Church permitted two of the hospital's [Good Samaritan Medical Center in Johnstown, Pennsylvania] top executives to complete a leveraged buyout that allowed a hospital system to pursue its network goals and a Catholic hospital to keep its identity without being owned by the church." The consultant commented, "[t]hese deals are uncommon, but they're coming." Bruce Japsen, Vision and Mission Have Come Together, MODERN HEALTHCARE, Aug. 8, 1994, at 76.
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the largest for-profit system in the United States.\textsuperscript{40} Columbia/HCA has begun to actively seek deals with Catholic hospitals,\textsuperscript{41} and it is counting on mutual interest from the Catholic hospitals' side. "As the Catholic hospitals see Columbia as a joint-venture partner, they'll want to have deals where Rick (Scott, Columbia's president and chief executive officer) and the pope have an equal vote."\textsuperscript{42}

The implications of the trend toward Catholic/non-Catholic hospital deals for rural areas are of two types. Many rural hospitals are non-profit community and public hospitals.\textsuperscript{43} Rural hospitals are particularly vulnerable to closure,\textsuperscript{44} in part because they tend to be smaller, have lower occupancy rates, and increasing rates of uncompensated care\textsuperscript{45} compared to urban hospitals. Many rural hospitals are seeking to strengthen their financial viability by joining with other hospitals. Catholic hospitals and systems have and will continue to merge or affiliate with these hospitals.

As mentioned, twenty-nine percent of existing Catholic hospitals are currently located in rural areas. Recent expansion activity among hospitals and systems has aimed toward establishing urban-rural

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\textsuperscript{40} In 1995, Columbia/HCA "bought or entered into joint ventures for 41 hospitals with 8,708 beds and estimated revenues of $2.5 billion . . . . The hospital monolith has already announced letters of intent for an additional 25 hospitals, which have 4,800 beds and estimated annual revenues of $1.5 billion during the first quarter of 1996." Julie Johnson, \textit{Columbia/HCA on Hospital Buying Spree}, 39 AMERICAN MEDICAL NEWS, Jan. 22, 1996, at 9. The first major deal between Columbia/HCA and a Catholic system took place in 1995 when Columbia formed a partnership with Cleveland-based Sisters of Charity of St. Augustine Health System, a four-hospital system. Bruce Japsen, \textit{News}, MODERN HEALTHCARE, May 22, 1995, at 2.

\textsuperscript{41} Columbia plans to use CSA (Sisters of Charity of St. Augustine) as an entry point to deal with other Catholic hospitals. Johnson, supra note 40, at 9.


\textsuperscript{43} UNITED STATES GENERAL ACCOUNTING OFFICE, \textit{REPORT TO CONGRESSIONAL REQUESTERS, RURAL HOSPITALS: FACTORS THAT AFFECT RISK OF CLOSURE} 9 (June 1990) (for-profit hospitals represent fewer than 10\% of all rural hospitals) [hereinafter RURAL HOSPITALS].

\textsuperscript{44} \textit{Id.} at 3. ("Between 1985 and 1988, the rate of hospital closures was 29 percent higher in rural than in urban areas (5.3 vs. 4.1 per 100").

\textsuperscript{45} U.S. CONGRESS, \textit{OFFICE OF TECHNOLOGY ASSESSMENT, HEALTH CARE IN RURAL AMERICA} 11 (Sept. 1990) ("Nearly three-fourths of rural hospitals have fewer than 100 beds. These small hospitals are in particular difficulty; they have the fewest admissions, the lowest occupancy, and the highest expenses per inpatient day of all rural hospitals.") [hereinafter HEALTH CARE IN RURAL AMERICA].
networks. As investor-owned organizations like Columbia/HCA seek to expand, the number of deals with rural Catholic hospitals may increase.

C. Structuring the Deals: Church Hierarchy and the Business of Healthcare

Despite the willingness of many in the Church hierarchy to have Catholic hospitals join with non-Catholic hospitals, Church officials still have great concerns about maintaining the Catholic identity of hospitals in these deals and about expanding the impact of the health care ministry through these deals. Thus Church officials assume an active role in scrutinizing and shaping the structure of Catholic/non-Catholic hospital alliances.

The Standards for Catholic Healthcare: The Directives. As discussed below, the ultimate definition of Catholic identity in health care varies from deal to deal. However, there are official standards or guidelines for health care that is Catholic. Pope John Paul II has issued several statements that speak to health care issues. For Catholics in the United States, the National Conference of Catholic Bishops ("NCCB") has published the Ethical and Religious Directives for Health Care Services. The NCCB first issued the Directives in 1971, and then revised the Directives in 1975, and most recently in November 1994. The purpose of the Directives, as stated in the Preamble, "is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain

46. In the Directives section on Forming New Partnerships, the Introduction states, "[o]n the one hand, new partnerships can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession . . . . On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services." Directives, supra note 35, at 25-26.

47. See, e.g., DONUM VITAE: INSTRUCTION ON RESPECT FOR HUMAN LIFE IN ITS ORIGIN AND ON THE DIGNITY OF PROCREATION (Feb. 22, 1987); ENCYCICAL LETTER, EVANGELIUM VITAE: THE GOSPEL OF LIFE (March 25, 1995).

48. THE OFFICIAL CATHOLIC DIRECTORY describes the National Conference of Catholic Bishops as "a canonical entity," whose "purpose is to foster the Church's mission by providing the Bishops of the United States of America with an opportunity to exchange views and insights of prudence and experience and to exercise in a joint manner their pastoral office . . . . The National Conference of Catholic Bishops is composed of every Bishop, residential or titular, who serves the Church in the United States, its territories or possessions." THE OFFICIAL CATHOLIC DIRECTORY lxxxv (1995).

49. Ethical and Religious Directives for Catholic Health Care Services, 24 ORIGINS 449, 449 (Dec. 15, 1994) (providing both the text of the directives and commentary).
moral issues that face Catholic health care today. The Directives provide a textual reference not only for the bishops in the United States but also “the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services.” It is the Directives that contain the prohibitions on certain health care services, the services that are vulnerable to elimination when Catholic and non-Catholic hospitals join.

The Decisionmaking Structure. The Vatican must approve any deal involving $1 million of Church assets. The diocesan or local bishop must approve every deal within the diocese. Where the alliance affects a Catholic system with hospitals located in more than one diocese, the bishop in each diocese where a hospital is located must give the go ahead. The Vatican has consistently approved the deals placed before it. But diocesan bishops' willingness to support Catholic/non-Catholic hospital alliances depends a great deal on the flexibility of the particular bishop. In some cases, the deal is made despite the disapproval of the bishop(s). For example, in 1994, Holy Cross Health System Corporation sold its 3-hospital, 10-clinic Utah division to for-profit Healthtrust despite the bishop's attempt to block the sale. Likewise, in the face of Cardinal Joseph Bernardin's strict guidelines on Catholic/non-Catholic deals, St. Elizabeth's Hospital affiliated with the non-Catholic University of Chicago Hospitals network. As a result, the Archdiocese of Chicago moved to take away the Catholic

50. DIRECTIVES, supra note 35, at 1.
51. Id. at 2.
52. For a description of the prohibited health care services, see infra notes 96-136 and accompanying text.
53. Cynthia Gibson, Catholic Hospitals and Health Care Reform, 15 CONSCIENCE 14, 22 (Summer 1994); see also Anderson, supra note 33.
54. Directive 68 states that “[t]he diocesan bishop’s approval is required for partnerships sponsored by institutions subject to his governing authority.” It also advises that “[d]iocesan bishops and other church authorities should be involved as such partnerships are developed.” DIRECTIVES, supra note 35, at 26.
56. Sister Margaret Mary Modde, a consultant specializing in Catholic canon law who has worked on several hospital alliances, has said that Vatican approval has taken as little as five days. See Anderson, supra note 33.
identity of St. Elizabeth's Hospital, even though the Vatican had endorsed this deal.

Another source of influence on the trend toward consolidation is the Catholic Health Association of America ("CHA"). The CHA is a policy-making and political organization that represents health care organizations sponsored by the Catholic church. The CHA's approximately 1200 members include Catholic hospitals, health care facilities, religious orders, health care systems, and extended care facilities. The CHA's stated aims are to "participate in the life of the Church by advancing the healthcare ministry; [and] assert leadership within the Church and society through programs of advocacy, facilitation, and education." For many purposes the aims and presence of the facilities and organizations forming the Catholic health care network were virtually synonymous with the CHA. However, the recent trend of Catholic with non-Catholic hospital alliances has created a break between CHA and some Catholic hospitals. After the Sisters of Charity of St. Augustine Health System formed a partnership with Columbia/HCA, CHA members voted to exclude for-profit hospitals from membership. For some Catholic

58. Paul Galloway, Catholic Hospital Loses Ties, CHICAGO TRIBUNE, Feb. 20, 1996, at 1; Oloroso, supra note 7.
60. The CHA has a staff of 90 and a $10,000,000 budget. ENCYCLOPEDIA OF ASSOCIATIONS, NATIONAL ORGANIZATIONS OF THE U.S., HEALTH AND MEDICAL ORGANIZATIONS 8 (1995). The Association's president and members have actively participated in congressional budget hearings affecting health funding by testimony or published statements. For example, the CHA supported President Clinton's national health care proposal and, more recently, has opposed the substantial reduction of Medicare and Medicaid. See, e.g., Rational Restructuring of Medicare and Medicaid Jeopardized by Proposed Unprecedented Spending Reductions, PR NEWSWIRE, May 10, 1995. The CHA also seeks to influence health law and policy as amicus in cases addressing the right to die, abortion, and other choices limited by Catholic doctrine. For example, the Catholic Health Association is listed as amicus in the recent 9th Circuit case addressing physician aid-in-dying. Compassion in Dying v. State, 79 F.3d 790, 792 (9th Cir. 1996), cert. granted 117 S. Ct. 37 (Oct. 1, 1996) (No. 96-110). The CHA's brief supported the State of Washington's ban criminalizing assisted suicide.
62. Raquel Santiago & Bruce Japsen, CSA to Consider other Options, CRAIN'S CLEVELAND BUSINESS, Sept. 11, 1995, at 3. CHA president, John E. Curly, Jr., described the membership's concern that investor-owned health organizations see health care "as a commodity exchanged for profits." He also expressed concern that "for-profit chains will allow abortions in the Catholic hospitals in which they are partners." Id. Like the St. Elizabeth's deal in Chicago, the Vatican endorsed this alliance. Della De Lafuente, Catholic Hospitals Meet Here, CHICAGO SUN-TIMES, Mar. 26, 1996, at 43. For further discussion of CHA's membership criteria, see J. Stuart Showalter & John L. Miles,
hospitals contemplating alliances, continued CHA membership may be a factor.\(^6\)

From the Catholic hospital side of a deal, the local bishop, and in some cases, the Vatican and the CHA, wield influence from outside the hospital at issue. From inside the hospital, the sponsors and board of trustees are parties to the deal. Catholic organizations sponsor Catholic hospitals. Most sponsors are religious orders, and most of the sponsoring religious institutes are orders of nuns.\(^6\) A diocese may sponsor a hospital. Roman Catholic dioceses sponsor approximately ten percent of Catholic hospitals.\(^6\) Lay organizations may also sponsor a Catholic hospital. In fact, occasionally the CHA admits a lay-sponsored hospital as a member. Sponsors, for most intents and purposes, own the hospitals.\(^6\) Therefore, sponsors have a great deal of power over board of trustee membership and over the decision of whether or not to seek an affiliation with another hospital.\(^7\) It is the sponsors and board of trustees who decide to proceed with a deal, despite disapproval by a diocesan bishop and/or the CHA. It is also the sponsors and board of trustees who play a direct role in laying down conditions for preserving


63. For example, St. Joseph's Health Services, Rhode Island's only Catholic hospital, was considering an alliance with one of two non-Catholic health systems. During preliminary talks between St. Joseph's and Columbia/HCA, the CHA issued a statement urging Catholic hospitals to choose other Catholic or non-profit hospitals as affiliates. St. Joseph's then ended talks with Columbia/HCA and focused on developing a plan with Lifespan, a non-profit health care network. Felice J. Freyer, St. Joseph Health Services Nears Affiliation with Lifespan Network, THE PROVIDENCE JOURNAL-BULLETIN, Mar. 28, 1996 at A-1.

64. HEALTH CARE LIMITED, supra note 5, at 9.

66. Within the Church structure, property held by religious orders and dioceses ultimately belongs to the Church.

67. For a good description of the religious order's powers with respect to the health care facility, see Showalter & Miles, supra note 62, at 1133-38.

A religious order generally maintains a number of reserved powers over its corporation . . . . The major superior and the executive council generally reserve for themselves those powers that are necessary for Catholic health care providers to meet their canonical responsibilities. These include the power to establish the institution's philosophy, to amend the corporate charter and bylaws, to appoint the board of trustees or directors, to sell, lease, or encumber corporate real estate, and to merge or dissolve the corporation. Id. at 1134 (citations omitted).
the Catholic identity of a Catholic hospital engaged in negotiations with a non-Catholic hospital or system. 68

Preserving “Catholic Identity” Using Concepts of Legal Identity. As stated in its preamble, “[t]he Ethical and Religious Directives are concerned primarily with institutionally based Catholic health care services.”69 That means, in part, that Catholic hospitals must follow the Directives. However, as indicated above, each bishop has a great deal of influence over how a hospital will follow the Directives. In addition, the variety of corporate structures that may result from a merger or affiliation 70 leaves room for sponsors, trustees, and other parties to a deal to arrange ownership and management issues to simultaneously preserve Catholic identity and continue health care services that the Directives prohibit.

Many of the deals made between Catholic and non-Catholic hospitals illustrate the concerns that motivate this Article. Health care services, particularly those for women, were eliminated in order to preserve the Catholic identity or mission of the institution. For example, in Everett, Washington, the town’s only two hospitals agreed to merge. After the merger, Sisters of Providence Health System remained, and all abortion and some sterilization procedures were cut along with the previously separate entity of General Hospital Medical Center, Providence Hospital. 71 Even when the resulting hospital is not a Catholic hospital, services may be cut. 72 In Lorain, Ohio, a new health center was formed by the merger of the city’s only two hospitals, Lorain Community

68. Obviously, the issue of whether or not to affiliate with a non-Catholic, particularly a for-profit non-Catholic hospital may cause division between and among the sponsors, the trustees, and the administrators. See, e.g., News at Deadline, MODERN HEALTHCARE, Aug. 7, 1995, at 4 (reporting that the chief executive officer at St. Francis Hospital in Wilmington, Delaware, resigned, “citing concern about an impending deal between for-profit U.S. Healthcare and the hospital’s Roman Catholic parent, Franciscan Health System.”). The same story indicated that two other trustees had formally resigned and that three of the remaining twelve announced that they would resign. Id.

69. DIRECTIVES, supra note 35, at 2.

70. For a careful description and analysis of models currently being used, see Phyllis E. Bernard, Privatization of Rural Public Hospitals: Implications for Access and Indigent Care, 47 MERCER L. REV. 991 (1996).


Hospital and St. Joseph Hospital and Health Center. The resulting health center is shared jointly by the two previous owners and is not considered to be a Catholic hospital. However, the Chief Executive Officer explained that reproductive services, including tubal ligations and vasectomies, were dropped "to make accommodations to the church's ethical directives." Deals with for-profit hospital systems have had similar outcomes. Joint ventures or other types of alliances between for-profit hospitals and Catholic rural hospitals will not necessarily result in a more inclusive set of health care services.

In some cases, deals have fallen through because of disagreement over whether or not to continue services banned by the Directives. But, in many cases, the parties have used partnerships and affiliations to create entities that are part Catholic in identity and part non-Catholic. One church official has acknowledged that "bishops increasingly allow collaboration arrangements to tolerate some services prohibited by the church—such as elective sterilizations—to be performed at non-Catholic hospital partners." In one consolidation, a Catholic hospital formed a new corporation with a community hospital, but each facility retained its own legal status so that the former community hospital could

74. Id. at 4.
75. Id. at 41.
76. Therese Cox, Sisters to Establish Charity Foundation with Profits, CHARLESTON GAZETTE & DAILY MAIL, Mar. 5, 1996, at 4D (reporting that when Columbia/HCA entered a 50-50 venture with St. Joseph's Hospital of Parkersburg, Columbia agreed that no abortions or sterilizations would be performed).
77. Bon Secours Health System, a Catholic system, pulled out of a multi-party plan to form a partnership to own Hilton Head Hospital in South Carolina. The other partners refused to "withhold any services based on moral and ethical grounds." Catholic System Drops Out of Hilton Head Deal, MODERN HEALTHCARE, July 18, 1994 (quoting John Shea, V.P. of business development for Bon Secours Health System). See also Bruce Japsen, Church Puts Faith in System Mergers in Light of Healthcare Reforms, MODERN HEALTHCARE, June 6, 1994, at 43 (describing how a potential three-hospital merger collapsed in Portland, Maine, because of Mercy Hospital's concerns about being associated with a system that allowed abortions).
78. For noncorporate types, like myself, here is a clear, yet simple explanation: "In an affiliation, a non-Catholic hospital remains a non-Catholic hospital, but it is in some way connected to the system." Shari Roan, When the Church and Medicine Clash, L.A. TIMES, Feb. 2, 1995, at A1 (quoting Corrine Bayley, senior vice president of mission and values for St. Joseph Hospital in Orange, California). A merger is a purchase. As Ms. Bayley explained, "[in our case, St. Joseph purchased Mission [Mission Hospital Regional Medical Center in Mission Viego, California], so Mission now has the same (ethical) requirements as St. Joseph. So they had to change as to what they can do." Id.
79. See Anderson, supra note 33.
continue to perform sterilizations. In many cases, the continuation of services depends on whether the deal is structured so that the Catholic institution is not funding the facility where the services are provided. What all this suggests is that maintaining inclusive health services is possible in a Catholic/non-Catholic hospital deal, and that using concepts of legal identity to protect Catholic identity can be the key.

D. Concerns Particular to Rural Area Hospitals

Two examples of mergers that I set forth above suggest the particular risk for rural area hospitals. In the Everett, Washington and Lorain, Ohio examples, the mergers took place between the only hospitals in town, leaving no other hospital that would provide the services dropped in the deal. In Everett, Washington, there were freestanding clinics that continued to offer abortions. The fact that was offered to mitigate the decision to eliminate reproductive services was that Lorain Community Hospital did not provide abortions anyway. However, in some rural areas, there may be no alternative health care provider of the banned services. The fact that the only remaining hospital in town is now Catholic further decreases the chances of establishing full reproductive health care in the area.

The impact seems more striking given the lack of correlation between the presence of a Catholic hospital and the presence of a majority Catholic population. Of the forty-six Catholic sole community providers,

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81. See, e.g., Bill Snyder, Saint Thomas, Vandy Near Joint Operating Pact, NASHVILLE BANNER, Dec. 21, 1995, at A1 (stating that under the planned agreement, "the two hospitals will remain independently owned, but they could share costs, revenue and more than 1,200 hospital beds"); Stuart Vincent, Port Jeff Hospitals in Alliance, NEWSDAY, May 9, 1996, at A25 (outlining a joint venture between the two hospitals in Port Jefferson on Long Island; each hospital will retain its own identity and will jointly operate many services, but services such as in vitro fertilization, vasectomies, and abortions were excluded from the agreement in order to permit the community hospital to continue providing them).
82. Houtz, supra note 71.
83. ACLU May Sue, supra note 73.
84. Catholic health care institutions are also forming "Integrated Delivery Networks." If a Catholic provider forms an integrated delivery network in a rural area, the alternative providers may also be subject to the Directives. In Lane County, Oregon, Sacred Heart Health System not only provides about 70% of the hospital services, but has also affiliated with several major physician practice groups. As a requirement for affiliation, physicians must stop performing abortions and artificial insemination. RISKY BUSINESS, supra note 8, at 3.
only two are located in counties where Catholics constitute a majority of the population. One provider, Spohn-Kleberg Memorial Hospital, is located in Kleberg County, Texas, where the population was 50.1 percent Catholic in 1990. Even ignoring the fact that many Catholics object to restricting health care choices based on religious doctrine, a significant percentage of those whose choices have been cut are non-Catholics.

On the other hand, consolidations seem to be economically necessary to remain competitive, and in some cases, to prevent hospital closure. As mentioned, the rate of hospital closures in rural areas is higher than in urban areas. While approximately forty-two percent of rural hospitals are public and forty-eight percent are nonprofit, only ten percent of rural hospitals are private for-profit. Yet, for-profit hospitals are more likely to close than public and nonprofit hospitals. This suggests that in terms of minimizing future hospital closures, maintaining affiliations between community and Catholic hospitals may be desirable to maintain nonprofit status. Even where the community hospital's primary motivation is remaining competitive, community hospital boards may also be very concerned about preserving the hospital's mission. For that reason, a nonprofit Catholic hospital may be more appealing

85. **Health Care Limited**, *supra* note 5, at 38-41, contains a list of the Catholic sole community providers. The list includes the county location, the county population, and the percentage of Catholics in each county.

86. *Id.*

87. **EDK Associates**, *supra* note 4, at 3.


89. **Rural Hospitals**, *supra* note 43, at 7 ("rural for-profit hospitals were 8 times as likely to close as publicly owned rural hospitals").

90. Although the largest group of rural hospitals are public, so far, mergers and affiliations between public and nonprofit hospitals are uncommon. The most likely alliance is between rural community and Catholic hospitals.

91. I have probably oversimplified this point. A study of both urban and rural hospital closures in the 1980s concluded that

*four factors had a large effect and were considered of particular importance.

Hospitals that had fewer than 100 beds, had occupancy rates of 40 percent or less, were owned by a for-profit entity or were located in either the Northwestern or Southern regions of the United States were at least 3 times more likely to close than the comparison groups.

89. **Rural Hospitals**, *supra* note 43.

92. *See* Jim DeBrosse, *Article Lauds Hospital Deal*, **Dayton Daily News**, Apr. 16, 1996, at 5B (describing the results of a Moody's Investors Service analysis of joint operating agreements between Catholic and non-Catholic hospitals). "Although they fall short of complete mergers, joint operating companies like the one formed last year between Good Samaritan and Miami Valley hospitals offer financial advantages for both hospitals without sacrificing their individual missions." *Id.*
than a for-profit hospital or system. The board of Sequoia Hospital, a community hospital in Redwood, California, recently chose to affiliate with Catholic Healthcare West rather than with Columbia/HCA because of concerns that an investor-owned company would put profit ahead of patients. Thus, Catholic hospitals represent both particular benefits as well as risks to rural communities.

III. IMPACTS ON THE MARGINS

The elimination of health care services does not simply reduce the number of treatment choices, but also narrows the identity of those benefitted by available health care. Conversely, when health care services are dropped, patient groups with marginal access to health care shift or expand in identity. Services eliminated by Catholic/non-Catholic hospital alliances tend to impact primarily, but not exclusively, on women, particularly on women with low incomes. There are both legal rules and social norms that reinforce the marginalizing effects of these cuts and rural socio-economics. Ultimately, what results is a trade-off between majoritarian efficiency concerns and the health concerns of those on the margins.

A. Women First

The Ethical and Religious Directives for Catholic Health Care Services set forth three groups of Directives that include prohibitions of health care services. Some of the prohibitions fall directly on women and some fall on both women and men. All but one of the prohibited services are clearly legal, and under some laws, are required. When the deals are done, however, most of the services that get dropped are those for women.

The Directives. The Morning After Pill. Large doses of estrogen or estrogen-progestogen, marketed as Estinyl and Ovral, can disrupt the

94. Not all of the Directives prohibit services. Some state ethical principles and rules for permissible choices. Directive 23, for example, speaks of the need to protect human dignity. And Directive 30 states that living persons may donate organs when the organ's removal "will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor." DIRECTIVES, supra note 35, at 15.
95. For example, Illinois requires hospitals to at least inform rape victims that drug treatments are available to prevent pregnancy and to provide information about how to obtain the treatment known as the "morning after pill." Dean Olsen, Pill Policy Will Help Victims of Rape, PEORIA JOURNAL STAR, Nov. 13, 1995, at A1.
process of conception by preventing a fertilized egg from implanting in a woman's uterus. The treatment is routinely offered to women who have been raped. In fact, most states require hospitals to have protocols for treating rape victims and under these protocols, hospitals offer the morning after pill. But, Directive 36 requires that the morning after pill be offered only if there is no evidence that fertilization has occurred. Some bishops have ordered Catholic hospitals in their dioceses to not offer the morning after pill. For example, Bishop John Meyers of the Peoria Diocese had pressured St. Francis Medical Center to stop offering the morning after pill to rape victims. St. Francis was the only Catholic hospital in the diocese to provide Estinyl to women who had been raped. Rather than adhere to the Bishop's concern, St. Francis began working on a procedure to more accurately estimate whether a woman might be ovulating. On November 3, 1995, after eighteen months, representatives of St. Francis announced a detailed policy. Under the policy, blood and urine tests are used "to measure the presence of luteinizing hormone and progesterone, another hormone, to map out rape victims' menstrual cycles." If the tests indicate that the woman is about to ovulate or has ovulated in the past three days, and is therefore at risk of fertilization, the hospital will not provide the morning after pill. Instead, she must seek out the treatment elsewhere.

97. See Olsen, supra note 95.
98. DIRECTIVES, supra note 35, at 16. For a good discussion of the morning after pill as an example of conflicts between a hospital's religious identity and legal duties, see Boozang, supra note 2, at 1447-53.
99. Two reasons have been expressed. First, some believe that interfering with the implantation of the fertilized egg is tantamount to abortion. See, e.g., Olsen, supra note 95. Second, some worry that the morning after pill prevents ovulation and acts as a contraceptive. See, e.g., Report Approved by British Bishops, Use of the "Morning-After Pill" in Cases of Rape, 15 ORIGINS 633 (Mar. 13, 1986). But see Diamond, supra note 96, at 9-10 (concluding that scientific evidence does not support the claim that the morning after pill suppresses ovulation).
100. See Olsen, supra note 95; Michael Hirsley, Bishop Reignites Ethics Struggle, CHICAGO TRIBUNE, Feb. 25, 1994, at N1; Robin T. Edwards, Bishop Rules out Post-Rape Pills in Peoria, NATIONAL CATHOLIC REPORTER, Mar. 11, 1994. Some hospitals question the woman about the timing of her menstrual cycle to determine whether fertilization is likely.
101. See Olsen, supra note 95.
102. Id.
Assisted Conception Methods. There are a series of Directives that ban the use of assisted conception methods for unmarried persons, the use of donated ova and sperm, surrogacy, and any method that separates marital intercourse from conception. Translated into existing technologies, the Directives disallow artificial insemination by donor, and any in vitro fertilization method, including zygote intrafallopian transfer and intracytoplasmic sperm injection. On the other hand, the Directives permit the use of drugs to stimulate ova and sperm production. They also seem to permit artificial insemination by husband and gamete intrafallopian transfer where the man ejaculates the sperm during intercourse while wearing a condom containing a pinhole. The sperm can then be used in the assisted conception methods. The pinhole prevents the condom from having a contraceptive effect and creates the possibility that conception occurred "naturally."

Abortion. Directive 45 contains the strongest prohibitory language of all the Directives. It states that abortion "is never permitted." The Directive also speaks directly to health care facilities. "Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation." On the other hand, treatments that "have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman" are permissible even though they may terminate the pregnancy.

103. No one Directive expressly prohibits use of assisted conception methods by unmarried persons, but the introduction to this set of directives states, "just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act." DIRECTIVES, supra note 35, at 18.
106. Directives 38 and 41, supra note 35, at 18-19.
108. See JOHANNES HUBER, POSSIBLE MODIFICATIONS OF ARTIFICIAL FERTILIZATION TECHNIQUES: BIOLOGICAL CONSIDERATIONS WHICH MAY INFLUENCE THEOLOGICAL CONSIDERATIONS, IN GIFT OF LIFE: CATHOLIC SCHOLARS RESPOND TO THE VATICAN INSTRUCTION 67-72 (Edmund Pellegrino, John Collins Harvey & John P. Langan eds., 1990) (describing a GIFT procedure that would arguably not violate Catholic ethical principles); THE POPE JOHN CENTER, supra note 107, at 128-135 (explaining the distinction between permissible assisted insemination and impermissible artificial insemination). Both artificial insemination and GIFT are controversial within the church. Id.
110. Id.
Prenatal Testing and Genetic Screening/Counseling. The Directives do not prohibit these services, but do restrict their use. When the information acquired from these services might be used to choose abortion, the services are not permissible. As a result, some Catholic hospitals simply do not offer genetic screening and counseling.

Contraception. Directive 52 distinguishes between impermissible contraceptive practices and permissible natural family planning. More specifically, Directive 52 prohibits Catholic health institutions from condoning contraceptive practices, but says that health institutions should provide instruction about the Church's teaching on "natural family planning." The Directive makes it clear that this information is appropriate for married couples only.

Counseling about the Use of Condoms to Prevent HIV Transmission. The strict ban on contraceptive practices and on sex outside of marriage has lead some hospitals to prohibit even informing patients who are HIV positive about using condoms to prevent the transmission of the virus. The Church's position is that the morally appropriate ways to prevent HIV transmission are to not use intravenous drugs, to "just say 'no'" to sex (for unmarried persons), and to practice marital fidelity.

Clinical Trials for Women. In 1993, the federal government recognized that clinical trials of new drugs almost always excluded women. This practice has created several problems in addition to the denial of access. For example, if a drug receives FDA approval and is distributed without prior testing on women, women then take the drug in the absence of the careful controls of clinical testing, and without being told of risks that might be particular to women. Accordingly, clinical tests including women are now more common. But many of the trial protocols require that women use contraceptives to prevent pregnancy,

112. Directives 50 and 52, supra note 35, at 20.
114. Mireya Navarro, Ethics of Giving AIDS Advice Troubles Catholic Hospitals, N.Y. TIMES, Jan. 3, 1993, at 1. Note that many states require persons who test positive for HIV to receive counseling that includes information about condom use to prevent transmission. See, e.g., COLO. REV. STAT. ANN. § 25-4-1405(5) (West 1985). In New York, the church and the state compromised by agreeing that patients could be referred to other agencies to receive this service. Navarro, supra, at 1. Some state laws require only referral for counseling. See, e.g., IND. CODE ANN. § 16-41-14-10 (West 1995). For further discussion, see Boozang, supra note 2, at 1471-75.
117. Id. at 369-86.
and therefore potential harm to a developing embryo or fetus. Because of Directive 52, some Catholic hospitals will not participate in clinical trials that include women.\textsuperscript{118}

\textit{Voluntary Sterilization.} This Directive distinguishes between direct and indirect sterilization. It bans only direct sterilization or procedures intended solely to prevent conception. Procedures that treat a pathology and also cause sterility are permissible.\textsuperscript{119}

\textit{Proportionate Life-Preserving Means.} Directive 56 describes a person's "moral obligation to use ordinary or proportionate means of preserving his or her life."\textsuperscript{120} This language indicates that some decisions to withdraw or refuse treatment would be impermissible.\textsuperscript{121} The obligation lies on the patient, but the concern is that the hospital may refuse a patient's legally valid request based on this Directive.

\textit{Euthanasia.} The Directive defines euthanasia as "an action or omission that of itself or by intention causes death in order to alleviate suffering,"\textsuperscript{122} and instructs Catholic health care institutions to not condone nor participate in euthanasia. While pain treatment that incidentally hastens death is permissible both under U.S. and Catholic law,\textsuperscript{123} this would make physician aid-in-dying unavailable. This point was moot until very recently. In early 1996, both the Ninth and Second Circuits of the Federal Courts of Appeal recognized a constitutional right to physician aid-in-dying, albeit on different grounds.\textsuperscript{124}

\textit{Employee Benefits.} Catholic hospitals often restrict health care benefits of hospital employees based on the Directives.\textsuperscript{125} In other

\begin{itemize}
\item \textsuperscript{118} See, e.g., Maureen Dobie, Clinical Drug Tests: Women Need Not Apply, INDIANAPOLIS Bus. J., Jan. 22, 1996, at 15 (reporting that St. Vincent Hospital of Indianapolis "turned down a study recently because the sponsor was unwilling to modify language [regarding birth control] in the consent form").
\item \textsuperscript{119} Directive 53, supra note 35, at 20.
\item \textsuperscript{120} Id. at 22.
\item \textsuperscript{121} For a more detailed analysis, see Boozang, supra note 2, at 1454-71.
\item \textsuperscript{122} Directive 61, supra note 35, at 23.
\item \textsuperscript{123} Id.
\item \textsuperscript{124} Compassion in Dying v. Washington, 79 F.3d at 793-94 (holding that "insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment."); Quill v. Vacco, 80 F.3d 716, 731 (2d Cir.), cert. granted, 117 S. Ct. 36 (Oct. 1, 1996) (No. 95-1858) (holding that the "New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest.").
\item \textsuperscript{125} See, e.g., Kristin Davis Stacy Stover, The Agonizing Price of Infertility, KIPLINGER'S PERSONAL FINANCE MAGAZINE, May 1, 1996, at 50 (describing how one woman, an employee at a Catholic hospital, was denied health insurance coverage for infertility
\end{itemize}
words, employee health care benefits may not include coverage for health services banned by the Directives. For many employees, they have the effect of denying access to those services altogether. Only twenty-seven percent of women surveyed knew that belonging to a Catholic health plan restricts access to certain medical procedures.  

The Services Dropped. Of the dozens, if not hundreds, of media and industry reports about the effect of Catholic/non-Catholic hospital alliances on the availability of health care services, nearly all focus on reproductive health services. That may indicate that the services most likely to be dropped when a hospital becomes Catholic are abortion; sterilization; birth control drugs, devices, and information; and in vitro fertilization. Or, that may signal that reproductive health services are the most media-worthy services of all these affected. Even cautiously viewed, these reports indicate that most alliances result in the elimination of some, if not all, reproductive health services.

A study of the fifty-seven Catholic/non-Catholic hospital alliances formed between 1990 and 1995 shows that in ten deals, all reproductive health services were dropped. Nonabortion reproductive health services were continued at the non-Catholic hospital in twelve deals. Of course, that means that abortion services are not provided in these twelve non-Catholic hospitals. Reproductive health services were moved to legally and physically separate facilities as the result of eight alliances. In three deals where a Catholic hospital merged with a non-Catholic hospital, services remained the same at both the Catholic and non-Catholic hospitals. Nineteen institutions refused to provide information for the study. Even if services remained the same after the formation of the nineteen institutions who refused to provide information, reproductive health services were eliminated or segregated after most of the Catholic/non-Catholic alliances in 1995.

The elimination of reproductive health services impacts more heavily on women than it does on men. Men use birth control devices and information and sterilization directly. The availability or nonavailability of the other services also affects the lives of men, but the primary impact falls on women for three reasons. First, women use all of the reproduc-
tive health services and all of the other services banned by the directives. Second, because it is women who bear children, the consequences of making reproductive health services unavailable or less available always affects the woman's health and life, even where the absence of services also impacts directly on the man. Finally, the services most likely to be eliminated or banned are used exclusively by women—abortion services. Even where reproductive health services have been moved to a separate facility, women are more likely to be more seriously affected. The most notable example of this is sterilization. Many women have tubal ligations immediately after a cesarean delivery. This reduces medical risks, financial cost, and saves time for the patient. Where tubal ligations are performed in a separate facility, women who choose sterilization after childbirth must undergo two separate surgeries.

**Trafficking in Women's Health.** In Catholic/non-Catholic hospital deals, the non-Catholic hospital's decision to eliminate services that impact primarily on women is not made thoughtlessly, but the decision-making factors are weighted. The decisions to drop abortion and other services seem to presuppose that women's health services are separable, or perhaps already segregated, from health in general. These decisions also measure health services for women in terms set by majoritarian efficiency concerns, not in terms defined by women's experiences.

Generally, the non-Catholic hospital spokesperson explains the decision to drop health services for women in terms of trading. We had to give up these services in exchange for the weightier financial and health benefits of the deal. Often, the non-Catholic hospital administrator claims that the deal benefits the community. "Hospital administrators defended the move [to drop abortion services because of a merger with a Catholic hospital], saying . . . that [the] consolidation of the hospitals' services offers the best guarantee of reliable health care for the entire community." This type of claim seems to assume that women are not part of the entire community, or that women are part of the community, but their interests and choices are somehow separable from the community's.

There are at least three types of trades. In one, the significance of the health service is measured by the number of patients who use it. When Merritt Peralta Medical Center (Oakland, California) ended abortion services upon merging with Catholic Sisters of Providence Hospital, the

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132. *Id.* at 14-15.
chief executive officer explained, "[w]e had to balance the needs of 10 patients a week against the needs of approximately 5000 other patients a week."\(^{134}\) This is the needs of the many credo in its most basic and illogical form. Clearly, if you identify one particular treatment choice and weigh it against all other treatment choices, the patients who make that choice will lose.

A second type of trade justifies ending one health service that impacts primarily on women by preserving another. When St. Joseph's Health Care Center of Tampa, Florida, took over Humana Women's Hospital, the new facility no longer provided abortions and voluntary sterilizations. However, it formed an affiliation rather than a direct ownership interest in the fertility clinic, thereby preserving in vitro fertilization services.\(^{135}\) Weighing women's health care services against women's health care services will always result in the elimination of women's health care services.

A third type of trade bolsters the decision to cut services by characterizing it as an advantage for women. New York Medical College holds "affiliation contracts to provide doctors and supervise medical care at Metropolitan Hospital Center in Manhattan and Lincoln Medical and Mental Health Center in the South Bronx."\(^{136}\) As a result, physicians on the Medical College's payroll do not perform abortions, even at the other two facilities. The dean of the medical school stated, "They [abortions] are cheaper at clinics anyway."\(^{137}\) The irony of this rationale is that women's health services are provided by clinics because other facilities failed to provide these services in the first place.

**The Margins of Rural Area Health Care.** The socio-economic factors particular to rural area populations shape the impacts of cuts in health care services due to Catholic/non-Catholic hospital alliances. Significant factors include poverty, health insurance, marital status, and the presence of migrant farmworkers. Each of these factors create greater barriers to health care in rural areas than in urban (and non-rural) areas. More specifically, these factors expand the numbers of those on the margins of health care in rural areas.

\(^{134}\) Id. (quoting Ken Jones, Summit's chief executive officer).


\(^{137}\) Id.
Despite the fact that rural areas have experienced a population and employment boom in recent years, poverty and unemployment persist at greater levels in rural areas than in urban areas. The poverty rate is higher for African-Americans in rural areas. In addition, rural areas include migrant farmworkers, "one of the most economically disadvantaged occupational groups in the United States." Low income and poverty make access to alternative health care facilities more difficult, especially given the lack of public transportation in rural areas.

Both low income and low wage-earning employment correlate to a lack of private insurance. "Rural residents are much less likely than urban ones to have employment-related insurance." In addition, poor rural residents are less likely to have Medicaid coverage. A government study suggests that because poor rural families, especially those living on farms, tend to be two-parent families, few families qualify for Medicaid. Lack of private or government health insurance often prevents access to health care. Therefore, rural areas have a greater population of patients marginalized by low income and employment status.

On the other hand, the Catholic health care mission includes an express commitment to provide care to the poor. Arguably, Catholic hospital affiliations or mergers with community hospitals would help continue or even expand health care services for the poor. Evidence suggests, however, that Catholic hospitals provide less indigent and

139. HEALTH CARE IN RURAL AMERICA, supra note 45, at 38-39 ("Rural residents have relatively low incomes. The average median family income in rural areas in 1987 was $24,397, about three-quarters of the average urban family income of $33,131. One out of eight urban families lived in poverty in 1987, compared with more than one out of every six rural families"); Prepared Statement of Jill Long Thompson, Under Secretary of Rural Development, before the Senate Committee on Appropriations Subcommittee on Agriculture, Rural Development and Related Agencies, Apr. 25, 1996 ("535 rural counties endure persistent poverty, with more than 20 percent of the residents below the poverty level in 1960, 1970, 1980, and 1990").
140. HEALTH CARE IN RURAL AMERICA, supra note 45, at 40. ("the ratio approaches one out of two for black families in rural areas").
141. VICTOR J. OLIVEIRA, U.S. DEPT OF AGRICULTURE, AGRICULTURAL ECONOMIC REPORT NO. 658: A PROFILE OF HIRED FARMWORKERS, 1990 Annual Averages 1 (February 1992) [hereinafter A PROFILE OF HIRED FARMWORKERS]. "The median weekly earnings of hired farmworkers, $200 in 1990, was only 56 percent of the median $360 received by all employed wage and salary workers." Id. at 5.
142. HEALTH CARE IN RURAL AMERICA, supra note 45, at 43.
143. Id. at 46.
144. Id.
other charity care than do other nonprofit hospitals.\textsuperscript{145} A study of Texas hospitals indicated that public hospitals provide the greatest amount of charity health services, followed by nonprofits, and for-profits.\textsuperscript{146} The study also showed that Catholic hospitals in Texas have been providing less charity care than other nonprofits. So while Catholic hospitals do care for the poor, they are not the only, nor necessarily the most generous, type of hospital to do so.

When health services are dropped in a rural area subject to high rates of poverty and low levels of insurance, the impact may fall most sharply on poor women. Contraceptive, abortion, and tubal ligation services are services that poor women, as well as relatively more privileged women, use and need. The elimination of these services in a rural area hospital may completely bar access for women who live in poverty because of inability to pay for transportation to another facility or to pay for nearby private health services.

Ultimately, those women pushed to the far edges of the rural health care margin may be African-American women and Latinas. Most rural

\textsuperscript{145} A Catholic Health Association report of 1989 showed that Catholic hospitals provided uncompensated care (including both charity and bad debt) in the amount of 4.6% of their total expenses. CATHOLIC HOSPITAL ASSOCIATION, PRESERVING A TRADITION OF SERVICE: REFLECTIONS ON THE TAX-EXEMPT STATUS OF NON-FOR-PROFIT HEALTHCARE INSTITUTIONS 5-12 (1989). Subsequent to this report, CHA redefined charity care as "community benefits." CATHOLIC HEALTH ASSOCIATION, A COMMUNITY BENEFITS REPORT ON CATHOLIC HEALTHCARE PROVIDERS 5 (1991). But a 1993 Modern Healthcare study used CHA's "community benefits" definition and found that Catholic hospitals still provide less charity care than other nonprofits. According to that study, public hospitals provide community benefits at 8.7% of gross patient revenues; other religious hospitals provide 3.4%; secular nonprofits render 3.0%, Catholic hospitals provide 2.3%, and for-profit hospitals give 1.3%. Jay Greene & Judy Nemes, Not-for-Profits Lead Rise in Income Growth, MODERN HEALTHCARE, May 24, 1993. For further discussion, see HEALTH CARE LIMITED, supra note 5, at 12; Inside the Industry Catholic Hospitals: Struggling in a Competitive Market, 4 AMERICAN POLITICAL NETWORK, Mar. 13, 1996, at 11.

\textsuperscript{146} Greene & Nemes, supra note 145. Texas is the only state that requires nonprofit hospitals to provide a certain level (4% of net patient revenues) of care to the poor in order to retain tax-exempt status. For further discussion of this law, see infra notes 218-21 and accompanying text. The legislature enacted the law to nudge nonprofit hospitals into providing more charity care. But "the MODERN HEALTHCARE analysis shows that public hospitals still shoulder an overwhelming portion. Of the 450 hospitals that report to the state, 10 collectively had $1.1 billion in charity-care charges, or more than half the charity care in Texas in 1994." Sandy Lutz, Special Report; Charity Care in Texas: Numbers Don't Tell the Story, MODERN HEALTHCARE, May 6, 1996 at 36. The Catholic hospital with the highest percentage of charity charges reported spending $10.1 million in 1994, or 11% of net patient revenues. That figure nears the level of care provided by public hospitals in the state. But the total charity charges for the other 25 Catholic hospitals in Texas showed charges that amounted to only 6% of patient revenues. Id. at 42.
residents are white. But African-Americans in rural areas have significantly higher poverty rates. Twenty-nine percent of migrant farmworkers, whose poverty and mobility create significant access problems, are Latino. So, while more white women may be impacted by the elimination of health care services, poor women of color may be more likely to experience the cut in services as total barriers.

B. Legal Rules that Reinforce the Margins

Conceptually, at least, the refusal of Catholic hospitals to provide these services violates principles of autonomy, bodily integrity, and patient choice that underlie the doctrine of informed consent and right of privacy or 14th Amendment liberty claims. However, two types of legal rules seriously enable Catholic hospitals to drop health services without legal sanction. Conscience clauses protect physicians and other medical staff who refuse to provide treatments that violate their religious beliefs. The State Action Doctrine draws a line between the state and hospitals, even those that receive significant government funding and support, for purposes of defining the scope of constitutional protections. Other scholars have provided thorough and useful analysis of these types of rules. I intend to merely sketch the ways in which the legal rules reinforce the margins.

Conscience Clauses. The oldest conscience clause is federal law. Congress enacted the Church Amendment in response to a district court's decision in Taylor v. St. Vincent's Hospital. The court

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147. HEALTH CARE IN RURAL AMERICA, supra note 45, at 38.
149. The same problem occurs in urban areas. The elimination of services in an urban community isolated by poverty and race may create a complete barrier, despite the presence of other hospitals in the same metropolitan area. See, e.g., Kirk Johnson, In Hartford, A Hospital Ails and Services to Poor Suffer, N.Y. TIMES, Aug. 8, 1989, at B1.
150. Certainly, other principles such as equal access and resource allocation with respect to gender, race, and class have been violated as well. However, neither the doctrine of informed consent, nor the constitutional values of autonomy and bodily integrity have been developed in ways that adequately express these principles.
151. See, e.g., Lynn D. Wardle, Protecting the Rights of Conscience of Health Care Providers, 14 J. LEGAL MED. 177 (1993). While I disagree with Professor Wardle's argument that conscience clauses should be expanded, I have learned a great deal from his thorough research and careful analysis. See also Boozang, supra note 2, at 1481-93, for a thoughtful discussion that includes a response to Professor Wardle.
152. See 401 of PL 95-45 (1973); see also 214 of PL 93-3-348 (1974).
153. 369 F. Supp. 948 (D. Mont. 1973), aff'd, 523 F.2d 75 (9th Cir. 1975), cert. denied, 424 U.S. 948 (1976). Mrs. Taylor wanted a tubal ligation performed immediately following the delivery of her child by cesarean surgery. St. Vincent's policy required transfer to the only other hospital in town. The district court's injunction enabled her to have the tubal
enjoined St. Vincent's so that a patient's tubal ligation could be
performed there. Congress also passed a law protecting individuals and
entities receiving federal funding from government actions that would
require participation in sterilization and abortion procedures that violate
religious beliefs or moral convictions. Later, the conscience clause
expanded in two ways. Many states enacted conscience clauses, and
Congress amended the federal law to protect individuals from being
required "to perform or assist in the performance of any part of a health
service program or research activity funded in whole or in part under a
program administered by the Secretary of Health and Human Services"
if participation would violate "his religious beliefs or moral convic-
tions." Because Catholic hospitals take Medicare patients, Catholic hospitals
receive federal funding administered by the Secretary of Health and
Human Services. Therefore, doctors and other medical staff are
protected against being required to perform any service that would
violate their beliefs and convictions. With the strong encouragement of
the Catholic Health Association, the Clinton Administration incorporated
an expansion of the federal conscience clause in the Health Security Act.
If enacted, that law would have protected health facilities as well as
individuals from performing any treatment that violated their beliefs
and convictions. It also would have allowed Catholic hospitals as
employers to not provide benefits even if otherwise required by law. In other words, Catholic hospitals as a whole, as well as employees of
Catholic hospitals, could invoke federal law. As is, federal law protects
Catholic hospitals with respect to sterilization and abortion procedures,
but not with respect to other services. Catholic hospitals set policies
that, for example, prohibit artificial insemination or distribution of
family planning information about contraceptives, but technically the
law protects the hospital physicians and staff, not the institution.

Recently, the U.S. Senate and the House of Representatives passed
different versions of the Medical Training Nondiscrimination Act of
1995. Generally, these bills provide an exception for individual
medical residents and institutions that would enable them to opt-out of

\begin{itemize}
\item \textbf{154.} 42 U.S.C.S. § 300a-7(b) (Law. Co-op 1991).
\item \textbf{155.} Id. § 300a-7(d).
\item \textbf{156.} Health Security Act § 1162. The text of that provision reads, "[a] health
professional or a health facility may not be required to provide an item or service in the
comprehensive benefit package if the professional or facility objects to doing so on the basis
of a religious belief or moral conviction." Id.
\item \textbf{157.} S. 971, 104th Cong., 1st Sess. (June 29, 1995); H.R. 1932, 104th Cong., 1st Sess.
(June 27, 1995).
\end{itemize}
the requirement that OB-Gyn programs train residents to perform elective abortions.\textsuperscript{158} The training requirement is not law, but policy that a private accrediting body, the Accreditation Council for Graduate Medical Education ("ACGME"), approved in early 1995.\textsuperscript{159} The ACGME policy already contains an opt-out clause for residents and institutions, but it requires institutions such as Catholic-affiliated training hospitals to refer residents who want abortion training to other programs. Both bills would eliminate the referral requirement.\textsuperscript{160}

Nearly all of the state conscience clauses are narrower than the federal conscience clauses.\textsuperscript{161} Most state statutes provide for conscientious objection to abortion; less than half of those statutes also cover other procedures—contraception, sterilization, euthanasia, and artificial insemination.\textsuperscript{162} Catholic hospitals that refuse certain health services are more likely to be in violation of state law than of federal law.\textsuperscript{163}

For the most part, courts have upheld conscience clauses against Establishment Clause and right of privacy challenges.\textsuperscript{164} So, to the

\textsuperscript{158} These bills are currently in committee to iron out the differences between them. For a discussion of the differences, see Diane M. Gianelli, Compromise Reached on Training Rules for Abortions, 39 AMERICAN MEDICAL NEWS 3 (Apr. 8, 1996).

\textsuperscript{159} The requirement became effective on January 1, 1996. Gianelli, supra note 158.

\textsuperscript{160} Id. A 1990 district court decision serves as background to this legislative activity. In St. Agnes Hospital of Baltimore, Inc. v. Riddick, 748 F. Supp. 319 (D. Md. 1990), the court refused injunctive relief to a Catholic hospital seeking to block the ACGME's withdrawal of accreditation. The ACGME's action was based on several factors, including St. Agnes' refusal to perform and provide clinical training in abortion, sterilization and contraceptive services, and to refer residents to rotations in hospitals that did provide this training.

\textsuperscript{161} Wardle, supra note 151, at 179-80.

\textsuperscript{162} Id. at 180. In addition to statutes identifiable as conscience clauses, most, if not all, natural death acts or living wills contain conscience clauses for physicians and other medical personnel who object to the withdrawal or withholding of life-sustaining treatment. See, e.g., CAL. HEALTH & SAFETY CODE § 7185 (West 1996). The ballot initiatives permitting physician aid-in-dying also contained conscience clauses.

\textsuperscript{163} See, e.g., In re Requena, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986) (holding that Catholic hospital, St. Clare's, must comply with patient Beverly Requena's request for withdrawal of artificial nutrition and hydration despite its policy against participation in such withdrawal, when St. Clare's failed to present a convenient and suitable transfer facility); Brownfield v. Daniel Freeman Hosp., discussed infra at notes 229-32 and accompanying text.

\textsuperscript{164} Chrisman v. Sisters of St. Joseph of Peace, 506 F.2d 308 (9th Cir. 1974) (holding that the Church Amendment precludes a claim for injunctive relief under 42 U.S.C.S. § 1983 against a Catholic hospital that refused to permit the sterilization of a woman). See also Poelker v. Doe, 432 U.S. 519 (1977) (determining that the refusal by a public hospital affiliated with a Catholic medical school to provide abortion services did not violate an indigent woman's right to choose an abortion). On the other hand, at least one state court has been willing to limit the impact of the conscience clause. Doe v. Bridgeion Hosp. Assoc., 366 A.2d 641 (N.J. 1976), cert. denied, 433 U.S. 914 (1977) (holding that a New
extent that conscience clauses, or perhaps more accurately, strong free exercise/weak establishment concerns, protect Catholic hospital decisions to drop services that impact on the margins, conscience clauses reinforce an understanding of community health that tends to devalue the needs of women, particularly women with low incomes.

The State Action Doctrine. The preceding discussion may suggest that claims aimed at Catholic hospitals for failure to provide services, other than abortion and sterilization, might succeed because the conscience clauses do not reach other services. But what the conscience clauses do not reach, the State Action Doctrine does. In other words, it is possible to imagine an argument that because Catholic hospitals receive federal funding, they are obligated to provide services to which patients have a right. The argument asserts that the connections between the government and the hospital make the hospital a state-actor so that failure to provide these services would violate the patient's civil rights under the Civil Rights Act of 1871, 42 U.S.C. § 1983. However, the State Action Doctrine is drawn so narrowly that not even significant federal funding and regulation of a hospital's activities make the hospital a state-actor. Without a state-actor, there is no civil rights violation at law.

The parallel between the conscience clause/free exercise concerns and the narrowness of the state-action doctrine in the Catholic hospitals

Jersey conscience clause protecting hospitals that refuse to provide abortions does not apply to nonprofit hospitals without religious affiliations).


166. See, e.g., Jones v. Eastern Maine Medical Center, 448 F. Supp. 1156 (N.D. Me. 1978). Both the board of trustees and the maternity ward nursing staff adopted policies refusing to provide second trimester abortions. Id. at 1160. Despite the stipulated facts that the private, nonprofit hospital was state-licensed, exempt from federal, state and local taxes, had entered a bond agreement with the state authority through which the hospital received over $21,000,000 in financing, received federal Hill-Burton grant monies of $400,000, met Medicare and Medicaid regulations and received much of its revenue from reimbursements, and received state and non-Hill-Burton grant monies (Id. at 1158-59), its adherence to the policies was not state action. Id. at 1161. The court's decision was based on the finding that there was no direct connection between the abortion policies and the fact that the hospital had received state and federal money, tax exempt status, etc. Id. at 1161. See also Taylor v. St. Vincent's Hosp., 523 F.2d 75 (9th Cir. 1975). Even though the court distinguished this case from Chrisman v. Sisters of St. Joseph of Peace, 506 F.2d 308 (see supra note 164), because St. Vincent's had the only maternity ward in town, the court found that the hospital's refusal to perform a tubal ligation following cesarean delivery was not state action. 523 F.2d at 78. In short, the hospital's monopoly status was not directly connected to the hospital's policy. Id.
context is striking. Both sets of legal rules enhance the authority of those backed by institutional power—the medical personnel and the hospitals. Both sets of rules seem to isolate individuals from access to institutional power and from protection by the state. Those most often impacted by Catholic hospitals' failure to provide certain health services in rural areas are also those most likely to be isolated by law.

IV. REDEFINING COMMUNITY HEALTH CARE BY WORKING FROM THE MARGINS

While this is the prescriptive part of the article, I am not trying to set forth a solution. Figuring out how to re-situate the health needs of women, poor people, and people of color in these deals will result from political action that uses the legal system as part of the strategy. That process has already begun. My prescriptive analysis is, more accurately, a collation of the ideas, practical points, and legal moves that others have developed and/or tried. The political perspectives and the errors are my own. I hope this information will aid the process.

A. Organizing Intervention

Working From the Margins. In this part of the discussion, I talk about the need to organize efforts to intervene in Catholic/non-Catholic hospital deals in order to ensure that the list of essential community health care needs includes those of women and others most likely to face other access barriers. When I use the term "organizing intervention," I mean organizing for the purpose of avoiding chaos, preventing duplicated efforts, creating order, and getting the job done. I also mean organizing for the purpose of collective action aimed at transformation of consciousness and lived reality. Others have already pointed out the risk that in organizing we tend to perpetuate top-down structures of communication and decisionmaking, and that in doing so, we continue and reinforce subordinations we claim to be erasing.\(^\text{167}\) I think the biggest risk of

that occurring in an organized effort to intervene in Catholic/non-Catholic hospital deals may arise from the need to prioritize among intervention efforts.

It seems possible that the trend of Catholic/non-Catholic hospital alliances may overburden organizational resources. We may not be able to commit resources in every community where services might be dropped. We may not be able to contribute the same level of support in every community. In that case, we would have to set priorities. Rural communities, and other communities in which the marginalized groups are extremely isolated by geography, poverty, racism, or other factors, should receive support first. Making community health care inclusive means working from the margins. If, as an alternative, we set priorities by other standards, such as number of people impacted (density of population), communities that would automatically yield publicity, or even first in line, we run the risk of making the same kind of trades that some non-Catholic hospital administrators already have—those that measure the interests and health care choices of women and others on the margin in numbers that have little to do with their lives, and more to do with our own sense of accomplishment or our own sense of the big picture. As a principle, I suggest that if and when priorities must be set, we choose first to share efforts with those who usually get sacrificed first.

Changing the Decisions, Challenging the Process. In the Introduction, I pointed out that the corporate clothing of these decisions makes them seem remote and not subject to question. One of the major problems, in fact, is that too often we hear about the decision to drop certain health care services after the deal is done. In formulating

168. For example, Leonard Hospital, recently purchased by St. Mary’s, is in Troy, New York. Leonard Hospital’s service area “includes a substantial proportion of low-income individuals who reside in inner-city Troy . . . more than one in five households had no car, making timely access to medical providers difficult.” The Center for Reproductive Law & Policy, Seton Health Systems Operates in a Financially and Medically Needy Part of New York State (information sheet) (1996).

169. In Portsmouth, Virginia, where Maryview Hospital took over nonprofit Portsmouth General Hospital, citizens and hospital employees asked the city council to stop the sale. In response, the city council held a public forum to discuss the history of the hospitals and the buyout, but claimed inability to intervene. “We have two private companies making a deal; there’s nothing we can do,” [council member] Griffin said. “We won’t even get the report back until everything is done.” Toni Whitt, Portsmouth Forum to Air Hospitals’ Merger History, Virginian-Pilot & Ledger-Star, May 15, 1996, at B3.
a strategy for addressing the marginalization of women's health care in Catholic/non-Catholic hospital deals, we can begin to think in terms of at least three goals—finding ways to open up the decisionmaking process, implementing an understanding of inclusive community health care, and finding ways to intervene after services have been dropped. One-on-one, litigation-focused lawyering\textsuperscript{170} may have a role in achieving the third goal listed. Community-based lawyering methods, in which the primary goal is to change the decisionmaking process, as well as the choices being made, may best serve the other goals.

In the existing decisionmaking process for Catholic/non-Catholic hospital deals, there are few, and often no, official spaces in which persons or groups not directly party to the deal can participate. It is true that when public hospitals merge or affiliate, most states have rules requiring notice and public hearings.\textsuperscript{171} However, the most likely deals seem to be those between privately owned community hospitals and Catholic hospitals.\textsuperscript{172} In addition, even where the law creates a forum for the public, using the public hearing process as the key strategy assumes that the process sufficiently addresses the needs of groups like women and poor people.\textsuperscript{173} It may be, in fact, that the process perpetuates exclusion on gender, race, class, and other lines. Within the official process, women, residents of communities of color, and residents of low income areas may lack the credibility and the influence to challenge the corporate interests at stake. We should be wary about using strategies that only aim for participation in the existing processes. We should also think about challenging the decisionmaking structure and process.

At this point, I acknowledge the obvious point that protecting health services for those on the margins is not necessarily the same as


\textsuperscript{172} Most of the hospitals merged or affiliated with Catholic hospitals are community hospitals. See REPRODUCTIVE HEALTH AT RISK, supra note 38, at 13-15. In addition, the largest percentage of rural hospitals are community hospitals. See supra note 90 and accompanying text.

\textsuperscript{173} See Cole, supra note 170, at 701 (citing the example of low-income community groups who have challenged the siting of environmentally harmful projects in their neighborhoods through the public hearing process, only to see the officials approve the permit. "Such communities learn the hard way that the public participation process is not designed to hear and address their concerns, but instead to manage, diffuse, and ultimately co-opt community opposition to projects.")
transforming the majority community's understanding of community health. The former goal may be accomplished without reaching the latter. Maintaining abortion and other women's health services is essential in terms of women's lives and principle. Period. Maintaining these services is also linked to the goal of transformation. But the transformation is usually more difficult to accomplish.

I agree with those who believe that supporting existing community organizations or forming new ones is the key to the transformative project, including the project of changing decisionmaking processes for good. So, while most of the ideas I list below target the decisions being made in a Catholic/non-Catholic hospital deal, I believe that the organizing efforts around this event are at least as important as changing the terms of the deal.

**Coordinating Efforts: Tracking, Organizing, Public Education, and Monitoring.** Ideally, potential and intended Catholic/non-Catholic hospital alliances could be identified early and tracked. Leaving local residents to find out about a deal and initiate a response may not be as effective as a nationally-coordinated effort. Because the law does not often require public notice or public hearings, local residents are often the last to hear of a deal affecting the area hospital. By the time the parties announce the deal, they have already decided to or have cut services. As a result, there may not even be time to intervene. Even if news of a pending deal gets out, most who hear the news probably will not realize that Catholic hospitals can limit health care services based on church doctrine.

Public education about the potential effects on health care choices may address the latter problem. Major mainstream media outlets have issued stories about Catholic/non-Catholic hospital deals in the past few

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175. Figuring out how to track Catholic/non-Catholic hospital deals before they are final is a project in itself. Federal antitrust law requires pre-merger notification in many cases. Perhaps use of pre-merger notifications could facilitate tracking. Industry publications, such as MODERN HEALTHCARE, include announcements of negotiations, pending deals, and notices of intent. In addition, computer searches through media databases using search terms such as “Catholic w/1 hospital!” can be used to locate local and national newspaper stories about pending deals.

176. EDK ASSOCIATES, supra note 4, at 3 (reporting survey results that show that the majority of women surveyed did not know that Catholic health facilities may ban some health care services).
years. Continuing this flow of information is important so that residents who hear of a Catholic/non-Catholic alliance in their area understand the potential effects on health services. Building a centralized or coordinated tracking mechanism would buttress public education efforts. For example, news media stories about risks to health care very often rely on statistics and publications that Catholics for a Free Choice have prepared. One particularly effective publication charts the Catholic/non-Catholic mergers and affiliations that took place between 1990 and 1995, and the resulting impacts on health services.\textsuperscript{177}

The tracking can also be linked with efforts to facilitate and support local organizing efforts. This would save each community from having to re-invent the wheel, so to speak. To some extent, this work has already begun. The California Women's Law Center ("CWLC") has been successful at enabling local organizing efforts. These efforts resulted in a public meeting in Grass Valley, California, despite the absence of legal requirements for one, and a statement by Mercy Health System of Sacramento that its affiliation with Sierra Nevada Memorial Hospital would not lead to any cuts in services.\textsuperscript{178} The CWLC also has, in 1996, been working with residents in Redwood City, California where the local hospital board voted to combine with Catholic Healthcare West. In addition, The CWLC has recently received a James Irvine Foundation grant.\textsuperscript{179} That money will be used to collaborate with the National Health Law Program for the Initiative to Preserve Women's Access to Reproductive Health Services. The Initiative will focus on addressing the elimination of reproductive health services that result from Catholic/non-Catholic hospital alliances.\textsuperscript{180}

The Center for Reproductive Law & Policy ("CRLP") has been active on the legal front.\textsuperscript{181} In May 1996, the CRLP announced that it would form a statewide MergerWatch.\textsuperscript{182} This indicates that it might be useful to coordinate regional tracking efforts, rather than to create one national tracking project. As mentioned, Catholics for a Free Choice is

\begin{enumerate}
\item\textsuperscript{177} \textit{Reproductive Health at Risk}, supra note 38.
\item\textsuperscript{178} For further discussion of this deal, see infra notes 192-95 and accompanying text.
\item\textsuperscript{179} Interview with Susan Fogel, Staff Attorney, Cal. Women's Law Center, Los A., Cal., (June 25, 1996) [hereinafter Fogel].
\item\textsuperscript{180} While the Initiative focuses on protecting reproductive health services, a CWLC staff attorney anticipates that collaborative work with groups focusing on other health care services, such as end-of-life care, will take place. Fogel, supra note 179.
\item\textsuperscript{181} See infra notes 204-08 and accompanying text (discussing Leonard Hospital and St. Mary's in Troy, NY; use of certificate of need process).
\item\textsuperscript{182} \textit{Center for Reproductive Law & Policy Press Release, Agreement Reached in First-Ever Suit Against Merged Hospital for Dropping Reproductive Health Care} (May 14, 1996) [hereinafter CRLP Press Release].
\end{enumerate}
already active in the work of public education and tracking these deals. Other progressive legal organizations have also participated in the effort to preserve women's health care.183

Having an ongoing tracking and organizing-support effort should enable the continuity of local community organizations. I mentioned above the critical role of community organizations in the transformative project of implementing norms of inclusive community health. There is a second need for continuing the activities of community organizations. Even if a Catholic/non-Catholic hospital deal does not result in the discontinuance of health services of women and others on the margin, monitoring can ensure that services are not dropped later. Local organizations will be in the best position to monitor the availability of health services.

Basically, I have sketched a standard organizing structure. This structure is two-tiered, based on partnership or cooperative models of sharing information and resources. At the regional level, existing policy and advocacy organizations could share or allocate the tasks of tracking, providing technical, informational, and perhaps other support to community organizing efforts. The community group would focus on the potential or pending Catholic/non-Catholic hospital alliance, and share information with the regional cooperative. That information could be used for public education and to improve or support efforts in other communities.

B. Intervening

Here, I focus on the more immediate goal of obtaining different decisions about necessary health care services, rather than on the broader transformative goal. In the first section, I review pressure points or built-in reasons that intervention might work. I then describe and evaluate several types of arrangements that have been used to minimize the health care impact on women of a Catholic/non-Catholic hospital alliance. Finally, I recount the possible legal tools that have been tried or talked about as intervention mechanisms.

Pressure Points. In some cases, the fact that the local residents have come together and voiced their opposition to having women's health services dropped may be sufficient.184 This is not as naive as it may sound. Community hospitals are governed by boards composed of

183. See, e.g., Guillermo X. Garcia, ACLU Protest End of Contraception Services at Hospital, PLAIN DEALER, Feb. 6, 1995, at 1B.

184. See infra note 192-95 and accompanying text (discussing Sierra Nevada Memorial Hospital and Mercy Health Systems of Sacramento in Grass Valley, Cal.).
community members. As residents and as board members of a community hospital, those decisionmakers may be very sensitive to organized efforts that oppose cuts in services. Many non-Catholic hospitals are already wary about conditions that Catholic hospitals might place on a deal. In addition, as some of the deals I have described indicate, the Directives do not mandate that every service be dropped in every deal; much depends on the Catholic hospital’s individual decisionmakers. Different bishops have been more and less flexible about permitting arrangements in which abortions, sterilizations, contraceptive, and other services are continued. Also, different hospitals have been willing to resist conservative bishops to form a financially necessary or desirable alliance with a non-Catholic facility.

Examples of Deals Made to Continue Services. Hospitals have used several different types of deals to protect or continue services banned by the Directives. The effect of these deals on the community, and particularly on women, ranges from no change, to inconvenience, to significant barrier to access. So while I cite these deals as examples of what can be done to preserve health services, I also point to problems that should be avoided when possible.

In the best case scenario, services remain the same. This has been accomplished by using the law to maintain facilities with separate—Catholic and non-Catholic—identities, so that services can continue at the non-Catholic hospital. The non-Catholic entity should be monitored after the deal is made to find out if, and when, any services are dropped. For one thing, diocesan bishops change, and so may an agreement between the hospital and the community. In a rural area, this arrangement may be critical because there may be no alternative provider of services subject to being cut. In addition,
Catholic hospitals that refuse to provide services sometimes condition staff and admitting privileges on a physician's agreement not to provide those services at all. Many rural areas are already short on physician services. By restricting hospital privileges, the Catholic hospital may effectively prevent banned services from being provided anywhere in the area. Such a restriction may also discourage other physicians from locating in the area.

Several deals have been structured so that services are moved to another facility. In Ohio, Community Hospital of Springfield built a separate facility for sterilizations before completing a merger with Ohio-based Mercy Health System.\(^{189}\) Petaluma Valley Hospital, a public facility in California, approved a $3 million building for an outpatient surgical clinic primarily for women's health services.\(^{190}\) The hospital's directors approved this in anticipation of an affiliation with Santa Rosa Memorial Hospital, a Catholic facility that does not permit elective abortions and tubal ligations. This arrangement was made despite a public forum at which women protested the "fragmentation" of women's health care services.\(^{191}\) One effect of this type of arrangement is that it makes elective tubal ligations following cesarean delivery more difficult and more expensive. In a rural area with a small or scattered population, this arrangement may not be financially viable.

In a few cases, one of the parties to the deal has not built a separate facility, but contributed money to an existing facility or organization. The obvious point is that, in fact, women's health services were eliminated. The contribution of funds may have helped an alternative provider continue services, but the deal ultimately resulted in reducing women's options. In addition, these deals have expressive content—this type of deal sends a message that women's health services may be liquidated.

There are deals made that do eliminate or prevent some services. Sierra Nevada Memorial Hospital, the only hospital in Nevada County, California, solicited Mercy Healthcare Sacramento as a partner to obtain necessary financial support. When local residents heard about

\(^{189}\) Bruce Japsen, *Church Puts Faith in System Mergers in Light of Healthcare Reforms*, MODERN HEALTHCARE, June 6, 1994, at 32. See also Joyce, supra note 188 (describing Catholic Maryview Medical Center's plan to find another company to run a sterilization clinic in Portsmouth, Virginia, before buying Portsmouth General Hospital).


\(^{191}\) "Linda Purrington of Petaluma said she was disgusted by the idea of a separate center. 'It's as if my reproductive organs were not part of me,' she said." Guy Kovner, *Women's Care Stirs Protest at PVH Forum*, PRESS DEMOCRAT (Santa Rosa, Cal.), Jan. 19, 1996, at B1.
negotiations, they worked with the California Women's Law Center to organize. As a result, a town meeting was called and four hundred people attended. The affiliation agreement signed is called the "community sponsorship model." "Hospitals that affiliate with Mercy are not asked to absorb the ethical directives 'verbatim,'... but are asked to follow 'common values' that include such general concepts as preserving a patient's dignity and confidentiality." However, the common values also include a commitment to the principle of "the sanctity of life from the moment of conception until death." Although the agreement may eliminate withdrawal or refusal of treatment in some cases, it clearly means that physician aid-in-dying and abortion cannot be performed. Hospital officials assured residents that nothing would change. Sierra Nevada did not offer abortion services before it affiliated with Mercy. However, now the hospital cannot add those services. Given its isolated location, some local residents will simply not be able to obtain those services.

Legal Tools. If a deal is being formulated that does not express the health care needs of women and others in the community, then legal levers may be necessary. The following list only suggests claims that might be viable.

192. Roan, supra note 78, at 14.
193. Id. (quoting Cindy Holst, a spokesperson for Mercy Healthcare Sacramento).
194. Id. at 12.
195. "If the hospital stopped doing it, family planning services would be nonexistent in this area. You would have to go to (about 50 miles) Sacramento for it. For me, that would be an extreme hardship. We use MediCal, so our options are already limited." Id. (quoting Marsha Bartholomay, a single mother who lives in the nearby town of Rough And Ready).
196. I mention three other possibilities. First, effective January 1, 1996, the Accreditation Council for Graduate Medical Education ("ACGME") requires that obstetrical residents receive training in abortion services. See OB/GYN Residents: Abortion Training Will be Mandatory, AMERICAN POLITICAL NETWORK, Feb. 15, 1995. That means that teaching hospitals are required to provide abortion services. The rule includes an exception or conscience clause for institutions with "moral or religious objections" to abortion. These institutions must "arrange to have the abortion training done at some other institution." Id. While the ACGME rule probably will not apply in the vast majority of Catholic/non-Catholic hospital alliances, it may be effective in challenging the elimination of services. During an earlier incarnation of the abortion training requirement, the Maryland District Court found that the ACGME's withdrawal of accreditation from a Catholic hospital for failure to comply did not violate the Free Exercise Clause. St. Agnes Hospital of the City of Baltimore, Inc. v. Riddick, 748 F. Supp. 319 (D. Md. 1990). But, note that the House and Senate have both passed bills that would expand the exception so that religious hospitals would not have to provide abortion training elsewhere. See supra note 157 and accompanying text. Second, Catholic hospitals may require physicians to drop services such as abortion and sterilization altogether as a condition of obtaining staff/admitting privileges.
in itself create a negotiating position for those whose health care is at risk. The legal action might be what makes the parties to the deal pay attention, or the legal action might threaten a critical portion of the deal, such as financing. Of course, the legal action might result in a settlement, injunction, or other favorable decision. However, there is always the risk that an unfavorable decision might leave women in a worse position than if no legal action had been taken.197

Public Hearings and Referendums. As mentioned above, some laws require notice to the public, a public hearing, or some other type of public input. Again, these laws usually apply to public, but not community, other nonprofit, or for-profit hospitals. For example, a California law requires that deals between public hospitals and non-profits that involve at least fifty percent of the public hospital’s assets must be put to a referendum by that hospital district’s voters.198 In spring, 1996, Sequoia Hospital, in California, decided to affiliate with Catholic Healthcare West. The deal could result in the elimination of elective abortions.199 The deal is not final, however, until voters in the hospital’s district area approve the terms.200 Public hearings and referendums take at least a little time to arrange. During that time, organizing efforts could be used to educate the public and coordinate opposition to cuts in services. One of the risks is that low turnout may indicate to the hospital board that the services are not important. Moreover, the hearing or referendum may be structured in a way that makes ratification of the board’s terms automatic.

Financing Process. Many hospital restructurings and transfers are funded by tax-exempt bonds. If the hospital(s) ask the local government to sponsor the bond issuance, there may be a public hearing. Poverty lawyers have used the tax-exempt bond process to intervene on behalf of their client’s needs.201 In the Catholic/non-Catholic hospital alli-

Gibson, supra note 53, at 21. In an area with few physicians, this could effect a restraint on trade or competition under state law. Third, occasionally a restructuring may violate either state law or the hospital’s grant deed. See Jane Perkins & Judith Waxman, Hospital Financing in the 1980s, CLEARINGHOUSE REV. 148, 150 (June 1986).

197. I thank Susan Fogel for reminding me of this point. Fogel, supra note 179.

198. CAL. HEALTH & SAFETY CODE 32121(p)(3)(d) (1995) (“Before the district transfers, pursuant to this paragraph, 50 percent or more of the district’s assets to one or more nonprofit corporations, in sum or by increment, the elected board shall, by resolution, submit to the voters of the district a measure proposing the transfer.”). The requirement does not apply when the public hospital merges with a for-profit entity.


201. Perkins & Waxman, supra note 196, at 149.
ance, a request could be made to condition the sponsorship on maintaining certain health services, or funding those services at another facility. It may be that the bonds cannot be issued while there are legal challenges to the deal. In this situation, a legal challenge might provide negotiating power.\textsuperscript{202}

\textit{Certificate of Need.} At least one advocacy group has successfully used state certificate of need laws to prevent a Catholic hospital from eliminating access to reproductive health services. Many states require a state-issued certificate of need for hospital deals that anticipate a change in services or the transfer of significant assets. Typically, the statutory or regulatory language describing the standards for certificate of need approval are very broad. New York's law, for example, requires the state to approve certificates of need based on "public need." While the interpretation of this type of broad standard will vary from state to state, it may be possible to intervene on behalf of persons adversely affected by the proposed change, or to file an appeal in state court after an adverse administrative decision.\textsuperscript{203}

When Leonard Hospital in Troy, New York, and St. Mary's Hospital merged, the resulting Seton Health Systems did not provide contraceptive and sterilization services, nor direct referrals for care. The Center for Reproductive Law & Policy, on behalf of two women, Family Planning Advocates of New York, and two chapters of Planned Parenthood filed a suit\textsuperscript{204} against New York's Department of Health arguing that the relevant state agencies "did not do a sufficient review for women's health care" under certificate of need requirements.\textsuperscript{205} More specifically, CRLP argued that the Department of Health granted a certificate of need that violated state laws requiring hospital clinics to provide family planning services or make direct referrals.\textsuperscript{206} Under the original certificate of need, Seton Health would have referred patients to a government agency that would then (in theory) provide a direct referral. Seton Health Systems and the state agency signed an agreement on May 14, 1996, that "requires Seton Health Services to provide patients with a detailed up-to-date list of providers of contraceptive and sterilization services" and that mandates "that the Seton

\begin{footnotesize}
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\item 202. In Tennessee, the bond counsel for a hospital planning to renovate its obstetrics department for private patients refused to issue a clearance letter after legal services attorneys intervened. The letter was issued after the hospital agreed to provide an obstetrician for low-income patients. \textit{Id.} at 149.
\item 203. Perkins & Waxman, \textit{supra} note 196, at 149-50.
\item 204. CRLP \textsc{Press Release}, \textit{supra} note 182.
\item 205. Tena Jamison, \textit{Should God Be Practicing Medicine?}, 22 \textsc{Human Rights} 10, 10 (Summer 1995).
\item 206. CRLP \textsc{Press Release}, \textit{supra} note 182.
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employee follow up to determine whether a patient obtained the family planning or sterilization services she needed and/or requested.\footnote{207} This suit illustrates the potential for intervening after the deal is made. It also provides a basis in New York for intervening in the original certificate of need process.\footnote{208}

\textit{Medicaid Requirements.}\footnote{209} There may be Medicaid requirements that can be used to protect particular health services. Medicaid law requires coverage of a list of services, including family planning services. When the state approves, through its certificate of need program or other law, a Catholic/non-Catholic hospital alliance that results in the elimination of required services, the state has arguably violated its duty under the Federal Social Security Act. 42 U.S.C. sec. 1396(a)(A)(1) requires that “a State plan for medical assistance must provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them.”\footnote{210} At least two courts have found that a state would be out of compliance when dental services are not available in all counties.\footnote{211} Thus, in an area where more than one provider takes Medicaid patients, a Catholic/non-Catholic hospital alliance that eliminates services would not violate the statewide availability requirement. But in an area where the community hospital is the only place for Medicaid patients to obtain the eliminated services, the state is arguably out of compliance.

Federal regulatory statutes that apply to state agencies administering Medicaid require that Medicaid patients have equal access to services that are also available to the general public. The statute provides that the agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients, at least to the extent that those services are available to the general population in the

\footnotesize{207. Id.; Memorandum of Understanding Between Seton Health Systems, Inc. and The New York State Department of Health (Final Draft, May 1996).}
\footnotesize{208. See also Massachusetts Hospitals Will Continue to Consolidate and Merge, P.R. NEWSWIRE, Apr. 12, 1988 (discussing Massachusetts law which requires an extensive Determination of Need approval for a merger or acquisition changing more than half a hospital's governing board or changes in service). No merger nor acquisition has been blocked entirely by the DoN process, but in some cases, conditions have been attached, and the process, with public hearings, can drag on for over a year. Jamison, \textit{supra} note 205, at 12-13 (stating that Sarah Wunsch, a Massachusetts Civil Liberties Union Foundation lawyer, recently submitted a letter to the state's Determination of Need Program expressing concern about a proposed consolidation between Holyoke Hospital and Sisters of Providence Health Systems).}
\footnotesize{209. Fogel, \textit{supra} note 178.}
At least one court has enforced this provision. It might be possible to enforce this requirement against the state where a Catholic/non-Catholic hospital alliance has eliminated services for Medicaid patients, and where those services are still available for patients who have private means of accessing other providers.

State Law Requirements for Health Care. Some states may have laws requiring counties or other local governments to provide a certain level of indigent care. In those states, it may be possible to enforce language describing the standard of required care against the county where a Catholic/non-Catholic hospital alliance has made services unavailable. There may be a standard tantamount to the equal access requirement of Medicaid law, or, as in California statutory law, the state may require that counties provide care “humanely.” In 1989, a California appellate court found that the requirement of humane care did refer to the kind of services to be provided as well as the manner in which they are provided. The court found that by failing to provide dental care, Butte County had failed to satisfy the humane care requirement because the lack of dental services left plaintiffs living with pain and infection. Again, interpretations of these broadly worded standards of care may vary a great deal from state to state. In these cases, the risks include a court's decision to interpret the language so narrowly as to give the government more room to eliminate, or overlook the elimination of, services in the future.

State Charitable Care Requirements. Catholic hospitals do provide care for the poor because they treat a large number of Medicare and Medicaid patients. But, as mentioned above, Catholic hospitals

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213. Clark, 758 F. Supp. at 576-78. A federal district court in California found the state had violated the equal access requirement where: (1) the percentage of dentists participating in DentiCal was significantly below the required two-third participation rate; (2) the state’s reimbursement rates of DentiCal dentists was only 40% of their usual rates; (3) there was a steady stream of reports that recipients were having trouble obtaining care; and (4) that recipients utilized the service at a very low rate. The court’s analysis focused on interpreting the language “available to recipients at least to the extent that those services are available to the general population.” Id. at 575. However, the court cited to a House Budget Committee report that indicates that the analysis could, and perhaps should, focus on services available in a smaller geographic area rather than the state as a whole. Id. at 576.
216. Id. at 415.
provide less charitable care than other nonprofits. As not-for-profits, Catholic hospitals receive a great deal of federal and state benefit by virtue of their tax-exempt status. However, most existing law fails to require actual charity care for indigent patients in return for those benefits. In fact, the position of the Internal Revenue Service has the effect of placing “sole responsibility for indigent patients on public hospitals in both emergency and non-emergency situations.” Two states have recently enacted laws that require nonprofits to provide some accounting to justify their nonprofit status.

Texas enacted a state tax law that requires nonprofit hospitals to provide charity care and community benefits “in a combined amount equal to at least five percent of the hospital’s or hospital system’s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.” California’s law, effective in 1996, does not require nonprofit hospitals to provide charity care. Instead, the law uses the community benefit concept which can, but does not have to, include charity care. Under this law, the nonprofit hospital must provide an accounting of what they do for their communities, and how they will meet the communities’ needs. These statutes arise at a time of growing debate over whether nonprofit hospitals deserve tax-exempt status. Because these laws are so recent, it is not yet clear how they might be used to challenge the elimination of services by a Catholic/non-Catholic hospital alliance. Perhaps a hospital’s failure to comply with charitable care and community benefit requirements could be used to question the state’s approval of a certificate of need. It may be that these laws have only the indirect result of reducing the number of those on the margins by improving health care access for the indigent. In rural areas where income levels are lower than in urban areas,

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218. Id. at 15. Federal income tax exempt organizations under § 503(c)(3) qualify for what amounts to a package of tax benefits.

219. Nonprofit hospitals fulfill federal tax law requirements for tax exempt status if they use revenue “to acquire equipment, add facilities (which are often denied to the poor), improve patient care for the paying patients, and amortize institutional debts.” Id. at 24.

220. Id. at 17-18. Note that the Emergency Medical Treatment and Labor Act may require hospitals with emergency rooms to provide screening for emergency medical conditions and either stabilizing treatment or transfer to another facility for patients with such conditions. 42 U.S.C.A. § 1385dd(a) & (b) (West 1995).

221. TEXAS TAX CODE § 11.18(d)(1)(f) (Vernon’s 1996).


223. Id.

adding or increasing health care of the indigent could have a significant
effect on the margins.

Antitrust Law. Hospital mergers and acquisitions have been one of
the few active areas of federal antitrust activity. However, although
many antitrust actions are investigated or litigated, relatively few result
in declaring a deal to be in violation of law. Hospitals in small
markets, however, raise particular concerns. The possibility for use of
antitrust law to prevent the elimination of services in a Catholic/non-
Catholic hospital alliance may lie in the state regulators. In 1990, the
Washington State Attorney General's Office agreed to end the state's
antitrust investigation of the merger of the only two hospitals in
Bellingham. The attorney general placed conditions on the deal,
including the requirement that the resulting hospital continue its status
as a nonprofit community hospital governed by local citizens, that it
provide a specific amount of charity care, and that it use price control
formulas. Two of these conditions were attached to the certificate
of need approval. So, while these actions may be unusual, the
Bellingham example suggests the possibility of using state antitrust law
to leverage community-centered health care.

Informed Consent. Ideally, legal intervention would prevent the
elimination of health care services in a Catholic/non-Catholic hospital
alliance. However, health services may have already been dropped in
these deals; health services, particularly those for women, will most
likely continue to be dropped in the future as Catholic and non-Catholic
hospitals join. In some cases, the refusal to provide these services will
be actionable. In some of those actionable cases, a court may order a
Catholic hospital to provide services banned by the Directives and
eliminated by the alliance.

In these cases, patient self-determination is the basis for legal action.
The biggest legal obstacle comes from the conscience clauses. However,
as mentioned, many state conscience clauses only apply to abortion, or
abortion and sterilization. In Brownfield v. Daniel Freeman Marina
Hospital, a California appellate court found that a Catholic hospital
did breach the duty to disclose, which "arises from the fact that an adult
of sound mind has 'the right, in the exercise of control over [her] own
body, to determine whether or not to submit to lawful medical treat-

225. See Karen Donovan, Group at Work on First Guidelines for Hospital Mergers,
226. David Burda, State's Conditions Guide Merged Hospital's Actions, MODERN
HEALTHCARE, Mar. 19, 1990, at 34.
227. Id.
228. See supra text accompanying notes 161-62.
In *Brownfield*, the hospital admitted the plaintiff after she had been raped. The hospital refused to provide information about the morning after pill, despite an express request from the victim's mother. In response to the lawsuit, the hospital argued that the state's conscience clause protected its refusal to provide information. The court determined that the morning after pill does not constitute abortion, so the conscience clause for abortion did not protect the hospital. In some cases, the court may be willing to interpret the hospital's rights of conscience narrowly, thereby giving the patient's interests greater weight.

While patient self-determination cases may be reactive rather than proactive, they may still have broad implications. In essence, the court in *Brownfield* recognized a duty to provide information about services even if the Directives or hospital policy ban the services, as long as the conscience clause does cover those services. As Professor Boozang has pointed out, that duty could include information about nonabortion family planning services such as contraceptives, and use of condoms to prevent HIV transmission.

I have deliberately used the term "legal tools" to characterize the legal rules analysis above for the purpose of emphasizing the point that efforts to use the legal system would be most appropriate and useful as part of a collective of coordinated activities. The activities would include those of local, regional, and perhaps national organizations. They would pair the goal of transformation with that of preventing and challenging the elimination of health care services. These efforts would work first to address the needs of women, poor people, people of color, and others most often and most likely to be on the margins of health care access.

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230. *Id.* at 413-14 (quoting from the California Supreme Court's landmark informed consent opinion in *Cobbs v. Grant*, 8 Cal. 3d 229, 242 (1972)).

231. *Id.* at 413. For further discussion of this case, see Boozang, *supra* note 2, at 1452-53. Also see *Gray v. Romeo*, 697 F. Supp. 580 (D. R.I. 1988) (holding that the right of Marcia Gray, a woman in a persistent vegetative state, to refuse medical treatment overrides any countervailing state interests, that the state conscience clause does not apply because it was limited to abortion and sterilization procedures, and that "if Marcia Gray cannot be promptly transferred to a health care facility that will respect her wishes, the Rhode Island Medical Center must accede to her requests." *Id.* at 591.

232. See, e.g., *In re Requena*, 517 A.2d 869 (N.J. Super. 1986). "We construe that policy [to not participate in withholding or withdrawing artificial feeding or fluids] as valid and enforceable only if it does not conflict with a patient's right to die decision and other protected interests." *Id.* at 444.

233. 208 Cal. App. 3d at 405.

V. CONCLUSION

I am not usually intrigued by discussions about mergers, affiliations, or anything corporate, for that matter. In fact, this type of talk often intimidates me. Certainly the topic of religion often makes me want to back off. But I have learned, in thinking my way through this Article, that the corporate or religious clothing of acts may mask the fact that they are acts like many others. That is, they are not socially or politically neutral, and they are not necessarily sacred. The health care services most often eliminated in alliances between Catholic and non-Catholic hospitals are those for women, particularly women with low incomes, and often women of color. The rural location of some of these deals exacerbates the impacts on the margins because geographic isolation compounds the socio-political isolation of these groups.

On the other hand, I am not in favor of simply opposing Catholic/non-Catholic hospital alliances. Alliances with any hospital that helps retain medical services in rural areas is a plus. Catholic hospitals may have their own particular benefits for rural areas. Fortunately, the flexibility of corporate structures seems to allow for the protection of both an inclusive set of health care services and of religious identity in many, if not most of these alliances. So in many alliances, health care services are not at risk. In others, it is possible to intervene in the negotiating process, despite the closed-door nature of the deals, to prevent the trading away of women's health. The interventions that I have outlined—tracking, organizing, using legal tools, and monitoring—are, I believe, best used as part and parcel of collective action. Finally, even where health care services are protected in a Catholic/non-Catholic hospital alliance, women, poor people, and people of color may still face significant barriers to health care; we should continue the work from the margins.