



# Is Your Health Care Compromised?

How the Catholic Directives  
Make for Unhealthy Choices



CATHOLICS FOR CHOICE

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# Introduction

**A**t a time in US history when healthcare can be challenging to access even by those with good insurance coverage, how is it possible to say that Catholic healthcare can be bad for your health? This report will answer that question by showing how the religious rules followed by such institutions take precedence over your health needs and wishes. There are prohibitions on abortion—even for miscarriage management—restrictions on provision of in vitro fertilization to help women struggling with infertility and for ectopic pregnancies, bans on modern contraceptive methods including sterilization and often an unwillingness to honor advance medical directives. This would be less egregious if it were clear that a hospital is Catholic-owned, but that is not neces-

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sarily the case. You may find yourself in a hospital you've used for decades that only recently merged with a Catholic healthcare institution, and options you had once exercised are no longer available to you. Between 2001 and 2016, the number of hospitals affiliated with the Catholic church increased by 22 percent. Do you know if your local hospital is one of them? And how do you feel about your healthcare being guided by the bishops' interpretation of the Catholic faith, rather than by medical necessity or your own religious beliefs?

Apologists for Catholic healthcare claim that doctrinally based conflicts in patient care rarely—if ever—happen. And if they do, occasionally putting patients' well-being on the line shouldn't eclipse all of the service Catholic hospitals provide for the community, especially, they claim, for the poor.

This report details the evolution of Catholic-owned or -affiliated healthcare in America from humble neighborhood hospitals in the early 1800s to billion-dollar conglomerates whose service to the most vulnerable deserves examination. Today, Catholic-sponsored health systems comprise 10 of the top 25 health systems in the US. The report explains the impact on patients of the *Ethical and Religious Directives for Catholic Health Care Services* (the *Directives*), guidelines mandating that health professionals and hospitals follow standards set by popes, bishops and Vatican councils. And it gives real-life examples of Americans whose lives have been adversely affected by the *Directives*.

Perhaps most importantly this report tackles the thorny issue of how these *Directives* sometimes are in direct conflict with Catholic teachings. Catholicism places a primacy upon the individual conscience. And yet Catholic healthcare often denies patients—and health professionals—of all faiths the opportunity to make choices based upon their own conscience.

This situation often occurs with the blessing of the government, which often grants expansive refusal rights to Catholic hospitals allowing them to refuse to provide reproductive healthcare services. Abortion—or the miscarriage management deemed abortion—is forbidden, even when it is to save a woman's life. This freedom to deny care, Catholic healthcare deems a moral good and a community service, one that must be protected by a well-oiled lobbying machine.

As you read through this report, you too may conclude that Catholic healthcare can and should do better.

## Could Catholic Healthcare Be Bad for Your Health?

In 2009, a case was brought before the ethics committee at a hospital in Phoenix, Arizona. The patient, a 27-year-old mother of four who was 11 weeks pregnant, was suffering from pulmonary hypertension, failure of the right side of her heart and cardiogenic shock.<sup>1</sup>

It was a clear-cut situation that needed a life-saving abortion. That's how the facility summed up its decision to allow the termination: "In this tragic case, the treatment necessary to save the mother's life required the termination of an 11-week pregnancy."<sup>2</sup>

Then the statement concluded, "This decision was made after consultation with the patient, her family, her physicians, and in consultation with the Ethics Committee, of which Sr. Margaret McBride is a member."<sup>3</sup>

But this wasn't a secular hospital. This was St. Joseph's Hospital and Medical Center, a Catholic hospital. When St. Joseph's vice president, Sister McBride, supported authorizing the abortion for the woman, it came at a high cost.

In May, Bishop Thomas J. Olmsted released a statement to the *Arizona Republic*: "I am gravely concerned by the fact that an abortion was performed several months ago in a Catholic hospital in this diocese."<sup>4</sup>

The patient lived, but McBride was punished for allowing the abortion. The hospital transferred McBride to another position.<sup>5</sup> She also received the penalty of excommunication for one who, Bishop Olmsted stated, "formally cooperates" in an abortion. "The Catholic Church will continue to defend life and proclaim the evil of abortion without compromise, and must act to correct even her own members if they fail in this duty," the

bishop said. Sister McBride's "correction" was to be deprived of the sacraments.

In December 2010, Bishop Olmsted went one step further and decided that St. Joseph's could no longer call itself "Catholic" because he had no confidence that the facility provided treat-

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ment consistent with "authentic Catholic moral teaching."<sup>6</sup>

Sister McBride's excommunication was finally lifted one year later. One of the conditions was her resignation from St. Joseph's.<sup>7</sup>

Without someone like Sister McBride to help them get the care they need, pregnant women in distress who end up at Catholic hospitals are kept in the dark about what is happening to them and what their treatment options are. And even if they find out, these patients' only available decision may be whether they are well enough to go somewhere else for the care they need. If they're lucky, a kindly doctor will give them \$400 for the 80-mile cab ride.<sup>8</sup> The less fortunate might be sent home with nothing more than pain medication.<sup>9</sup>

# A. From Neighborhood Hospitals to Billion-dollar Conglomerates

**T**hough there may not be crucifixes on display, US hospitals are looking a lot more Catholic these days—and the trend seems likely to continue. Catholic-run or -affiliated institutions make up a growing share of the healthcare sector because of mergers with secular hospitals. But there is an unresolved contradiction in the Catholic-affiliated hospitals that represent 14.5 percent of hospitals nationwide.<sup>10</sup> Each owes allegiances to medical science and government policy but is governed by leaders and teachings from the Catholic church.

Today the Catholic Health Association (CHA) is the trade association representing Catholic healthcare institutions throughout the US. Overall, these hospitals receive billions of dollars each year through patient revenue and taxpayer funding. But Catholic hospitals had a humbler beginning in this country—in the 19th and 20th centuries—when they focused on the Catholic social justice mission of caring for the poor.

Between 1829 and 1900, in a time when anti-Catholic sentiment was common, Catholic women religious founded 299 hospitals, aimed specifically at serving the poor.<sup>11</sup> In the 19th century, Catholic hospitals were also established to serve new Catholic arrivals to the American shores. In addition, hospitals were instituted in urban communities, where they were often dedicated to a particular immigrant community, such as German, Italian, Polish or Irish Catholics<sup>12</sup>—groups that were not always well-received by public hospitals.<sup>13</sup> This tradition continued in the late 19th and early 20th centuries within neighborhoods with high concentrations of immigrants, though beds were open to all.<sup>14</sup>

Larger trends within the church had an impact upon Catholic healthcare, however. The number of religious sisters in the US has dwindled by 72

percent from 1965 to 2014<sup>15</sup> and with it, the number of nuns who serve as the chief executives of Catholic hospitals.

Medicine was changing, too. In the mid-1980s, the free-standing individual and small group practices that had been the norm started to become less common in the face of a changing market.<sup>16</sup> At that time, the advent of health maintenance organizations (HMOs) meant providers had to assume more financial risk for their practice, and hospitals preferred working with groups of

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doctors rather than individuals.<sup>17</sup> Then, by the mid-1990s, hospitals began merging for financial shelter to allow these once-independent providers and facilities to save money, to control a larger share of the market and to gain an advantage in negotiating fees with insurers.<sup>18</sup>

Between 2001 and 2016, the number of Catholic-owned or -affiliated hospitals increased by 22 percent, while the total number of short-term acute-care facilities fell 5.9 percent.<sup>19</sup> Catholic hospitals are now present in all 50 states and treat one out of six patients.<sup>20</sup> The eight Catholic health systems that are among the best health systems in the country today are also among the 25 largest hospitals in the US.<sup>21</sup>

Catholic-run and -affiliated institutions received \$27 billion in net revenue from Medicaid and Medicare in 2011.<sup>22</sup> These resources grant

Catholic healthcare entities an oversized and harmful influence over health policy in a number of areas. For example, the three largest Catholic-sponsored health systems—Ascension Health, Catholic Health Initiative (CHI), and CHE Trinity Health—have demonstrated dramatic growth in size and economic power.<sup>23</sup> The largest Catholic health system, Ascension Health, is not only the largest nonprofit health system but also the fourth-largest health system in the country.<sup>24</sup> The CEOs of Ascension and CHI were included 11 and 12 times respectively on *Modern Healthcare*'s list of the 100 most influential people in healthcare.<sup>25</sup>

Though Catholic healthcare is in some ways comparable to its secular counterparts, there is one major exception. Catholic facilities do not provide a full range of reproductive healthcare services and often don't follow accepted medical standards. Instead, they follow the *Ethical and Religious Directives for Catholic Health Care Services* (the *Directives*), a set of guidelines mandating that health professionals

and hospitals follow standards set by popes, bishops and Vatican councils.

These 72 directives explicitly forbid Catholic facilities from providing a variety of standard healthcare procedures, including abortion, in vitro fertilization (IVF) and modern forms of contraception. They also establish that patients' advanced medical directives can be ignored.

The sheer size of Catholic healthcare in the US means that its commitment to the *Directives* has a far-reaching impact on both patients' access to reproductive healthcare and physicians' ability to provide comprehensive healthcare.<sup>26</sup> Yet, many people who are served by the Catholic healthcare systems—Catholics and non-Catholics—are unaware that these binding, doctrinally based rules exist until their healthcare options are suddenly cut short.<sup>27</sup> For instance, the for-profit Steward Health Care system contains six hospitals that retained their Catholic policies after merging, but the system's website makes no mention of these restrictions.<sup>28</sup>

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## B. Caring for the Community?

**S**ome communities feel the restrictions of Catholic healthcare more than others. In rural areas—where, according to a 2015 report, 220 Catholic hospitals are located<sup>29</sup>—patients may not have other choices. Forty-six Catholic facilities are designated as sole community hospitals—meaning these Catholic hospitals are the only facility within at least 35 miles and they serve Catholics and non-Catholics.<sup>30</sup>

Consider the residents of a three-county area in Arizona who are served by one hospital that is part of a Catholic network.<sup>31</sup> The population of Arizona is 21 percent Catholic, meaning an estimated 79 percent of those patients belong to other faiths or none.<sup>32</sup> Residents of Alaska, Wisconsin, Iowa, Washington and South Dakota

face a similar situation, where over 40 percent of acute care beds are in hospitals that follow Catholic rules.<sup>33</sup>

When patients show up at Catholic facilities for emergency care, as happens nearly 20 million times each year,<sup>34</sup> they expect the same treatment options offered at other facilities. It's not just an expectation, Medicaid and Medicare require it. Accepting federal funds has church-state implications—faith-based organizations are expected to follow civil rights laws.<sup>35</sup> Both Medicaid and Medicare require that patients be informed of their right to participate in care planning, being informed of their health status, receiving basic care and possessing the right to request or refuse care.<sup>36</sup>

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## 2011 figures show that Catholic-sponsored or -affiliated hospitals reported the lowest percentage of gross patient revenues coming from Medicaid.

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Catholic hospitals' compliance with these standards is necessary, given that in 2011, 45.7 percent of their total revenue comes from federal funding—similar to other types of hospitals.<sup>37</sup> This funding stream is only likely to increase as more people enroll in Medicare and Medicaid managed care plans.<sup>38</sup> Since Medicaid, in particular, covers low-income individuals, this would seem to be in keeping with Catholic healthcare's mission to care for the poor. In reality, however, 2011 figures show that Catholic-sponsored or -affiliated hospitals reported the lowest percentage

of gross patient revenues coming from Medicaid. This means that even for-profit facilities provide more care to Medicaid patients, with public hospitals receiving the highest percentage of reimbursements for caring for economically vulnerable patients.<sup>39</sup>

One would expect Catholic healthcare's service to the poor would translate into a greater than average amount of charity care—treatment for those unable to pay, for which hospitals do not expect to be reimbursed. “Yet charity care represented only 2.8 percent of Catholic hospitals' revenue in 2011, less than the overall average among hospitals and half of the 5.6 percent provided by public hospitals.”<sup>40</sup>

In a little more than a decade, Catholic hospitals increased their revenue, but did not increase their care for patients who could not pay. According to Barbra Mann Wall's *American Catholic Hospitals: A Century of Changing Markets and Missions*, “[C]ost containment became a major issue in the 1990s” and some felt Catholic healthcare had “drifted too close to the business spectrum and too far from the original mission of serving all in need.”<sup>41</sup>

### Mary—Swedish Hospital, Seattle, Washington

In 2012, a woman went to Seattle's Swedish Hospital, more than 24 weeks pregnant and in pain.

“They said that they couldn't save the fetus but it still had a heartbeat, so there was nothing they could do. They had to wait for the heartbeat to stop,” “Mary” later told the Seattle paper *The Stranger*.

As she lay on the hospital bed, she heard that the only option at Swedish was to do nothing—wait “for nature to run its course”—or she could take herself to another hospital.

“It was a nightmare,” she recalled about her hospital stay, hardly the time to ask about religious restrictions to care. And there seemed no reason to—Swedish Hospital was secular. Mary couldn't have known that earlier that year, Swedish Medical Center formed an alliance with Providence, a healthcare institution that operates 32 hospitals in five states. Through this relationship, Catholic policies forbidding intervention until the fetal heartbeat ceases reached Mary at Swedish.

“I still feel helpless about it,” she told reporters. “I'm afraid of getting pregnant again.”<sup>42</sup>

## C. What are the *Directives*?

**T**he Ethical and Religious Directives for Catholic Health Care Services, authored by the United States Conference of Catholic Bishops (USCCB), govern Catholic-owned—or, as we have seen, Catholic-affiliated—institutions, including hospitals, clinics and HMOs. These rules are an invisible presence looming in the consultation room—as the *Directives* promise, patient care will never be separated from the bishops’ vision of a Catholic identity.

The first unofficial version of the *Directives* was drafted in the 1940s as “guidance in ‘sound Catholic teaching’” upon the request of the Catholic Hospital Association.<sup>43</sup> Now known as the Catholic Health Association, CHA sent this document to be approved by the local bishops for Catholic hospitals operating in their dioceses.<sup>44</sup> While many dioceses approved these first directives, some did not, resulting in what CHA called a “geographical morality”<sup>45</sup> where some services were allowed in one diocese but not in a neighboring diocese. The key issue driving the divide between the dioceses in accepting these initial *Directives* was the disagreement among Catholic theologians about tubal ligation, permanent sterilization for women.

Some maintained this sterilization method was morally acceptable when performed in order to protect a woman from medical complications in a future pregnancy, thus protecting her health and perhaps saving her life.<sup>46</sup> All agreed that sterilizations for any other reason were prohibited. CHA asked the National Council of Catholic Bishops (NCCB, later the USCCB) to create a standardized set of directives that would have the force of canon law and settle the growing disputes and disparity around the provision of reproductive healthcare in Catholic hospitals.<sup>47</sup>

In 1971, the NCCB granted CHA’s wish, in part. The bishops wrote and approved the first official edition of what would become the *Ethical and*

*Religious Directives for Catholic Health Care Services*. The creation of the *Directives* sent a clear message: All Catholic hospitals had to abide by the same set of rules devised by the bishops.

There have been numerous changes to the 1971 version. The 1990s and 2000s brought strict bans on new reproductive health technologies, changes to directives for medically assisted nutrition<sup>48</sup> and, in response to Vatican directives, tighter rules related to mergers are in the process of being implemented.<sup>49</sup> There are a total of 72 directives as of the 2009 edition.

**Under the *Directives*, women who are patients at a Catholic hospital have:**

- No access to abortion—even in cases of rape or incest (Directive 45)
- No ability to choose modern contraception, including sterilization (Directives 52, 53)
- Restrictions upon treatment for ectopic pregnancy (Directive 48)
- No access to in vitro fertilization (Directives 39, 40, 41); none of the benefits of embryonic stem cell research (Directive 51)
- No deference to their advanced medical directives (Directive 24)
- No access to emergency contraception (EC), except in cases of sexual assault after it can be proven that pregnancy has not occurred (Directive 36)<sup>50</sup>

These rules are an “authoritative guidance on certain moral issues that face Catholic health care today,”<sup>51</sup> according to the USCCB.

The *Directives* have the power to interfere with patient care and standard medical practice



in Catholic hospitals and their affiliates. Like Mary in Swedish Hospital, patients may be refused specific services without regard to their health. And their physicians may be forced to go against their professional ethics. All because

the *Directives* say that “each person must form a correct conscience based on the moral norms for proper health care,” and the bishops are in charge of what that means for hospitals, and by extension, patients.<sup>52</sup>

## Tamesha Means—Mercy Health Partners, Muskegon, Michigan

In 2010, Tamesha Means was 18 weeks pregnant when her water broke and she was rushed to the only hospital in her county, Mercy Health Partners. Means was diagnosed with premature rupture of membranes (PROM) and sent home. The medical staff did not inform Means that given her condition and the gestational age, the fetus had practically no chance of survival. Nor did they say that she had an infection and continuing the pregnancy would put her health and life at significant risk.<sup>53</sup>

The next day, Means returned to the hospital with bleeding, painful contractions and an elevated temperature. After she was given pain medication her fever subsided, and Means was sent home once again. Later that evening, she returned to the hospital a third time in excruciating pain. As the medical staff was planning to send her home once more, Means started to miscarry and gave birth to a very premature child who died within a few hours.<sup>54</sup>

Mercy Health Partners, bound by the *Directives*, did not follow medical standards for PROM with signs of infection, according to a later analysis by OB/GYNs.<sup>55</sup>

In February 2016, a leaked report from a Muskegon County health official stated that the same hospital, Mercy Health Partners, put the health of five women at risk by forcing them to undergo dangerous miscarriages when they could have been offered other options or transferred to another hospital to prevent delivery.<sup>56</sup> All of the incidents involved pre-viable fetuses, and some women suffered infection or unnecessary surgery.<sup>57</sup>

## D. The *Directives* in Real Life: Patients and Providers

**T**he Hippocratic Oath is an early standard for doctors’ ethics that dates back to approximately the 5th century BCE.<sup>58</sup> Today’s version is a holistic code that says, “I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.”<sup>59</sup> It also asks doctors to swear, “Above all, I must not play at God.”<sup>60</sup> Catholic hospitals

don’t offer the same assurances to patients. A pregnant woman may find her health secondary to her fetus because her providers are first bound to a doctrinally based code, rather than a medical one. Doctors’ professional ethics also come second because the *Directives* mandate “standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop’s pastoral responsibility.”<sup>61</sup>

Physicians at Catholic hospitals often feel a conflict between the *Directives* and patient care. Dr. Mitchell Creinin told Southern California Public Radio that during his tenure at an East Coast university hospital, doctors from a nearby Catholic hospital would call once or twice a month. They were seeking treatment for miscarrying women in distress. According to Creinin, the other doctors would say, “We know what she needs, but we can’t treat her. We’re going to send her one mile down the road to you so you can help her.”<sup>62</sup>

A recent survey of obstetrician-gynecologists working at Catholic hospitals found that the majority referred patients to non-Catholic facilities for services prohibited at their facility. Some did

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## A Catholic hospital in Washington State delayed granting a termination for the heavily bleeding “Maria” until she needed a blood transfusion.

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so covertly, while others provided referrals for services like contraception more openly. In one case, a physician related a story about a pregnant woman diagnosed with brain cancer. The woman’s physician wanted to provide a termination. The hospital administration said, “Take her to another place. Those places are available to you. We don’t have to do it here.”<sup>63</sup>

### Abortion

Directive 47 permits abortion care if its “direct purpose [is] the cure of a proportionately serious pathological condition of a pregnant women...when [it] cannot be safely postponed until the unborn child is viable.” At first glance, this directive could seem geared towards pregnant patients’ well-being. In practice, the phrase “as their direct purpose” proves

a significant barrier to medical treatment. The concept is based on the “principle of double effect,” an idea from a 13th century work by St. Thomas Aquinas.<sup>64</sup> Applying the double effect principle requires medical hair-splitting between what treatment is directed towards the woman versus the fetus.

This means that when a pregnant woman’s health or life is at risk, Catholic hospitals are expected to follow preordained formulas that favor the potential life of the fetus over her health. No matter what a woman and her caregivers determine to be the best course of action for her needs, the *Directives* don’t have her best medical interest in mind. Or, the treatment may come too late because the doctrinal determinations slow down the process.

### Fetal Heartbeat

In 2012, Savita Halappanavar was refused an abortion at an Irish hospital prior to an “inevitable spontaneous miscarriage,” despite evidence of a severe infection and her deteriorating condition.<sup>65</sup> Doctors waited until after the fetal heartbeat had stopped because, according to a medical consultant present, “As long as there is a fetal heartbeat, we can’t do anything.”<sup>66</sup> Or, as a midwife explained, “because Ireland is a Catholic country.”<sup>67</sup> After another 48 hours, Savita had a spontaneous miscarriage, but the delay proved fatal. She died of septic shock and *E. coli* one week after her admission.<sup>68</sup> Halappanavar was deemed to be in “critical” danger only after it was too late to save her life.

Fetal heartbeat rules have also impeded care for miscarrying women in the US. For example, a Catholic hospital in Washington State delayed granting a termination for the heavily bleeding “Maria” until she needed a blood transfusion.<sup>69</sup>

A 2012 study found that most physicians surveyed at Catholic hospitals recommend a “watch and wait” strategy if a fetal heartbeat could be detected. One physician stated that he often tells pregnant women in distress that “we can’t do anything but watch you get infected.” He suggests that women discharge themselves and drive to another hospital to get the care they need.<sup>70</sup>

Similar qualitative research told of a physician

who was prevented by an ethics committee in a Catholic-affiliated hospital from providing appropriate care to a woman who was in septic shock. The patient had a 106-degree fever but there was still a fetal heartbeat. The doctor said, “[The patient] was so sick in the [ICU] for about 10 days and very nearly died.”<sup>71</sup>

Clinicians have related other cases of women caught in limbo because the fetus they were miscarrying still had a heartbeat. Lori R. Freedman, assistant professor at UCSF’s Bixby Center, has studied the phenomenon. According to Freedman’s research, “Some physicians intentionally violated protocol because they felt patient safety was compromised.”<sup>72</sup>

### Ectopic Pregnancies

An extrauterine pregnancy, also known as an ectopic pregnancy, occurs when a fertilized egg attaches somewhere other than the wall of the uterus, often in the fallopian tube. Occurring at a rate of 19.7 percent per 1000 pregnancies in North America, ectopic pregnancies can be fatal without intervention. It is the leading cause of maternal mortality in the first trimester in the United States.<sup>73</sup>

There are several ways to treat an ectopic pregnancy, some potentially more dangerous than others. Two common methods require an invasive surgical procedure, while another much less risky procedure involves a non-surgical medical abortion.<sup>74</sup> Secular hospitals tend to rely on the less-invasive methods, but these are precluded by the *Directives*.<sup>75</sup> Catholic hospitals may only use the two procedures that would not be considered “direct” abortions, even though these procedures increase the risk of ruptures, unnecessary surgery and infertility due to removal of the fallopian tube containing the fetus.<sup>76</sup>

Physicians at Catholic-affiliated hospitals who find their treatment options limited by the *Directives* may do their best to work around the restrictions. A report by Ibis Reproductive Health for the National Women’s Law Center related the story of Dr. Y, an OB/GYN at a semi-rural Catholic hospital. This doctor has provided the full range of treatment to

patients “under the radar” because she is neither allowed to tell the patient of treatment options barred by the *Directives* nor does the hospital keep the supplies for the nonsurgical procedure on hand. For patients with ectopic pregnancies, Dr. Y has provided medication from her private practice off the record when patients’ diagnosis was “unclear” and the policies at the hospital prevented timely diagnosis, increasing the risk of tubal rupture. Dr.

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Y and other physicians offer referrals and information secretly as they worry that rules imposed on Catholic hospitals will have a negative impact on the health of their patients.<sup>77</sup>

### Contraception

The introduction to the *Directives* says, “Contraception must not violate ‘the inseparable connection, willed by God...between the two meanings of the conjugal act: the unitive and procreative meaning.’” It also above refers to the *Humanae Vitae* encyclical written by Pope Paul VI, which is at the heart of the ban on modern contraception in Catholic hospitals. The “double effect” principle also applies to contraception: doctors may provide birth control or sterilization to treat a serious medical condition, but not if the primary intent is to prevent pregnancy.<sup>78</sup>

These policies have the greatest impact on women in rural areas. When Jane Phillips Medical Center in Bartlesville, Oklahoma, run by Ascension Health,

announced in 2014 that affiliated doctors could no longer prescribe birth control, it would have left only one OB/GYN licensed to do so. Thankfully, the hospital clarified that physicians retained the right to prescribe contraception when operating “under their own professional medical judgment.”<sup>79</sup>

### Nonpermanent Contraceptive Methods

“Catholic health institutions may not promote or condone contraceptive practices.”

—*Directives*, Directive 52

The *Directives* only allow the provision of information on natural family planning (NFP).<sup>80</sup> NFP refers to several methods of tracking a woman’s cycle and using periodic abstinence to prevent pregnancy.<sup>81</sup> Overall, the failure rate of NFP is 24 percent in the first year, according to the Centers for Disease Control and Prevention.<sup>82</sup> In 2011, only two percent of US Catholic women reportedly relied on NFP.<sup>83</sup>

Women are often surprised that the pill, IUDs and sterilization, among other methods, are not prescribed at Catholic hospitals or their affiliates.

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## There is one narrow exception to the ban on modern contraception in Catholic hospitals, and it’s not based on medical standards or scientific fact.

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One patient who was refused a tubal ligation as a result of delivering her second child within a Catholic healthcare system was subsequently refused a prescription for oral contraceptives because her OB/GYN “sold her practice to a Catholic health system.”<sup>84</sup>

### Emergency Contraception (EC)

There is one narrow exception to the ban on modern contraception in Catholic hospitals, and it’s

not based on medical standards or scientific fact. A woman who has been sexually assaulted may receive emergency contraception, but only after she has proved herself eligible—that is, she is demonstrably not pregnant. At issue is the allegation that all forms of EC can end a pregnancy, even though Plan B or levonogestrel, the most commonly dispensed form, does not act as an abortifacient.<sup>85</sup>

As Ascension Health, the largest Catholic health system in the nation, admits, there is no test to determine within 72 hours of unprotected sex if conception has occurred.<sup>86</sup> The test creates an unnecessary restriction, because EC does not interfere with the implantation of a fertilized egg.

Yet many Catholic hospitals will not dispense EC to “eligible” women. A 2005 survey showed that 55 percent of emergency rooms in Catholic hospitals refused to provide EC to sexual assault survivors. While many states were proactively working to pass legislation that requires hospitals to counsel survivors of sexual assault on EC, Catholic hospitals were at the forefront of the opposition to these efforts.<sup>87</sup>

On this issue, too, US Catholic women diverge from the bishops. A national survey from a five-year period (2006–2010) demonstrated that 11 percent of women, including Catholic women, had used EC.<sup>88</sup> Another survey revealed that 78 percent of Catholics preferred that their hospital offer EC to rape victims, and 57 percent believed it should be provided in broader situations at the woman’s request.<sup>89</sup>

### Sterilization

Sterilization has been a source of conflict in Catholic healthcare since the beginning of the *Directives*. In 2014, the Congregation for the Doctrine of the Faith, the Vatican’s office of doctrinal authority,<sup>90</sup> deemed sterilization “absolutely forbidden” both at Catholic hospitals and their affiliates.<sup>91</sup>

The *Directives’* ban on sterilization is not limited to tubal ligations, and also includes vasectomies. One patient at a Catholic hospital was refused a tubal ligation and a prescription for

contraceptives, and then her husband was refused a vasectomy, thus denying them the ability to plan their family according to their own best judgment.<sup>92</sup> Her husband’s doctor denied the procedure because his practice was also a part of a Catholic health system.

In Oregon, Bishop Robert Vasa of Baker, a member of the USCCB’s Task Force on Health Care, revoked the Catholic status of a hospital in his diocese, St. Charles Bend Hospital, after hospital administrators refused to stop performing tubal ligations.<sup>93</sup> In Texas, Bishop Alvaro Corrada of Tyler pressured CHRISTUS St. Michael’s hospital in Texarkana to stop performing tubal ligations when a report revealed that the hospital offered the medical procedure for sterilization.<sup>94</sup>

Several women have resorted to litigation to obtain surgical sterilization—and one was successful. In 2015, Rachel Miller was due to give birth by C-section. She wanted her doctor to perform a tubal ligation after delivery. Mercy Medical Center in California, a hospital under the Catholic Dignity Health umbrella, refused to allow the sterilization.<sup>95</sup> Miller would have been forced to travel to another hospital 150 miles away. Only after a lawsuit was filed alleging she suffered sex discrimination after being refused “pregnancy-based care” did the hospital reconsider and allow the tubal ligation to go forward following her delivery.<sup>96</sup>

The story of Jessica Mann, a pregnant 33-year-old diagnosed with a brain tumor, did not end so happily. Her nearby hospital, Genesys Regional Health, refused to perform the post-Cesarean sterilization her physicians ordered to spare her health the strain of future pregnancies. Genesys cited the *Directives*.<sup>97</sup> The ACLU filed a lawsuit on her behalf, as she was reluctant to leave behind her trusted physician, who had admitting rights only at Genesys.<sup>98</sup>

The ACLU summed up the unnecessary stressors Mann had to face while leaving her longtime doctor who was treating her brain tumor and finding a hospital willing to perform the sterilization. She had to “in less than a month, find a

new doctor, build rapport, get her up to speed on her precarious health condition, and convince her insurance company to cover treatment from her new, out-of-network provider.”<sup>99</sup>

Mann went public in an ACLU video out of what she called “an ethical obligation to fight for what is right and to be that voice for other women in the same situation or similar situation that I am in now.”<sup>100</sup>

## Assisted Reproductive Technologies

The assisted reproductive health technologies (ART) that help women have a family would seem to be an uncontroversial service for hospitals. In Catholic facilities, however, techniques that

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**In Oregon, Bishop Robert Vasa of Baker, a member of the USCCB’s Task Force on Health Care, revoked the Catholic status of a hospital in his diocese, St. Charles Bend Hospital, after hospital administrators refused to stop performing tubal ligations.**

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destroy extra embryos, that use donor sperm or eggs, or that employ artificial insemination—even by married couples—are prohibited by the *Directives*. Examples include IVF and using donor gametes. Surrogacy is also “not permitted” by the bishops’ rules because of the “uniqueness of the mother-child relationship.”<sup>101</sup>

One group of hospitals known to enforce the ban on ART is a collection of 22 Catholic hospitals in the Chicago area. According to the chair of the department of obstetrics and gynecology at Loyola University Health System, the group of hospitals “offers referral information,” but even then it’s

up to the individual physician as to whether to refer patients.<sup>102</sup>

### End-of-Life Issues

The *Directives* also block care for the terminally ill and patients living with chronic conditions. In 2009, a 90-year-old Oklahoma woman was incapacitated by a stroke. Her advanced directive indicated she did not want artificial hydration or nutrition if she could not recover.<sup>103</sup> The Catholic hospital where she was admitted, St. John Medical Center in Tulsa, OK, could not follow her wishes because it was bound by the *Directives*. Oklahoma's law requires that in such a situation, a patient should be transferred to a provider willing to comply.

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**Because the *Directives* are doctrine-based and not based on medical standards of care, it's no surprise that the bishops' policies collide with patient welfare.**

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The physicians at St. John attempted to transfer her, but the hospital administrators supported the patient's nephew, who requested they insert a feeding tube. The nephew relied on the intervention of Bishop Edward Slattery of Tulsa, who had previously ordered Catholic hospitals in his diocese to give such patients artificial nutrition and hydration.<sup>104</sup> The patient died while this debate was taking place.

The *Directives* also say that "suicide and euthanasia are never morally acceptable options."<sup>105</sup> Bishops in several states have fought "Death with Dignity" legislation aiming to legalize the practice at the state level. PeaceHealth, a large healthcare system in the western US, revealed in 2014 that it would not participate in care that hastens the

end of life. This includes not providing referrals or information and refusing to honor advance directives that "conflict with Catholic doctrine."<sup>106</sup> Facilities run by the Sisters of Providence health-care system in Seattle, Washington, are prohibited from even discussing the issue.<sup>107</sup>

### The Real Impact of the *Directives*

Because the *Directives* are doctrine-based and not based on medical standards of care, it's no surprise that the bishops' policies collide with patient welfare. Debra Stulberg, MD, and Lori Freedman, PhD, conducted a study on how OB/GYNs are affected by Catholic hospitals and found that 52 percent have had conflicts with the *Directives*,<sup>108</sup> to the point that many felt that the bishops' influence in clinical decisions is "indeed a part of their everyday reality."<sup>109</sup> One doctor stated that the "bishop has total control," and others expressed that the bishops prevent them from managing pregnancy complications as they were trained to do as medical professionals.<sup>110</sup> Jason, a pediatric subspecialist at the largest freestanding Catholic children's hospital, told NPR that his healthcare delivery is "frequently affected by Catholic doctrine" because he works at a Catholic institution.<sup>111</sup>

Nevertheless, some Catholic medical ethicists have tried to depict the bishops' rules as flexible enough not to interfere with medical practice. In a 2014 article,<sup>112</sup> Ron Hamel stated that the *Directives* "must always be taken into account with the clinical situation" because "ethical considerations cannot be raised in a vacuum." He then related some best-case scenario applications of the *Directives*, assuring that during pregnancy complications "respecting human dignity in these cases means seeking the well-being of both mother and fetus *to the degree that it is possible.*" [italics added]. This ambivalent support for women's health does not translate well into a clinical setting. Tameisha Means and Savita Halappanavar are prime examples of how little is "possible" for pregnant women in distress.

The *Directives* fail the test of real-life medical care.

## E. Collusion with the Bishops

**W**ithin the world of Catholic healthcare, the *Directives* are a real stumbling block to the delivery of comprehensive care. But the bishops' healthcare policies are only a small part of the larger problem.

Sr. Carol Keehan, president of CHA since 2005, has remained in the top 40—usually the top 20—of the most influential people in healthcare since 2010. The trade association for Catholic hospitals usually works hand in glove with the bishops' conference. CHA has been instrumental in constructing the very Catholic healthcare machine that disregards patient and provider rights. Like the USCCB, CHA is well funded, produces considerable revenue and reaps the benefits from working under the law that grants tax-exempt status to charitable organizations.

### Lobbying

CHA is designated by the IRS as a 501c(3) organization, which means that there are restrictions on lobbying and advocacy, although they still may dedicate a considerable portion of their assets to these pursuits. In 2013, CHA spent more than \$5 million on lobbying and advocacy activities to “shape the impact of federal legislation and policies to strengthen the viability of the Catholic health ministry.”<sup>113</sup>

The USCCB is also a 501c(3) organization,<sup>114</sup> and it, too, spends a considerable amount on lobbying and advocacy activities. The USCCB reported \$108 million in policy activity expenditures for the year 2014, including \$2.3 million specifically for anti-choice advocacy.<sup>115</sup> This figure represents 78 percent of the current operating fund for that year.<sup>116</sup>

After a 2009 *New York Times* story depicted CHA and USCCB following different policy objectives,<sup>117</sup> Sr. Keehan stated, “There is not a shred of disagreement between CHA and the bishops” in their fight against federal funding of abortion.<sup>118</sup> There is ample evidence to back up Keehan's assertion.

The bishops' conference frequently advocates for the same policy positions as the Catholic Health Association, when they are not writing joint letters to Congress. For instance, in 2015, members of Congress received a letter urging them to support the Abortion Non-Discrimination Act (ANDA), which would permanently codify the right of individual and institutional healthcare providers to refuse to provide, cover or refer for abortion. Archbishop Joseph E. Kurtz, president of the USCCB, and Sr. Carol Keehan of CHA were among the signatories.<sup>119</sup>

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**The bishops' conference frequently advocates for the same policy positions as the Catholic Health Association, when they are not writing joint letters to Congress.**

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The USCCB's Secretariat of Pro-Life Activities writes Congress regularly advocating the limitation of abortion access through legislation such as ANDA<sup>120</sup> or the Hyde Amendment, which limits the use of certain federal funds from paying for abortion.<sup>121</sup> In 2014, the USCCB took a stance against the inclusion of abortion coverage in managed care plans.<sup>122</sup> In 2016, the USCCB advocated for the Conscience Protection Act, which was based upon ANDA.<sup>123</sup>

CHA has also written to Congress in favor of the Conscience Protection Act<sup>124,125</sup> the Abortion Nondiscrimination Act,<sup>126,127</sup> and against the inclusion of comprehensive reproductive health services under the Affordable Care Act.<sup>128</sup> In 2011,

CHA wrote to Congressman Joseph R. Pitts in support of his bill, the Protect Life Act, which would prevent women from buying health insurance plans covering abortion under the Affordable Care Act.<sup>129</sup> The USCCB also supported the Protect Life Act.<sup>130</sup>

## Healthcare Reform

During the healthcare reform debate CHA emerged as a strong voice, particularly on the subject of federal funding for abortion. In 2010, Rep. Paul Ryan depicted CHA's support as definitive: "Do you think the Catholic Hospital Associations of America would endorse this bill if this was a pro-abortion bill?"<sup>131</sup> When the bill passed, President Obama gave

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**Working to make no-copay contraception unavailable to a large group of women workers does not expand access to healthcare. Nevertheless, the US bishops have waged their counterintuitive campaign in the press and in courtrooms.**

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a significant nod to CHA's Sr. Carol Keehan, saying, "We would not have gotten the Affordable Care Act done had it not been for her."<sup>132</sup>

Richard Doerflinger, longtime associate director of Pro-Life Activities at the USCCB, was well-known on Capitol Hill before leaving his post in 2016. A 2010 National Public Radio profile said Doerflinger had "emerged as a major player in the health care debate, one likely to play a pivotal role in the outcome."<sup>133</sup> According to the Huffington Post, "Doerflinger says he has been helping lawmakers write anti-abortion bills behind the scenes for decades, including the Stupak Amendment."<sup>134</sup>

The Stupak amendment prohibited individuals from buying health insurance that covers abortion, even if they pay for the abortion component with their own money. It passed in the House of Representatives in 2009.

Doerflinger was cited in Congress as an authority on healthcare reform<sup>135</sup> as well as the Hyde Amendment,<sup>136</sup> and thanked for his "incredible contribution" to discussions on preimplantation genetic diagnosis.<sup>137</sup>

## Affordable Care Act Contraception Policy

The Department of Health and Human Services (HHS) announced on August 1, 2011, that contraception would be included in the preventive services expected to be covered in employee health plans under the Affordable Care Act.<sup>138</sup> That same day, the USCCB issued a press release protesting the rule. Cardinal Daniel DiNardo, Archbishop of Galveston-Houston, Texas, wrote:

"Could the federal government possibly intend to pressure Catholic institutions to cease providing health care, education and charitable services to the general public? Health care reform should expand access to basic health care for all, not undermine that goal."<sup>139</sup>

Of course, working to make no-copay contraception unavailable to a large group of women workers does not expand access to healthcare. Nevertheless, the US bishops have waged their counterintuitive campaign in the press and in courtrooms, with a suit led by Bishop Zubik ending up in the US Supreme Court in early 2016.<sup>140</sup>

In July 2013, CHA released a statement indicating its agreement<sup>141</sup> with the amended policy, which contained certain accommodations for religiously-affiliated institutions, like Catholic hospitals—though not all the provisions requested by the bishops. "If you look at the final regulations it is very clear that we do not have to contract for, or pay for, or arrange for' contraception coverage," Keehan said in an interview.<sup>142</sup>



## F. Catholic Teachings and the Conscience

**W**hen a woman who is miscarrying is not informed of her treatment options, or not treated at all, this violates civil ideas of ethics, such as the American Medical Association’s expectation that a “physician shall, while caring for a patient, regard responsibility to the patient as paramount,” which means providing care with “respect for human dignity and rights.”<sup>143</sup> But the *Directives* also conflict with Catholic teachings.

Catholicism places a primacy upon the individual conscience. The *Catechism* states that “a human being must always obey the certain judgment of his conscience.”<sup>144</sup> The conscience, often called a “still small voice,”<sup>145</sup> is a great equalizing factor because every person has one. The problem with the bishops’ influence in Catholic healthcare is that according to the *Directives*, “each person must form a *correct* conscience based on the *moral norms* for proper health care.”<sup>146</sup> (italics added). This means that patients are not allowed to follow their own conscience in making reproductive health decisions at Catholic hospitals.

Fr. Richard McBrien, a well-respected theologian, wrote in his study *Catholicism* that even in cases of a conflict with the moral teachings

of the church, Catholics “not only may but must follow the dictates of conscience rather than the teachings of the Church.”<sup>147</sup> And the many patients at Catholic hospitals who are of other faiths or no faith are protected by Catholic teachings as well. The Second Vatican Council’s Declaration on Religious Freedom stated that religious freedom “means that all men are to be immune from coercion on the part of individuals or of social groups and of any human power, in such wise that no one is to be forced to act in a manner contrary to his own beliefs.”<sup>148</sup>

But Catholic healthcare rarely follows this Catholic teaching. According to scholar Roberto Blancarte, Catholicism is still ambivalent about pluralism even after the Declaration on Religious Freedom was issued in 1965. Blancarte says that in the document itself there is a tension between “religious freedom” belonging to everyone and the “freedom of the church.”<sup>149</sup>

The bishops and Catholic healthcare administrators must be aware that Catholic healthcare serves people of many faiths and no faith. They must feel that providing doctrinally bound care suits the freedom of the church and doesn’t present a problem for the individual conscience.

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## G. Catholics Disagree with the *Directives*

**W**hen Catholic healthcare facilities refuse care, punish doctors and put patients at risk by following the *Directives*, they do so against the wishes of the

majority of Americans—and notably, against American Catholics. The great majority of American Catholics believe that the primacy of conscience means that every person possesses

the moral wisdom necessary to make their own moral decisions—and should respect the rights of others to do the same.

Catholic healthcare entities that refuse to

provide certain services under the *Directives* still receive substantial amounts of government funding to serve the public and community's needs.

Catholics ardently disagree with this practice.

## Hospitals and Clinics That Take Taxpayer Dollars



**Seventy-seven percent** of US Catholic voters oppose refusal to provide certain procedures and medications to patients.<sup>a</sup>



The majority of Catholic Millennials (**58 percent**) believe similarly that it should be illegal for Catholic institutions to refuse to provide medical procedures on religious grounds.<sup>b</sup>

The bishops certainly have a right to voice their opinions on public policy, yet those opinions should not be construed to represent what the majority of Catholics believe on many issues, especially health-care. In reality, American Catholics disagree with the bishops on issues regarding individual health

decisions. Catholics' views on healthcare issues extend to both a belief in social justice and disapproval of using religion to discriminate inside and outside of the hospital. When considering healthcare entities that restrict treatment options in compliance with the *Directives*, Catholics clearly disagree.

## Catholic Opinion and the *Directives*

### Pharmacies and birth control prescriptions



**Seventy-six percent** of Catholic voters do not agree with withholding prescriptions for religious reasons.<sup>c</sup>

### Doctors assisting a terminally ill patient in ending his or her own life



**Fifty-two percent** of Catholic voters support this being legal,<sup>d</sup> and 61 percent of Catholic Millennials agree.<sup>e</sup>

### Stem cell research



**Seventy percent** of Catholic voters support using human embryos for research to find cures for disease.<sup>f</sup>

## Respect for Women's Conscience

Hospitals following a bishop's directive and refusing to perform an abortion necessary to protect a woman's health



Sixty-eight percent of Catholic voters disapprove of this practice.<sup>g</sup>

Insurance coverage for birth control, regardless of where women work



Seventy-one percent of Catholic voters support.<sup>h</sup>

### Legal status of abortion



Eighty-four percent of Catholic voters believe abortion should be legal in some or all circumstances. Ten percent believe abortion should never be legal, and six percent said they didn't know.<sup>i</sup>

## The Bishops' Directions to Voters

Despite the continued lobbying by the USCCB and others, Americans—including Catholics—are not persuaded that Catholic voters should vote according to the Catholic bishops' views.

### Voting according to the bishops' directions



Eighty-nine percent of Catholic voters disagree.<sup>j</sup>

- a. Beldon Russonello Strategists, Catholic Voters and Religious Exemption Policies Report of a National Public Opinion Survey For Catholics for Choice, Call to Action, DignityUSA and Women's Alliance for Theology, Ethics and Ritual (WATER) October 2014, p. 7. <http://www.catholicsforchoice.org/wp-content/uploads/2014/11/11.17.14-National-Catholic-Voters-Survey-2014.pdf>
- b. Beldon Russonello Strategists, The Views of Catholic Millennials on the Catholic Church and Social Issues, June 2015, p. 18. [http://www.catholicsforchoice.org/wp-content/uploads/2016/12/2015\\_BRS\\_Catholic\\_Millennials-2.pdf](http://www.catholicsforchoice.org/wp-content/uploads/2016/12/2015_BRS_Catholic_Millennials-2.pdf)
- c. See above, n. a, p. 6.
- d. Ibid., p. 16.
- e. See above, n. b, p. 7.
- f. See above, n. a, p. 16.
- g. See above, n. a, p. 12.
- h. Beldon Russonello Strategists, *National Public Opinion Survey for Catholics for Choice*, (Cross Tab Tables), 2014, p. 26. On file with the authors.
- i. Ibid., p. 35.
- j. See above, n. a, p. 14.

# H. The Expanding Reach of Catholic Healthcare

Researchers Lori Freedman and Debra Stulberg asked in a recent article, “What do individual patients, the public and policy makers know about Catholic health care?”<sup>151</sup> When it comes to mergers, the answer is often “very little.” When Catholic entities merge with non-religious hospitals, Catholic facilities bring confusing and hidden restrictions to the way a secular hospital operates. Without a good understanding of the double effect rule, for instance, a secular hospital might not understand the serious limitations the *Directives* place on miscarriage management.

Catholic mergers are touted like any business deal: In 2011, Seattle, Washington, was assured that the merger between a secular and Catholic hospital would benefit the community: “Swedish and Providence Join Forces to Improve Health Care.”<sup>152</sup> But much more goes on beneath the surface and, after decades of Catholic mergers, certain patterns have become evident. The list below focuses on reproductive health impacts, but mergers also deserve scrutiny on a financial level. According to a 2007 analysis in the *Journal of Health Economics*, membership in a multi-hospital partnership was associated with significantly higher prices.<sup>153</sup>

## Catholic Hospitals Tend to Have a Financial Advantage

- In August, 2015, Catholic-run Ascension Health signed a definitive agreement to make the secular Crittenton Hospital Medical Center a part of the Ascension Health Michigan network.<sup>154</sup> The *Wall Street Journal* reported that “untaxed investment gains” had helped increase Ascension Health’s 2007 net income to \$1.2 billion, commenting, “That’s more cash than Walt Disney Co. has.”<sup>155</sup>

By contrast, Crittenton had lost \$22.2 million on operations in 2013. CEO Roy Powell indicated that the merger meant there would be “limited impact” on the hospital services that did not comply with Catholic policy. Nevertheless, the alliance with the wealthier Catholic system came at a cost. In January 2015, tubal ligations were offered on Crittenton’s website.<sup>156</sup> By mid-2016, they were not.<sup>157</sup>

- “The Catholic churches and ministries are in a special position, in large part because of special exemptions and no-tax status they get from laws governing religious institution,” said Monica

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Harrington, co-chair of Washington Women for Choice and editor of the CatholicWatch blog.”<sup>158</sup> For instance, PeaceHealth, a Catholic health system, has a lucrative contract with the San Juan County Public Hospital District No. 1. According to 2011 terms, the district collects property taxes to fund PeaceHealth, and it must not compete with PeaceHealth for the services it offers. The tax subsidy totaled nearly \$1.5 million.<sup>159</sup>

## Mergers with Catholic Hospitals Are Controlled by the Local Bishop

- According to the *Directives*, bishops must examine and approve the terms of partnerships. They also have the power to halt agreements, as Bishop Richard Lennon of Cleveland did in 2013. He rejected a proposed merger between Catholic Health Partners and Summa Health System (SHS) because the contract stated Summa would not be subject to the *Directives*.<sup>160</sup>

In September, the deal was restructured so that HealthSpan Partners, an auxiliary organization registered by Catholic Health Partners, would acquire minority ownership of SHS. Summa, meanwhile would not be subject to the *Directives* and for 10 years could not be prohibited from providing procedures such as tubal ligations, vasectomies or contraception.<sup>161</sup>

By October, HealthSpan had joined the Kaiser Foundation Health Plan of Ohio. Spokesman Chuck Heald stated that HealthSpan would provide contraception, but that abortion and sterilization could be accessed by outside facilities.<sup>162</sup>

## Terms are Subject to Change by the Bishop

- Directive 72 refers to “binding agreements” with other healthcare organizations,<sup>163</sup> yet instructs that these agreements must be periodically assessed to ensure that they are in keeping with Catholic teachings. In 2001, Bishop James Sullivan of Fargo, North Dakota, ordered the Carrington Health Center to stop performing sterilizations. Sullivan reasoned that the original agreement between Carrington and the Denver-based Catholic Health Initiatives, which allowed tubal ligations, was flawed and not consistent with “certain teachings of the church.”<sup>164</sup>

## Agreements with Catholic Hospitals Can Become More Conservative Over Time

- In Manchester, New Hampshire, Catholic Medical Center (CMC) and Elliot Hospital announced in 1993 that they would merge into Optima

Healthcare. Elliot had provided abortions under limited circumstances, but controversy arose after an abortion was scheduled there in 1997, years after the service had supposedly been eliminated. “To appease the Catholic partners in Optima, the system’s board of directors voted to ban all abortions except in cases where the fetus was not viable,” the *St. Petersburg Times* reported.<sup>165</sup>

Subsequently, a local obstetrician, Dr. Wayne Goldner, wanted to schedule a termination at Elliot for a woman whose health was at risk. She

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**“When these mergers are negotiated, the terms are based on who the bishop is that day. If the bishop changes, all the rules and interpretations change too.”**

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was pregnant with a fetus with almost no chance of survival, and Elliot claimed to allow terminations for women whose lives were in danger.<sup>166</sup> The hospital would only accommodate Goldner’s request if he put a different diagnosis on the paperwork, or else he was told he could “wait until she has an infection or she gets a fever.”<sup>167</sup> Goldner refused, and his patient took an 80-mile taxi ride to a different facility.<sup>168</sup>

Dr. Goldner told the *Times*, “When these mergers are negotiated, the terms are based on who the bishop is that day. If the bishop changes, all the rules and interpretations change too.”<sup>169</sup>

- In October 2011, Seattle’s Swedish Hospital announced it would stop performing “elective abortions” as part of its affiliation with Catholic-run Providence Health & Services, but that it would “not become a Catholic organization.”<sup>170,171</sup> By 2014, Swedish claimed that it still did not

follow the bishops' *Directives*.<sup>172</sup> Yet one year earlier, Mary was denied a termination at Swedish Hospital because "[t]hey had to wait for the heart-beat to stop."<sup>173</sup> Catholic-run hospitals tend to have rules in place forbidding intervention before fetal heart tones stop,<sup>174</sup> and these policies can be traced to directives like number 45, and to the double effect rule, suggesting that the bishops' policies had been implemented there.

According to CatholicWatch.org, the 2011 attempt to paint the post-merger Swedish hospital as secular was a strategy to whitewash the merger deal "until all potential for criticism of the new business deal is gone."<sup>175</sup>

- Though University of Louisville Hospital called off the merger with Catholic Health Initiatives in

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## The Vatican vetoed the merger because it "poses too great a risk that Catholic teaching might be blurred or Catholic moral practices might be violated."

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2012, shortly thereafter the University Hospital announced it would partner with KentuckyOne Health, a system majority-owned<sup>176</sup> by Catholic Health Initiatives.<sup>177</sup> The new agreement says that the University Hospital has to "'respect' Catholic policies."<sup>178</sup>

In 2016, the University of Louisville exited from a contract that would have allowed Planned Parenthood patients experiencing post-abortion complications to receive care at the hospital. KentuckyOne Health said that it faced "incredible" outside pressure to stop the agreement, according to the *Courier-Journal*. Under a Kentucky law passed in March 2016, abortion clinics must have

a transfer agreement with a hospital to qualify for a license.<sup>179</sup> A new Planned Parenthood clinic had been seeking this agreement with the University of Louisville hospital.<sup>180</sup>

## Bishops Can be Overruled by the Vatican

- US Bishops are part of the global Catholic hierarchy that is centered in the Vatican in Rome. Occasionally, the Vatican will intervene on doctrinal matters, which can include the terms of a proposed merger or the services provided at a Catholic-run or -affiliated hospital.

In 1997, the Vatican halted a merger between St. Peter's Medical Center and the Robert Wood Johnson University Hospital, a secular facility, both located in New Brunswick, New Jersey. Bishop Edward Hughes of Metuchen had already approved the deal, which stated that Robert Wood Johnson would not perform any procedures that conflict with Catholic teaching. Bishop Edward T. Hughes of Metuchen, NJ, issued a statement explaining that the Vatican vetoed the merger because it "poses too great a risk that Catholic teaching might be blurred or Catholic moral practices might be violated."<sup>181,182</sup>

## Merger Terms Are Often Kept in Secrecy

- The public University of Louisville Hospital began negotiating a merger with Catholic Health Initiatives and Jewish Hospital in 2010, but Louisville Archbishop Joseph E. Kurtz waited nearly a year to make a statement about how the deal would affect the university hospital's identity or its services. On August 5, 2011, *USA Today* reprinted an interview between Kurtz and the *Courier-Journal* in which the archbishop stated he "couldn't foresee a situation in which University or Jewish hospitals would operate under Catholic ownership without also following the formal Ethical and Religious Directives for Catholic Health Care Service."<sup>183</sup>

Jack Conway, the Kentucky Attorney General, issued a report shortly thereafter referring to this new understanding: "While this evolving

explanation may represent an accurate description of the proposed legal structure of the consolidation, it has cast a cloud of vagueness and skepticism over the issue in the public eye.”<sup>184</sup> Gov. Steve Beshear called off the merger in December 2011.<sup>185</sup>

## Mergers Can be Structured to Avoid Oversight

- A merger proposed in 2014 between Providence Health & Service and St. Joseph Health, two Catholic hospital systems, involved nearly 50 hospitals in seven western states.<sup>186</sup> In 2016, 13 advocacy organizations and the nation’s largest nurses’ union petitioned Oregon Attorney General Ellen Rosenblum not to waive a standard public review of the deal.<sup>187,188,189</sup> The advocacy groups were concerned that the non-Catholic hospitals in the two systems, some of which were then providing some reproductive health services, would stop this type of care without community input.<sup>190</sup> Subsequently, Rosenblum did approve the merger without conducting a public review.<sup>191</sup>

In Washington state, for example, hospitals can avoid merger regulations by calling the deal an affiliation, partnership or collaboration. According to ProPublica, “the Swedish-Providence deal did not go through a full review, even though the combined health care system is by far the largest in the state” because there was no sale, purchase or lease of a hospital.<sup>192</sup>

## Catholic Mergers Have Church-State Implications

- As seen above, PeaceHealth receives tax subsidies to provide religiously circumscribed care, and it has an essential monopoly on healthcare in the region. Public moneys should not prevent the public from being able to access the care they need. Some have pointed out that these arrangements violate the separation of church and state guaranteed by the First Amendment.

Citizens in Newport, Oregon, used this reasoning to challenge a proposed merger between the Catholic-run Providence Health System and the government-owned Pacific Communities Health

District. The community was concerned that the merger stipulated that the district would have to respect the Catholic system’s “mission and values,” including the *Directives*.

Litigations lasted from 1999 to 2002, though the case was dismissed after Providence Health withdrew the merger offer. The litigation offers

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## Public moneys should not prevent the public from being able to access the care they need.

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some interesting objections to the agreement. One point of hesitation was regarding the transfer of government assets and operations to a religious entity. The “government shell” would continue to exist, implying a violation of the Constitution, which prohibits giving religion power over the government or preferring one religion over others—in this case, preventing Newport residents who were not Catholic from the free exercise of their beliefs.<sup>193</sup>

The constraints placed upon healthcare provision, particularly reproductive healthcare, by the *Directives* was also discussed.

Attorney Arthur B. LaFrance, counsel for the residents’ committee, reasoned that if religious groups “accept no public benefit, they need accept no public burdens. But the very purpose of the *Directives* is to respond to a health care context that, over the past decades, has interwoven all providers into a complex health care tapestry.” La France explained that this relationship is uncomfortable for the bishops “precisely because there is no escape; all hospitals, including Catholic hospitals, are in a sense “public.”<sup>194</sup>

These contradictions in Catholic partnerships were not resolved in Newport but they have recurred again and again in later mergers.

## Brackenridge Hospital, Austin, Texas: How Hospital Affiliations Have Become More Conservative

The cooperation between Catholic Seton Healthcare and Brackenridge Hospital, a public facility, began in 1995. Over the next 20 years, the two hospitals moved from a cooperative model of assuring reproductive healthcare to finally outsourcing it entirely. Brackenridge closely mirrors changes in the *Directives* and their enforcement by the Catholic hierarchy during the same period and today.

Year	Relationship between the 2 hospitals	Reproductive healthcare
1995	<ul style="list-style-type: none"> <li>• Seton Healthcare signs 30-year lease to operate Brackenridge, a public hospital<sup>195</sup></li> <li>• Conservative Catholics wrote to the Vatican in protest<sup>197</sup></li> <li>• The same year, the pope issued an encyclical warning administrators of Catholic health facilities that if they bend the church rules on reproductive services, their institutions could lose Catholic sponsorship.<sup>198</sup></li> </ul>	<ul style="list-style-type: none"> <li>• City council arranged for reproductive healthcare (except abortion) to continue at Brackenridge<sup>196</sup></li> </ul>
June 1997	<ul style="list-style-type: none"> <li>• The Congregation for the Doctrine of the Faith wrote to Bishop John McCarthy of Austin, instructing him to stop sterilizations and contraception at Brackenridge<sup>199</sup></li> </ul>	
September 1997	<ul style="list-style-type: none"> <li>• Bishop McCarthy defends the lease, saying, “every effort has been made to seek conformity with church teaching.”<sup>200</sup></li> </ul>	
August 1998	<ul style="list-style-type: none"> <li>• City negotiates amendment to lease.<sup>201</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Salaries for those providing sterilizations segregated from Seton<sup>202</sup></li> </ul>
2000		<ul style="list-style-type: none"> <li>• Approximately 400 sterilizations offered this year<sup>203</sup></li> </ul>
September 2000	<ul style="list-style-type: none"> <li>• Vatican instructs USCCB to revise <i>Directives</i> regarding relationships with non-Catholic hospitals.<sup>204</sup></li> </ul>	



June 2001	<ul style="list-style-type: none"> <li>USCCB releases new <i>Directives</i>. Catholic entities must ensure that merger arrangements are “consistent with Catholic teachings.” Sterilization is called “intrinsically immoral” for the first time.<sup>205</sup> “As one bishop put it: “Not only can’t you do it, but you can’t help others do it.”<sup>206</sup></li> </ul>	
October 2001	<ul style="list-style-type: none"> <li>Brackenridge recommends moving reproductive healthcare to a designated floor.<sup>207</sup> The city agrees to reimburse Seton \$9 million for renovations.<sup>208</sup></li> </ul>	<ul style="list-style-type: none"> <li>Sterilizations, contraception and in vitro fertilization will be offered on a 5th floor facility run by the University of Texas Medical Branch with separate elevators and entrances.<sup>209</sup></li> </ul>
Oct 2004	<ul style="list-style-type: none"> <li>Central Health hospital district, a new entity jointly run by Seton and voted for by city residents, begins operation. Central Health will own Brackenridge.<sup>210</sup></li> </ul>	
2007-2009		<ul style="list-style-type: none"> <li>Forty-five percent of women who delivered children at Brackenridge did so on the 5th floor; almost 1/3 of those had tubal ligations afterwards.<sup>211</sup></li> </ul>
February 2012	<ul style="list-style-type: none"> <li>Fifth-floor facility closes due to financial losses.<sup>212</sup></li> </ul>	<ul style="list-style-type: none"> <li>A new contract makes reproductive healthcare, including sterilizations, available one mile away from Brackenridge at St. David’s Medical Center (originally affiliated with the Episcopal church.)<sup>213</sup></li> </ul>
June 2013	<ul style="list-style-type: none"> <li>Agreement between Seton, University of Texas and Central Health to tear down Brackenridge and build the jointly held Dell Medical School, which will be subject to the <i>Directives</i>.<sup>214</sup></li> </ul>	<ul style="list-style-type: none"> <li>Contracts for faculty and residents prevent them from providing abortions, in vitro fertilization or contraception.”<sup>215</sup></li> </ul>
2016	<ul style="list-style-type: none"> <li>Three of four abortion clinics in Austin have closed.<sup>216</sup></li> </ul>	
2017	<ul style="list-style-type: none"> <li>Estimated opening of Dell Medical School<sup>217</sup></li> </ul>	

# Conclusion

Catholic healthcare is critically important in the US. One in six hospital beds is Catholic owned or affiliated, serving 5 million patients every year. Catholic healthcare institutions provide more than 515,000 full-time jobs, comprising 17 percent of all hospital staff in the US. They make up 20 percent of the sole community hospitals, meaning that millions of Americans rely on Catholic hospitals as their sole source of healthcare. Four of the top ten hospital systems are Catholic. They are recognized as prestigious institutions with quality care and compassionate providers.

However, the magnitude of Catholic healthcare does not provide the complete picture of its significance. In fact, we have seen how the perceptions of Catholic healthcare can be misleading to the point of dangerous.

Catholic hospitals were founded on the idea of providing care to those who need it most. Yet, charity care at Catholic hospitals averages less than at secular hospitals, at 2.8 percent compared to 5.6 percent. At the same time, they have continuously increased their revenue, and the top eight Catholic health systems in 2014 had on average 48 percent of their patient charges from the public dollars of Medicare and Medicaid.

Catholicism is grounded on individual conscience, and this teaching should be reflected in Catholic healthcare. However, the *Directives* are in direct conflict with this teaching, where individuals like Tamesha Means and Jessica Mann are restricted from following their conscience and instead are put in life-threatening circumstances during a miscarriage or high-risk pregnancy. Providers are similarly denied the ability to rely on their conscience to provide care in the best interest of their patients. Stories like that of Dr. Y, who must revert to providing care for patients with ectopic pregnancies outside of the Catholic hospital in which she is employed, demonstrate the

hurdles she is confronted with when the *Directives* restrict her from providing the conscience-driven care she believes in.

Local bishops and the US Conference of Catholic Bishops claim to speak for Catholics' needs and wants. But we know they are getting it wrong. Millions of Catholics and non-Catholics seek care at these hospitals, and are often unaware of their restrictions. Even more so, Catholic patients actually disagree with the *Directives*. Six in ten US Catholics oppose the idea that Catholic hospitals that take taxpayer dollars should be allowed

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**Local bishops and the US Conference of Catholic Bishops claim to speak for Catholics' needs and wants. But we know they are getting it wrong.**

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to use religious beliefs as a reason to withhold certain medical procedures and medications. However, mergers between secular and Catholic systems are still controlled by the local bishops, resulting in the imposition of the *Directives* on secular institutions and blatant disregard for best medical practice.

Catholic hospitals claim to help women. This isn't the reality when providers at Catholic institutions are required to favor the potential life of the fetus over the woman's health. Similarly, survivors of sexual assault seeking Emergency Contraception, an exception within the *Directives*, do not receive the help they need when they are

continuously turned away. Women like Rachel Miller and Jessica Mann are denied help and they are expected to travel over 150 miles or find a new doctor to receive surgical sterilization, even when the reason is to avoid a high risk pregnancy.

Catholic healthcare is growing every year and is unlikely to be permanently dismantled. It plays a critical role in providing healthcare, particularly for those with low incomes or those who live in rural areas. Until Catholic healthcare is exposed for the dangerous business it is, women will continue to be denied life-saving procedures and continue to be denied their conscience.

Whoever you are, there are several things you can do to protect access to reproductive healthcare for patients who seek these services at Catholic hospitals and for healthcare professionals who feel compelled to deliver this care. So, what steps can YOU take right now?

**If you are a healthcare consumer, ensure you are able to access the care you need by:**

- Finding out what restrictions might be in place at your local hospitals and health centers.
- Writing to your legislator asking for proactive measures to protect your access to healthcare at hospitals that might have religious restrictions from the *Directives*.
- Engaging in community input when a local merger/acquisition of a secular and religious institution is happening in your community.

**If you are a healthcare provider, provide care in the best interest of your patients by:**

- Interpreting the *Directives* in the broadest sense to provide the care your patients need.
- Providing timely referrals for your patients who need services restricted by your institution.
- Ensuring your patients receive comprehensive information about where to seek the services they need.
- Asking for written confirmation regarding the policy on delivery of restricted services

from officials at your institution or for those at which you have privileges.

**If you are an elected official, protect your constituents' access to reproductive health services by:**

- Supporting legislation that
  - Ensures institutions receiving tax-payer dollars are providing the full range of healthcare, including reproductive health services,
  - Ensures reproductive healthcare in emergent situations,
  - Ensures access to information where providers or institutions are allowed to refuse services on the basis of religion, and
  - Ensures that mergers between religious and secular institutions are regulated and community health options are given proper oversight.
- Seeking information and asking specific questions of the administration of local area Catholic hospitals in your district.
- Writing, speaking and educating your community about your concerns regarding the lack of access to reproductive healthcare and other restricted services in local Catholic healthcare institutions.

**If you are a journalist, share the truth about Catholic healthcare by:**

- Exposing the breadth and power of the *Directives* through mergers, patient stories and provider conflicts.
- Highlighting stories of mismanaged care for reproductive health services in your community.

We are a nation built on the foundation of freedom of religion and freedom from religion. We must not abandon those principles when our very lives depend on them. Catholic healthcare can and should do better. It is up to each of us to protect access to the healthcare that people need and the respect for conscience-based decisions that they deserve.

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