Emerging issues in Catholic healthcare: Do no harm?

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Emerging issues in Catholic healthcare: Do no harm?

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of the Prerequisite for Honors in Religion

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Introduction

This thesis explores the legal and ecclesiastical challenges that arise in Catholic healthcare, and specifically examines issues that arise when Catholic hospitals merge with secular hospitals. I identify the legal and ecclesiastical issues Catholic hospitals face and those that affect Catholic-secular hospital mergers. I consider the legal and ecclesiastical issues that help explain the failure of some mergers. My goal is to clarify the complex interplay of religion and government in this large segment of health care in the United States.

My interest in this topic began with a Facebook post in April 2013. My aunt posted an article from The Stranger, an alternative arts and culture magazine published in Seattle, and I clicked on the link and read the article titled “Faith Healers.” It details a recent hospital affiliation between Providence Health Systems, a Catholic healthcare system, and Swedish Medical Center, which is secular. The article’s author chronicles the story of an anonymous woman—she called her “Mary”—who is pregnant and who begins to experience a miscarriage. She goes to Swedish Hospital to try to save the fetus. Her doctor informs her that the fetus is dying and she will ultimately miscarry. Mary wants the doctor to abort the unviable fetus in order to prevent serious medical complications that can accompany miscarriage. The doctor refuses her request because the fetus still has a heartbeat, and due to the affiliation with Providence, Swedish can no longer perform abortions of fetuses with heartbeats. As the woman is debating whether to go to another hospital, the fetal heartbeat stops and the doctor is able to remove the fetus. However, the author of the article explained, the woman continues to wonder what would have happened if the fetal heartbeat hadn’t stopped for another few days. Would she
have experienced the life-threatening complications of miscarriage that caused the death of Savita Halappanavar in Galway, Ireland.

This story simultaneously frightened and fascinated me because my brother, my mom and I, my grandma, aunts, uncles, and most of my cousins were born at Swedish. Five of my relatives either work there currently or have worked there in the past, including both of my grandfathers; indeed, Tppers and/or Bridges have worked at the hospital over half of the one hundred and fourteen years it has been in existence. It is our “family hospital”—where births happen, where my grandfather died, and where we’ve all gone for various injuries and ailments. And reading this story about the effects of the merger with Providence and its potential consequences for quality of care shocked me.

My interest sparked, I began researching Catholic healthcare in general and Catholic and secular hospital mergers in particular. In this preliminary research I learned that one in six hospital beds in America are in Catholic hospitals, and Catholic hospitals make up seven of the top ten largest non-profit healthcare systems. Part of this growth is due to mergers between Catholic and secular hospitals, which have occurred for the last twenty-five years. The MergerWatch Project, an organization that advocates against mergers that introduce religious doctrine into medical care, estimates that since 1997 there have been over one hundred and forty agreements/affiliations/mergers between Catholic and secular hospitals.

Exploring the aftermath of these affiliations revealed the tremendous complexity of merging Catholic and secular healthcare systems and hospitals. Each merger was different. After some mergers, all the OB/GYNs on staff were removed; in others the hospitals stopped providing abortions but maintained all other reproductive services; in still other situations, the

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1 Halappanavar died of medical complications when doctors refused to perform an abortion because the fetus still had a heartbeat. Her death inspired protests in Ireland, the UK, and India (her home country).
hospital retained maternal care but stopped providing the core reproductive services—abortions, sterilizations, and contraceptives. Although I considered looking at a variety of mergers to assess the overall loss of services and to determine if there was a national trend, I found I couldn’t identify a national pattern since many hospitals did not disclose information about services lost after a merger.

I also found in my preliminary research that despite the fact that the Affordable Care Act (ACA) is currently the most hotly-debated issue with healthcare and the Catholic Church, the Church’s opposition to the ACA has not been particularly relevant in hospital mergers. There are a few reasons for this. First, the ACA is so new that no hospital merger I could find depended on rejection of the ACA or even discussed the ACA. Additionally, the debate about the ACA centers on the mandate to provide insurance covering contraceptives. The biggest legal and ethical issues in hospital mergers are abortions and sterilizations. Contraceptives are essentially a tertiary concern in these mergers and their consequent legal and ethical issues. Finally, I did not write about the ACA because hospitals and insurance providers are fundamentally different, and I did not believe I could effectively cover (and integrate) two such different topics in one thesis.

As it currently stands, the ACA does require organizations like Catholic hospitals and universities, which are considered different from churches/houses of worship, to provide insurance that covers contraceptives (although not abortions or sterilizations). However, the Obama administration has told these organizations that if they object to the mandate, third-party administrators will provide free contraceptive coverage to enrollees who want it. Catholic hospitals will not be required to provide their employees with insurance coverage for contraceptives. Third-party insurance offering coverage for contraceptives is a very different
issue than the topic of hospitals physically providing contraceptives, so insurance coverage and the ACA will not be covered in this thesis.

What I will treat in this thesis I divide into two parts. Part I explores the legal challenges that arise both in Catholic healthcare in general and in Catholic and secular hospital mergers in particular. This part is broken into two sections. The first section is titled “Ethical and moral issues unrelated to the Separation of Church and State,” and the second “Catholic healthcare, hospital mergers, and Separation of Church and State.” Although there are several types of legal arguments related to Catholic healthcare and hospital mergers, they essentially fall into these two categories. I also draw on personal interviews of physicians at Swedish Hospital in Seattle to discuss a growing concern among physicians in secular hospitals that have merged with Catholic healthcare systems: that their own rights are being violated as a result of having to follow Catholic rules about abortions and sterilizations. Part I of the thesis analysis finds that most legal problems that arise in the context of Catholic healthcare and mergers are unrelated to the First Amendment. First Amendment arguments (in this context) are either not utilized or unsuccessful.

Part II of this thesis examines the ecclesiastical issues that arise in Catholic healthcare and hospital mergers. The first section discusses the ethical rules that Catholic hospitals must follow in order to be designated as Catholic. In the remaining sections of Part II I analyze a particular Catholic hospital system, Dignity Health (formerly known as Catholic Healthcare West), to elaborate on the various ecclesiastical problems Catholic hospitals sometimes face. My analysis of this hospital system is largely chronological and traces the hospital system from its origins to the present day. After examining the history of Catholic Healthcare West/Dignity Health, which is one of the top ten largest non-profit hospital systems in the country, I recount a particular case at a CHW/Dignity hospital in which a woman needed a medical abortion because
of several health complications. Here I examine the Church’s response and the various complex moral and ecclesiastical problems involved in this case. Next I detail Catholic Healthcare West’s disaffiliation from the Catholic Church and their conversion to Dignity Health. Finally, I analyze the struggles Dignity still faces regarding its former affiliation with the Church. This second part of the thesis indicates just how complex the ecclesiastical issues surrounding Catholic healthcare are, and shows that oftentimes the problems Catholic hospitals and hospital mergers face actually derive from within the Church, rather than resulting from the external United States legal system.

This thesis synthesizes many forms of data. Part I deals with legal issues, and includes primary source analysis of state and federal laws as well as academic articles interpreting these laws. This section also draws from some news articles summarizing what happened after mergers or in specific legal cases. And, as noted above, Part I contains information obtained during personal interviews with physicians at Swedish Hospital. Part II relies largely on official Church doctrine regarding moral theology and theology specific to Catholic healthcare, obtained from the United States Council of Bishops archives and the National Catholic Bioethics Center, as well as newspaper articles. It also contains analysis of newspaper articles from around the country, in both national newspapers (New York Times) and local newspapers. Part II also includes limited discussion of academic articles, although they are not central sources for this portion of the thesis. Thanks to the rich resources of Wellesley College and the University of Oxford I was able to access a significant number of sources for this thesis.
Part 1: Legal issues

Introduction

Since passage of the Affordable Care Act in 2010, public debates about religious healthcare providers have often been framed in terms of the First Amendment, religious freedom, and separation of church and state. Newspapers are filled with statements from bishops such as Paul Loverde of Arlington and Francis DeLorenzo of Richmond, who argued, “the [Obama] administration has cast aside the First Amendment to the Constitution of the United States, denying to Catholics our nation’s first and most fundamental freedom, that of religious liberty.”

On the flip side, opponents of Catholic-secular hospital mergers often argue that government-subsidized hospitals that merge with Catholic hospitals are “violating the religious establishment clause” of the U.S. Constitution. However, an analysis of court cases in the last half-century demonstrates that in fact, the First Amendment is rarely invoked in decisions about religious healthcare.

This thesis examines religious healthcare in the context of Catholic and secular hospital mergers, and this part focuses on legal challenges to, and justifications for, these mergers. I find that these mergers are generally governed and limited by laws having to do with medical ethics and civic morality more than with First Amendment “freedom from religion” and “freedom of religion.” The terms “medical ethics” and “civil morality” are terms that are hard to define, but imply a set of codified values enforced for the good of individuals; these are the main issues at stake when courts consider mergers between Catholic and secular hospitals.

The groundbreaking right to an abortion in the 1973 decision *Roe v. Wade* is an example of a court case grounded in ethical and moral considerations rather than religious freedom or

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freedom from the establishment of religion, and *Roe v. Wade* is still used in court cases regarding mergers and religious healthcare today. In the 1973 case, the Supreme Court ruled that state laws criminalizing abortion “violate the Due Process Clause of the Fourteenth Amendment,” which ensures “the right to privacy, including a woman’s qualified right to terminate her pregnancy.”

So, according to the Court, a woman has the right to choose to terminate her pregnancy on the basis of privacy—each person has a fundamental right to privacy. This can be called a moral or ethical value.

Other laws and legal decisions regarding healthcare also tend to be grounded in specific ethical or moral values, which I outline in the first section of this part of the thesis. The first is the value of competition: some argue that Catholic-secular hospital mergers restrict competition and limit the “trade” of a certain service, in this case reproductive services. The next value I identify and examine is charity. Many hospitals are considered charitable trusts created with the explicit purpose of helping the public. When the missions of these charities change as a result of a hospital merger, the charities must take appropriate steps to notify the public and ensure their missions remain charitable. The final portion of this part’s first section analyzes values of informed consent, access to information, and quality healthcare. These are perhaps the most compelling values in the courtroom: courts have consistently held that patients have the right to know all of their treatment options and have the right to adequate medical care. Mergers today are often challenged on this basis.

In the second section of Part I, I analyze various First Amendment arguments used to defend and challenge Catholic-secular hospital mergers and also the conscience clauses that allow hospitals and religious institutions to deny women reproductive services on the basis of religious beliefs. Both the conscience clauses and the First Amendment arguments are relevant to

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religious institutions. The conscience clauses, enacted after *Roe v. Wade*, give religious institutions the right to opt out of providing services (abortions, tubal ligations, etc.) if providing these services is contrary to the institution’s “conscience,” or values. The First Amendment contains two protections that are relevant to mergers in various ways. First, the Amendment allows religious institutions to (largely) do as they please in their practice of religion. Second, the First Amendment prevents two institutions, the government and religious institutions, from becoming entangled. Some attorneys have argued that hospital mergers represent excessive entanglement of the government and religion. However, few cases have been successful in making this argument. Finally, some individuals affected by mergers invoke First Amendment protections in objecting to them. At the end of the section, I describe and discuss personal interviews I conducted with physicians at a (formerly) secular hospital that has recently affiliated with a Catholic hospital. A few of them mentioned that they felt that having to follow the Ethical and Religious Directives of Catholic Health Care violated their own right to freedom from religion. I explore their concerns and endeavor to assess the legal validity of the claims.

**Section 1: Ethical and moral issues unrelated to the Separation of Church and State**

* A. Antitrust Violations

Antitrust violations are “violations of laws designed to protect trade and commerce from abusive practices such as price-fixing, restraints, price discrimination, and monopolization.” The core antitrust laws are the Sherman Act (1890), the Federal Trade Commission Act (1914), and the Clayton Act (1914), all of which proscribe various business practices that limit competition.

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and the free market.\(^6\) The Clayton Act in particular addresses mergers and acquisitions. Chapter seven states:

“No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital … the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”\(^7\)

The Clayton Act essentially declares unlawful mergers and/or acquisitions that in some way “lessen competition” or “tend to create a monopoly.” “Competition” here can be considered an ethical value because it is a concept that lawmakers and courts have decided is important to uphold in order to ensure economic vitality.

This specific aspect of the Clayton Act could apply to Catholic and secular hospital mergers if “the merger will result in the restraint of trade due to a monopoly of a significant geographical area.”\(^8\) Some activists at the National Women’s Law Center argue that in this situation, “trade” would be considered reproductive services. A hypothetical situation in which this reasoning could apply would be a merger between a secular and Catholic hospital in a rural area. In this hypothetical situation, the secular hospital offers a full range of reproductive services and, after the merger, the hospital no longer offers reproductive services. In this case, the “trade” (reproductive services) is restricted due to a monopoly, because the newly merged hospital is the only one in the rural area and therefore the only place where people can receive healthcare. In this case, a legal argument against the merger would be founded not on separation

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of church and state reasoning, but rather on the basis of maintaining competition among healthcare providers.

_B. Charitable Trust Laws_

Some non-profit hospitals are considered charitable trusts, and therefore are subject to charitable trust laws. The Internal Revenue Service (IRS) defines charitable trusts as “one of the major forms of organization for federal tax purposes,” in which trustees have “responsibility for the protection and conservation of property for beneficiaries who cannot share in the discharge of this responsibility and, therefore, are not associates in a joint enterprise for the conduct of business for profit.”⁹ There are several parties to a trust agreement: the grantor (the person who contributes the property, also known as capital), the trustee (who manages the trust), and the beneficiary (the person who is able to use the property or capital).¹⁰ Charitable trusts in particular are required to give a certain amount of money to charity in order to be tax exempt and must be established for “charitable, educational, religious or scientific purposes.”¹¹ Providing charity is clearly an ethical value recognized and encoded into American tax law.

However, the individual states decide exactly which types of organizations (e.g. non-profit hospitals or other institutions) may qualify as charitable trusts. These laws do govern institutions (charities), but not on the basis of church and state separation. Charitable trust laws ensure that tax-exempt charities are honest with the government and with their beneficiaries. Not only is “charity” deemed a public value, but maintaining the charitable mission of the organization and upholding honesty and compliance with regulations are matters of both ethical and legal importance. The government requires charitable trusts to abide by laws regulating

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¹⁰ Henzke and Thomas 5.
charity and honesty—which are fundamentally ethical values. In addition to this, the fact that charitable trusts exist legitimates the concept of the value of “charity” within American tax law. Law makers have legally encoded this value.

An example of charitable trust laws being used to prevent a merger is a case in Manchester, New Hampshire, in 1994, in which the secular Elliot Hospital and Catholic Medical Center (CMC) decided to merge. They were both non-profit, tax-exempt community hospitals considered charitable trusts by the State of New Hampshire. Because of market conditions and competition from the Lahey Hitchcock healthcare system, both hospitals were experiencing revenue losses, and merging seemed the best option to remain viable. Studies commissioned by the hospitals indicated that merging would allow the hospitals to remain open and would save them approximately $150 million over a 10-year period. In February of 1994, the two hospitals decided to proceed with the merger and formed Optima Health. Under Optima, the two hospitals consolidated their administrative, support, and clinical services. Unlike other “alliances” or acquisitions, this merger completely refashioned two hospitals into one healthcare system, also known as a “full-ownership” merger. In addition to consolidating jobs and services, the physical buildings were also remodeled. Elliot Hospital was equipped to handle the acute care services of Optima, while Catholic Medical Center was converted into an ambulatory, or outpatient, care facility.

After the merger became public, opposition to it grew. In order to renovate Elliot Hospital, Optima had to gain state approval in the form of a certificate of need (CON) request.

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13 Eberhart.
14 Eberhart.
15 Eberhart.
16 Eberhart.
The State of New Hampshire’s Office of Health Services Planning and Review requires that hospitals wishing to “construct or modify health care facilities, acquire new medical equipment, or offer new inpatient care beds and services” must gain approval from their Health Services Planning and Review Board.\textsuperscript{17} In applying for this Certificate of Need, the details of the merger became public. A group of citizens formed a grassroots group called Save CMC (Catholic Medical Center). The group argued that by merging with Elliot Hospital, CMC would no longer be able to “fulfill its traditional commitment to religious health care.”\textsuperscript{18}

Exactly what Save CMC meant by this claim is unclear, although evidence suggests that a core issue was reproductive rights. Save CMC publicly claimed to be concerned that CMC would no longer have acute care services, and that “Optima wants to end acute care as we know it at CMC.”\textsuperscript{19} Save CMC argued that it would change CMC’s prior commitment to providing “more free care to uninsured people … [and] provid[ing] more tender loving care to patients.”\textsuperscript{20} So, because CMC would no longer provide acute care services after the merger (they would offer Optima’s ambulatory services), it would violate its religious commitment to serve the poor who need acute care. Presumably Save CMC thought Elliot Hospital would not take in as many uninsured patients. In addition, some members of Save CMC claimed that they did not want CMC to close for geographic reasons—“CMC is a very convenient hospital for a great many people” – people want to have access to the acute services there.\textsuperscript{21} However, this seems to be a somewhat unpersuasive argument against the merger since the hospitals are only located two and a half miles apart. The primary problem with the merger for opposition groups seemed to be

\textsuperscript{18} Eberhart.
\textsuperscript{19} Sager, Alan. “Should the Catholic Medical Center be Saved as an Acute Care Hospital? And if it should be Saved, How?” Speech given in Manchester, NH, 11 Oct. 1995.
\textsuperscript{20} Sager.
\textsuperscript{21} Sager.
about reproductive issues. Sometime in 1997, it was leaked to the public that a late-term abortion was scheduled at Elliot Hospital, and Save CMC “rallied around this ethical issue.”

In legally fighting the merger, Save CMC argued that Optima Health violated charitable trust laws. The group reasoned that because both hospitals had been considered charitable trusts, they were obligated to uphold their mission statements; in forming Optima Health, both hospitals had neglected to do this. In a sense, charitable trust laws do govern the actions of institutions (because charities function as institutions); however, the laws fundamentally work to ensure that charities are honest with the government about their activities (maintaining their tax-exempt status). As discussed previously, honesty and transparency can be considered values or ethics that the courts have chosen to uphold. In the Optima health case, Save CMC asked the state attorney general to investigate the merger as a potential violation of charitable trust laws, and the state attorney general agreed to do so in December 1997. The attorney general found that the merger had violated cy pres doctrine, an aspect of the charitable trust laws. “Cy pres,” literally meaning “so near” or “near as possible,” dictates that when a “charitable objective is originally or later becomes impossible or impracticable to fulfill,” then “the courts may substitute another charitable object which is believed to approach the original charitable purpose as closely as possible.” In brief, the court asserted its right to get involved in the way the two charitable trusts had dissolved their assets and reformed them into a new trust. In state law, this is often used for “corporate law containing statutes that provide for the distribution of assets upon the dissolution of nonprofit organizations.”

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22 Eberhart.
23 Eberhard.
In the court’s interpretation, by forming Optima Health, both Elliot Hospital and CMC were dissolving their nonprofit organizations, changing their original charitable missions, and distributing their assets elsewhere. New Hampshire requires tax-exempt nonprofits that do this to go through a special approval process; they must change the mission statements of the original charitable trusts, and also form new tax-exempt non-profits (in this case Optima Health). First, the charitable trusts must give “public notice” and hold “public hearing[s]” to inform the community of the changes. Then, they must give “notice of the proposed acquisition transaction” to the director of the state director of charitable trusts a full one hundred and twenty days before the “consummation of the transaction.” As with federal law, New Hampshire state law requires transparency if a charitable trust is to maintain its tax-exempt status. Optima Health had not been open with the public about the merger, nor had they gone through the proper steps to change the missions of the combined charities, so the merger had to be dissolved and the two original nonprofits, Elliot Hospital and CMC, had to be restored. In June 2000, Optima officially dissolved and the merged hospitals split back into two.

C. Medical Malpractice—Lack of informed consent and substandard care

Allegations of medical malpractice provide another significant legal challenge to mergers. These legal challenges have two branches: one is lack of informed consent, the other substandard care. These issues only arise after hospitals have merged and someone has encountered a potentially illegal situation at a hospital; before the mergers take place, medical malpractice cannot occur. Informed consent laws are generally governed by state law, with

27 7:19-b Standards for Acquisition Transactions Involving Health Care Charitable Trusts and Review by Director of Charitable Trusts.
28 Eberhart.
federal regulation governing “such matters as drug development and approval, dispensing controlled substances, and the oversight of research with human subjects.” Many of the informed consent laws are actually based on guidelines for medical ethics given by the American Medical Association, as will be evident in the examples that follow.

i. Lack of informed consent

“Informed consent” in layman’s terms generally means knowing all the risks before a medical procedure, but it actually means much more than this. According to the American Medical Association, “informed consent” includes all of the following elements: “the physician’s obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.” An informed patient is interpreted to mean one who understands “the nature of the decision/procedure; reasonable alternatives to the proposed intervention; and the relevant risks, benefits, and uncertainties related to each alternative.” Thus, an explicit component of being informed enough to give consent for a procedure is to know all of the potential treatment options or “therapeutic alternatives consistent with good medical practice.”

The legal argument against Catholic hospitals regarding lack of informed consent is that physicians at these hospitals do not provide patients with full information about “therapeutic alternatives” or options regarding reproductive health. Indeed, they are forbidden to do so according to Church policy. Physicians cannot talk with patients about contraception or dispense

contraceptives. This can be interpreted as not informing patients of all possible treatments. Similarly, the Church policy dictates that abortions are not permitted in Catholic hospitals. This often means in Catholic hospitals that abortion is not discussed, and therefore patients are not fully informed of their healthcare options.

In 1989, a woman challenged a Catholic hospital’s practice not to offer emergency contraception to rape victims on the premise that the hospital violated California law regarding standard of medical practice (one of the various ways of saying “informed consent”). Kathleen Brownfield, then a 21-year old student at Loyola Marymount University in Los Angeles, went to Daniel Freeman Marina Hospital (now Marina del Rey Hospital), a Catholic hospital, to receive emergency treatment after being raped.\(^{32}\) Her mother went with her to the hospital and asked “for information concerning the ‘morning-after pill,’ a ‘pregnancy prevention treatment,’” but a nurse at the hospital refused to give them information about the morning-after pill, saying she couldn’t because it was a “Catholic Hospital.”\(^{33}\) In addition, Brownfield was not told that if she wanted to use this treatment she should go to another emergency room or doctor within seventy-two hours, the time frame within which the treatment is effective.\(^{34}\) She claimed that she was denied treatment, not properly informed of her treatment options, and not referred to another provider who would give her treatment.

Brownfield filed several claims against the hospital on the basis of medical malpractice. All claims were predicated on the argument that the hospital did not provide “optimal” or “complete” emergency treatment. The first claim was that the denial of medical treatment constituted “unfair business practice in violation of Business and Professions Code section 17200

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\(^{34}\) Kathleen Brownfield v. Daniel Freeman Marina Hospital.
et seq.,” a “breach of respondent’s [Daniel Freeman Marina Hospital’s] implied contract to provide treatment consistent with the standard of medical practice in the community.”

Second, denial of emergency contraception was a violation of her “state and federal rights to liberty, happiness and privacy,” specifically 42 United States Code section 1985(3), which discusses depriving persons of rights or privileges. And finally, she claimed that the hospital engaged in a “breach of the fiduciary duty arising from the patient-physician relationship.”

The Court of Appeals dismissed most of her claims, but did say that the hospital did in fact violate Brownfield’s civil rights because they did not allow her to have complete control over her treatment, which is related to the issue of informed consent. The court declared that 42 United States Code Section 1985(3) requires that medical patients “have the right to self-determination in their treatment.” This mirrors AMA’s code of medical ethics, which states that providers are obligated to “help the patient make choices from among the therapeutic alternatives consistent with good medical practice,” or facilitate patients choosing their own treatment with proper guidance. In not giving Brownfield the morning-after pill, the hospital did not allow her to “exercise control over [her] own body,” and part of “meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the option available.” In addition, the court claimed that a “skilled practitioner of good standing” would have given her access to the morning-after pill, so the hospital’s refusal to “provide her with information concerning this treatment option” constituted medical malpractice.

35 Kathleen Brownfield v. Daniel Freeman Marina Hospital.
37 Kathleen Brownfield v. Daniel Freeman Marina Hospital.
38 Kathleen Brownfield v. Daniel Freeman Marina Hospital.
39 Kathleen Brownfield v. Daniel Freeman Marina Hospital.
40 Kathleen Brownfield v. Daniel Freeman Marina Hospital.
ii. **Substandard care**

Although I have not yet found a specific case in which someone successfully sued a Catholic or merged hospital for substandard care because she was denied a medically necessary abortion or other reproductive procedure, hospitals seem to fear lawsuits on this basis. As with informed consent, laws governing care and medical malpractice are grounded in medical ethics.

Substandard care is defined as “any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient.”\(^{41}\) Laws awarding damages to those who suffer substandard care are essentially based on the ethical principle that all patients are entitled to treatment within “accepted norms of practice,” or care of a certain quality.

Many potentially life-threatening conditions can be induced by pregnancy—ectopic pregnancy (a pregnancy that occurs outside the uterus), extreme hypertension (high blood pressure), placental abruption (when the placenta separates from the uterus), and so forth. All of these conditions can be alleviated with the termination of the pregnancy, also known as a therapeutic abortion. Although my research did not uncover a case in the United States in which a woman died because she was denied a therapeutic abortion, this occurred in Ireland in October 2012. As I mentioned in the introduction, Savita Halappanavar, a woman seventeen weeks pregnant, was having a miscarriage and went to the hospital in extreme pain.\(^{42}\) Although the fetus was no longer viable, the hospital would not perform an abortion and expedite the

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miscarriage because the fetus still had a heartbeat. As a result of the multiple-day miscarriage, Halappanavar contracted septicemia and died.\textsuperscript{43}

Catholic Hospitals in the United States evidently fear this outcome and potential lawsuits based on arguments about malpractice and substandard care, as evidenced by a specific situation in Phoenix, Arizona in 2009. A pregnant woman suffering life-threatening pulmonary hypertension, high blood pressure in the arteries in the lungs, was rushed to St. Joseph’s Hospital, a Catholic hospital.\textsuperscript{44} Doctors there determined that unless the eleven-week fetus was terminated, the woman would die. Because the hospital was Catholic, Sister Margaret McBride, an administrator at the hospital, convened an ethics committee to decide if the hospital could perform the abortion.\textsuperscript{45} The ethics committee ultimately decided that the hospital must perform the abortion to save the woman’s life. As a result of their decision (which I will discuss further in Part II) Sister McBride and the hospital suffered consequences at the hand of Bishop Thomas J. Olmsted of Phoenix. While the hospital’s decision undeniably reflected ethical concerns regarding the woman’s life, it seems likely that the committee also considered the serious legal consequences had they not performed the abortion and the patient died. Had this happened, a lawsuit on the basis of medical malpractice—along with much negative publicity—seems likely.

Section 2: Catholic healthcare, hospital mergers, and Separation of Church and State

A. Conscience Clauses

Conscience clauses offer the primary legal defense Catholic hospitals draw upon in refusing to provide certain medical services (abortions, contraceptives, etc.). Following the Supreme Court’s \textit{Roe v. Wade} decision, religious hospitals expressed concern that they would be

\begin{footnotes}
\item[43] Dalby.
\item[45] Boston.
\end{footnotes}
required to perform abortions. At first, the conscience clauses only protected hospitals from being required to provide abortions and sterilization procedures that conflicted with their religious beliefs. However, a year later Congress expanded the conscience clauses, stating that health care providers could refuse to perform any services that conflicted with their religious beliefs.

This protection is clearly premised on the First Amendment, which guarantees the free exercise of religion. These conscience clauses protect both individuals and organizations involved in delivering health care services from engaging in activities contrary to “religious beliefs or moral convictions.” The first portion of the law specifically states that the “receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act” or the “Developmental Disabilities Services and Facilities Construction Act” does not “authorize any court or any public official or other public authority to require” an “individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions.” In addition, the conscience clauses exempt institutions and facilities from having to provide a range of services. Hospitals do not have to “make its/[their] facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions,” and the hospital/entity also does not have to “provide any personnel” for sterilization or abortion. The text of the additional portion of the law

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46 Sloboda 144.
48 Boozang.
49 Boozang.
(added one year later) is that “no individual shall be required to perform or assist in the performance of any part of a health service program or research activity” funded “under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.”

The Supreme Court has consistently upheld the right of publicly-funded religious hospitals to deny elective abortions on the basis of the conscience clauses. In the 1977 case Jane Doe v. Poelker, Mayor of St. Louis, et al., a hospital owned by the city of St. Louis refused to perform a “nontherapeutic abortion” on an “indigent female.” Jane Doe’s lawyers argued that Starkloff Hospital’s refusal to provide an abortion violated her constitutional right to an abortion under the Equal Protection Clause of the Fourteenth Amendment, because the hospital used “publicly financed hospital services for childbirth but not for elective abortions.” However, the Supreme Court decided that the hospital had the right to deny Jane Doe an abortion on the basis of 42 USC § 300a-7. Starkloff’s specific staffing practice was to employ doctors and medical students from the St. Louis University School of Medicine, which is a Jesuit-operated medical school opposed to abortion. The doctors and medical students at the hospital refused to perform the abortion for this reason, and the Court decided that they were protected under the specific clause “[an] individual [does not have] to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions.”

51 “42 USC § 300a-7: Sterilization or abortion.”
53 Poelker, Mayor of St. Louis, et al. v. Doe.
54 Poelker, Mayor of St. Louis, et al. v. Doe.
There are, however, exceptions to conscience clauses when a hospital or health care organization cannot prove that they are religious in nature. The conscience clauses require that the abortion or other specific procedure be against the person or organization’s “religious beliefs or moral convictions,” and if this requirement is not met, they cannot refuse to give someone an elective (“at the woman’s request for reasons other than maternal health or fetal disease”\(^{55}\)) first-trimester abortion on the grounds of the conscience clauses. In 1974, two women attempted to get first-trimester abortions at three hospitals in New Jersey: Bridgeton Hospital in Bridgeton, Newcomb Hospital in Vineland, and Salem Hospital in Salem. The hospitals were non-profit and non-sectarian, and were all incorporated “for the purpose of making available to the public medical facilities where diverse types of medical services may be performed.”\(^{56}\) None had any religious affiliation—they were simply community hospitals. In addition, all occupied the unique position of being “the only general hospital open to the public situated in its respective municipality.”\(^{57}\) All of the hospitals would on occasion perform therapeutic abortions—abortions “induced when pregnancy constitutes a threat to the physical or mental health of the mother.”\(^{58}\) Although doctors at the hospitals were willing to perform elective abortions for these women, the members of the boards of directors did not want the women to have the elective abortions, and therefore tried to prevent them from doing so.\(^{59}\) The Supreme Court of New Jersey ultimately decided that because the hospitals were non-sectarian, their boards of directors could not use the conscience clauses as grounds to refuse elective abortions (when the hospital already provides


\(^{57}\) Jane Doe and Mary Roe, et al. v. Bridgeton Hospital, et al.

\(^{58}\) “Therapeutic abortion.” *Merriam-Webster*. Merriam-Webster, Inc.

\(^{59}\) Jane Doe and Mary Roe, et al. v. Bridgeton Hospital, et al.
therapeutic abortions and has the capability to provide elective abortions). 60 To refuse a constitutionally protected right (under Roe v. Wade) to a first-term elective abortion, hospitals must prove that they are religious in nature and that providing an abortion would violate the providers’ First Amendment rights.

B. The First Amendment

The Establishment Clause and Free Exercise Clause of the First Amendment to the U.S. Constitution are invoked in debates about Catholic-secular healthcare partnerships. Together, these clauses state “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof…” The First Amendment’s relevance to legal arguments about hospital mergers is very complex. For ease of understanding, this issue is broken down into two analytic units: first, arguments that the First Amendment provides the basis for allowing religious hospitals to act as they please; second, arguments that the First Amendment prevents governments from establishing or becoming entangled with religious organizations. The last part of this section examines the concerns about First Amendment rights of physicians.

i. Freedom to practice religion—the Free Exercise clause

The Free Exercise clause of the First Amendment protects “against personal religious harm and thus safeguards individual religious rights.” 61 The Free Exercise clause is violated when “government enforces a restriction that intentionally discriminates against religion, religious practice, or against an individual because of his or her religion.” 62 The Supreme Court

60 Jane Doe and Mary Roe, et al. v. Bridgeton Hospital, et al.
62 Kellhofer 10.
has stated on multiple occasions that “religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection.”

The Free Exercise clause applies to Catholic hospitals and healthcare institutions in two related ways. First, it allows them to refuse to offer services that are deemed against their religious beliefs—e.g. not providing abortions or sterilizations, is considered the free exercise of religious beliefs. The Catholic Church considers providing such services to be “sacrilege.”

Second, the Free Exercise clause allows Catholic hospitals to offer services they believe are an integral aspect of the Church’s stated mission, which is “Bringing Jesus’ healing of body, mind and spirit to the sick, whomever and wherever they are.” Since a necessary part of Church doctrine is ministering to the sick, any attempt to stop Catholic hospitals from doing this would be “prohibiting the free exercise” of religion.

As of yet, I have not found a specific case in which a Catholic hospital merged with a secular one (or even just a Catholic hospital) defended its right to refuse providing abortions solely on the basis of the Free Exercise clause of the First Amendment: their right to refuse to provide abortions has generally been affirmed in the Courts under the conscience clauses previously discussed. The First Amendment arguments remain widely discussed in the media and in academic literature, which is why they are discussed here.

1. Freedom from religion—the Establishment clause

The Establishment clause of the First Amendment states: “Congress shall make no law respecting an establishment of religion.” Since the writing of the First Amendment, the Supreme Court has interpreted this not as personal protection from religion, but rather as a limitation or

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65 Place.
boundary between the State and religion. It is a “structural restraint on governmental power” to “keep two centers of authority—government and religion—in their proper relationship.” Some have argued that the merging of a religious hospital and public/government-funded hospital constitutes a violation of the Establishment Clause, but the Supreme Court has disagreed with this or reasons that certain results of the merger (e.g. such as restricting access to abortion) violate other laws or court decisions, such as Roe v. Wade.

Opponents of mergers sometimes cite government involvement with religious hospitals as violations of the Establishment Clause; however, the Supreme Court decided in the 1899 case Bradfield v. Roberts that government funds can be used to support Catholic (and thereby all religious) hospitals. That precedent-setting case began in March 1897, when Congress appropriated $30,000 to build facilities to care for indigent veterans. Congress formed an agreement with Providence Hospital (run by Catholic nuns), oversaw constructing the facilities and staffing them once they were built. The complainant did not want his tax dollars to go toward a Catholic institution. He argued that because the corporation “is composed of members of a monastic order or sisterhood of the Roman Catholic Church, and conducted under the auspices of said church,” that “the commissioners of the District of Columbia are unauthorized” to give them money under the Establishment Clause. The Supreme Court sided with the government, and concluded that the purpose of appropriating the money was a secular one: namely, to provide healthcare to people in the District of Columbia. Since the purpose was secular, the Court reasoned, the United States government could then (and can continue to) give

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66 Kellhofer.
67 Esbeck, Carl H. “Differentiating the Free Exercise and Establishment Clauses.” University of Missouri School of Law Scholarship Repository: Faculty Publications. University of Missouri School of Law. Summer 2000.
68 Bradfield v. Roberts – 175 U.S. 291. Supreme Court of the United States. 4 December 1899.
69 Bradfield v. Roberts
70 Bradfield v. Roberts
money to religious hospitals and charities provided that the money allocated is for precisely secular purposes. Clearly, Bradfield v. Roberts did not directly discuss abortion and was decided long before Roe v. Wade (1973). However, that decision still provides the legal framework for Catholic hospitals that receive money for treating patients insured by the government programs Medicare and Medicaid.

Although no recently decided legal cases involve direct challenges to government-funded Catholic healthcare solely on the basis of the First Amendment, communities sometimes threaten hospitals considering mergers with lawsuits on this basis and/or they invoke Establishment and Free Exercise clauses in their state constitutions that were modeled on the United States Constitution. For example, in 1999 in Newport, Oregon, a governmental health care system called Pacific Communities Health District decided to form an “affiliation” with Providence Health System, a Catholic healthcare system (which I will describe later in this part of the thesis).72 Under the affiliation agreement, which was to be valid for twenty-nine years, the Health District would provide facilities and Providence would be “responsible for local health care services.”73 This would entail “the transfer of the District’s current assets and liabilities to Providence,” and Providence would “be responsible for the operation of the public health care facilities, receiving the income from its operation and paying all expenses.”74 In other words, Providence would essentially run Health District, and the name of the public hospital and clinics run by Providence would be called “Providence Pacific Communities Hospital.”75

73 Brief of Amici Curiae, In the Matter of the Petition of Gary Hoagland, et. al. Circuit Court of the State of Oregon for the County of Lincoln. 6 November 2000.
74 Brief of Amici Curiae, In the Matter of the Petition of Gary Hoagland, et. al.
75 Brief of Amici Curiae, In the Matter of the Petition of Gary Hoagland, et. al.
Community members argued that this affiliation violated both the U.S. Constitution’s First Amendment as well as Oregon State’s Constitution, which states “No money shall be drawn from the Treasury for the benefit of any religious [sic], or theological institution, nor shall any money be appropriated for the payment of any religious services in either house of the Legislative Assembly.” They claimed that transfer of “management of a public institution to a religious group, subjecting public assets, services and taxing authority to religious policies and principles,” as well as “continuing obligation to use public taxing authority to fund future operations and construction on Providence’s behalf,” violated both constitutions. Eventually, the number of complaints and threats to sue District Health by citizens and the ACLU forced District Health to file for judicial review of the affiliation. The ACLU requested that the local court “enter a judgment that all actions taken and proceedings conducted by the District and the Board in connection with the Agreement are in compliance with the provisions of applicable laws including, without limitation, all relevant constitutional provisions, statutes and regulations.” The judge ultimately decided that the case should go to trial in November 2000 to determine if the agreement violated either the Federal or State constitutions. The case went to trial, but before the judge could issue a judgment, Providence and Health District decided to withdraw from the merger. Although the groups did not give a reason for the withdrawal, members of the community opposing the merger considered the termination of the affiliation a victory. The outcome of this unresolved legal case may have reinforced the public idea that the First Amendment Establishment Clause is relevant to religious-secular hospital mergers. But in

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76 Constitution of the State of Oregon. Article 1, Section 5. 9 November 1857.
77 Lafrance 250.
78 Lafrance 253.
79 Petition of Gary Hoagland, et. al. Circuit Court of the State of Oregon for the County of Lincoln. DATE?!
80 Lafrance 275.
81 Lafrance 284.
fact, no decision on the relevance of the Establishment Clause was ever actually rendered by the Court.

iii. Physicians’ freedom from religion

The First Amendment is also deemed personally relevant to some individuals at hospitals that have undergone mergers. Personal interviews of physicians at a recently merged Catholic-secular hospital revealed that some physicians believe their own First Amendment right to freedom from religion is violated when they are not allowed to perform certain procedures that they have in the past. All of the physicians I interviewed had several years of experience at the hospital where they worked and hoped to finish their careers there. In part because of their commitment to women’s health, they purposely chose to work at a secular hospital in Washington State, which has some of the most progressive healthcare laws in the nation. When the hospital they worked at decided to merge with a Catholic hospital system, they were surprised and upset that they would now have to abide by the Church’s rules in their practice. They explained that they felt as though religion was being forced upon them, limiting their medical practice. Significantly, the physicians with whom I talked all asked to be anonymous because of fear of punishment from their employers.

a. History of healthcare in Washington State

Before discussing the particular hospital merger that troubled these physicians, it is important to describe briefly the history of healthcare in Washington and the legacy of Catholic missionaries in health work. The state of Washington has long been anomalous when it comes to healthcare, which makes its largest healthcare system merger a highly relevant study. Healthcare in Washington is unusual for a combination of reasons. Nuns founded many of the state’s early hospitals. Catholic nuns were among the first settlers of the Pacific Northwest and founded the
first hospitals decades before Washington became an official state; it was then known as Washington Territory.\(^{83}\) Today, nearly half of all hospital beds in the state are in Catholic hospitals, and almost a quarter of the state’s thirty-nine counties in the state only have Catholic hospitals.\(^{84}\) This number excludes counties like my home county (Walla Walla), which technically does not only have Catholic healthcare, but only has religious healthcare (Walla Walla County’s other hospital is Seventh-Day Adventist) and therefore offers few reproductive services.

In paradoxical contrast to the high numbers of Catholic hospitals in the state, Washington has uniquely strong laws regarding two healthcare procedures banned by the Catholic Church: abortion and euthanasia. In 1970, three years before Roe v. Wade, residents voted to make abortion a “statutory right.” In 1991, Washington adopted a law confirming that all residents have a “fundamental right to choose or refuse” contraception and abortion, and explicitly affirming that the state is not permitted to use “regulation or provision of benefits, facilities, services or information” to prevent people from accessing these services.\(^{85}\) It is the only state in the United States to have a statutory right to an abortion.\(^{86}\) In addition to this legal right to abortion and contraception, Washington also has a law permitting euthanasia for patients with terminal illnesses and fewer than six months to live (commonly referred to as a Death with Dignity law).\(^{87}\) It is one of three states (along with Oregon and Vermont) that allow “mentally competent, terminally-ill adult state residents to voluntarily request and receive a prescription

\(^{83}\) “About WSHA.” Washington State Hospital Association. 2014.
\(^{86}\) Johnson.
medicine to hasten their death.”

Hospitals and individuals are allowed to opt out of participating in Death with Dignity.

Finally, Washington is anomalous because of the low degree of religiosity in the state in comparison to the rest of the United States. A 2012 Gallup poll indicated that Washington is the eighth least religious state in the United States; it is tied for this position with Nevada, Hawaii, Alaska, and Connecticut. According to this poll, only thirty-one percent of Washington residents consider themselves “very religious,” while fifty-eight percent of residents of the most religious state, Mississippi, consider themselves very religious. As a nation, forty percent of Americans consider themselves “very religious.” Washington is well below this average. And yet, Washington is significantly above average in terms of number of hospital beds run by Catholic healthcare systems. As previously stated, one in six hospital beds in America are in Catholic hospitals, but nearly half of Washington’s hospital beds are in Catholic hospitals. This paradoxical contrast affects healthcare delivery in a variety of ways.

b. Histories of Providence and Swedish

The Sisters of Providence began administering healthcare in the Northwest region in the 1850s, forty years before Washington became a state. The Sisters of Providence, a Catholic religious order of women, formed in Montreal in 1843. In 1856, Mother Joseph of the Sacred Heart led a group of Sisters of Providence to what was then Washington territory. In 1858, the sisters opened St. Joseph Hospital in what is now Vancouver, Washington. It was the first

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91 Newport.
93 “History.”
permanent hospital in the Northwest and charged a fee of one dollar per day for healthcare. As increasing numbers of pioneers arrived in the Northwest, the demand for hospitals and schools grew. By 1902, the Sisters of Providence had twenty-nine institutions in the areas that today comprise Washington, Oregon, Northern Idaho, Montana, and British Columbia. In the 1980s, the hospitals in Oregon formally joined together to become a “federally qualified health maintenance organization” called The Good Health Plan. Following a merger with other Sisters of Providence hospitals in 1997, The Good Health Plan became Providence Health Plan. As of July 2013, Providence Health & Services is the tenth largest non-profit (and non-governmental) hospital system, with a total of thirty-two acute care hospitals. Of these top ten largest non-profit hospital systems, seven are Catholic.

Swedish Medical Center was founded decades later. In 1910, a small group of Swedish-Americans living in Seattle, led by Dr. Nils Johanson, decided that they wanted to provide Seattle with “a first-class nonprofit hospital.” The hospital grew tremendously each decade, including during the Great Depression, when the hospital opened the first cancer center west of the Mississippi river. In the 1980s and 1990s, the hospital acquired several other hospitals in the area, all of which became affiliated with Swedish Medical Center. In July 2000, Swedish bought Providence Seattle Medical Center (PSMC), a hospital formerly owned by the Catholic Sisters of Providence. PSMC offers services in neurology, orthopedic care, cardiology,
gastroenterology, psychiatry, and geriatric care. Until 2010, Swedish continued buying and building additional hospitals, and now has seven separate “campuses,” or hospital locations. Today, it is the largest healthcare provider in the Greater Seattle area, and in 2012 had 1,432 hospital beds, 10,395 employees, 55,214 inpatient admissions, and 8,747 babies born.

c. The affiliation

Although Swedish has largely been profitable since its inception, in March 2012 it was hemorrhaging money. Starting in the last few months of 2011, the hospital lost approximately $250,000 per day. In the year 2011, the hospital had $1.89 billion in total expenses, but only $1.825 billion in patient revenues, experiencing a loss of $65 million. In January and February of 2012 alone, the hospital experienced an operating loss of $16 million. Hospital officials listed several reasons for these losses. According to CEO Kevin Brown, major factors included higher insurance deductibles, job uncertainty leading to hesitancy to use health care services, and more people qualifying for Medicare and Medicaid (which “do not adequately cover the cost of providing care”). All of these factors led to fewer people going to the hospital—in one year, patient volumes dropped by eight percent. In addition to this, Swedish had recently built a new hospital in Issaquah, about forty-five minutes outside of Seattle. Although the healthcare system paid for the new hospital with tax-exempt bonds through the state, the Issaquah facility cost over $100 million. The new hospital, a large, 550,000 square-foot campus, opened at the beginning of November 2011, soon after Swedish begin experiencing massive financial losses.

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102 “Locations.” Swedish Medical Center. 2014.
103 “Our first 100 years: The Swedish Story.”
104 “Facets & Figures.” Swedish Medical Center. 2014.
106 Ostrom.
107 Ostrom.
At the beginning of October in 2011, Swedish announced that it was forming an affiliation with Providence. Although the affiliation was months in the making, it came as a surprise to physicians at Swedish, who knew the hospital was having financial troubles but were not aware that Swedish was pursuing an affiliation with another healthcare provider. The CEOs of Swedish and Providence, Dr. Rod Hochman and Dr. John Koster, respectively, said that the affiliation was one “born of economic necessity.” Healthcare in the region at the time was “in a tremendous [financial] crisis of just monumental proportions,” according to Koster. The formerly independent Swedish would become a division of Providence, and would be overseen by Providence’s board. The pair were careful to say that this was not a merger or acquisition but rather an affiliation. The difference between these, evidently, is that with an affiliation, Swedish keeps its name and status as a nonreligious organization. It did not have to attach “Providence” to its title.

d. Reproductive services before and after the affiliation

Providence and Swedish had vastly different approaches to reproductive services before the affiliation. According to a Providence brochure titled “Integrity and Compliance Program,” the healthcare system “requires adherence to all Ethical and Religious Directives as a condition for medical privileges and employment.” The Ethical and Religious Directives, specific Church rules for Catholic healthcare, will be discussed in the next section. One can assume that Providence enforces these rules, as I have not found information indicating otherwise. So we can

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110 “Swedish, Providence to join forces.”
112 “Swedish alliance with Providence is now complete.”
presume that they do not provide contraceptives, sterilizations, or abortions. Swedish, on the other hand, has consistently provided a range of reproductive services.

According to Swedish officials, Swedish has long offered tubal ligations, contraception, and the morning after pill.\textsuperscript{114} Swedish has not historically offered in-vitro fertilization or first-term abortions, because these procedures are typically performed in specialized clinics.\textsuperscript{115} However, the Swedish healthcare system has historically performed high-risk elective abortions. According to a physician at Swedish who wished to remain anonymous (hereafter referred to as Dr. Smith), these particular elective abortions were typically only ones in which the mother decided to terminate the pregnancy after the first trimester. He said that this would typically happen after the mother and her doctor became aware of a fetal abnormality, some of which cannot be detected until the second trimester (such as Down Syndrome). Because second trimester abortions are more complicated than first trimester abortions, they are often performed in hospitals. The doctor also noted that other abortions that took place at Swedish were ones in which the mother was experiencing a miscarriage or fetal death and needed to speed the miscarriage in order to prevent complications for the mother (as in the previously mentioned Ireland Halappanavar case, see Part 1 section C number ii).

Following the affiliation announcement in October 2011, Swedish spokesman Ed Boyle announced that Swedish would no longer perform elective abortions “out of respect for the affiliation.”\textsuperscript{116} The hospital’s stated position was that it would continue to perform emergency, medically necessary abortions, although spokesperson Colleen Wadden said that “it wouldn’t be appropriate to speculate on a hypothetical patient scenario” in which someone needed an

\begin{itemize}
\item \textsuperscript{115} “Under pressure on abortion, Swedish backs new Planned Parenthood clinic.”
\item \textsuperscript{116} “Under pressure on abortion, Swedish backs new Planned Parenthood clinic.”
\end{itemize}
emergency abortion. So the precise position on emergency, medically necessary abortions was left rather vague. The ambiguity of exactly what constitutes an “emergency abortion” has frequently been an issue elsewhere at Catholic hospitals, as evidenced in the St. Joseph’s hospital situation (which I will discuss further in Part 2 section 2). In the first year of the Swedish-Providence alliance, this lack of clarity caused significant confusion and anguish for nurses, physicians, and patients.

In her article titled “Faith Healers,” Cienna Madrid chronicles the experience of one anonymous Swedish patient, who she calls Mary. I discussed this article in the introduction, as it partly inspired this thesis. Although I provided a brief summary of it in the introduction, it bears repeating here. Mary was a little over twenty-four weeks pregnant when she began miscarrying. She checked into Swedish hospital. Although her doctors explained that they could not save the fetus, they also told Mary that “it still had a heartbeat, so there was nothing they could do. They had to wait for the heartbeat to stop.” Mary told her physician that she wanted to have an abortion rather than wait out the miscarriage, which already was incredibly painful. She was told she either had to “wait for nature to take its course” or leave Swedish in the midst of her miscarriage and check into another hospital. As she was weighing her options, the fetal heartbeat stopped, and the doctors performed the termination. After Mary’s story became public, the hospital refused to comment on the case. However, according to Chris Charbonneau, the CEO of Planned Parenthood of the Great Northwest, this was a training problem caused by “a lot of confusion and fear among staff about what was permissible and what wasn’t.” Since then, Swedish has apparently fixed this “training problem,” and established clearer guidelines as to

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118 Madrid.
119 Madrid.
120 Madrid.
what constitutes an emergency abortion. According to Charbonneau, “They [Swedish] have a commitment to me, in writing, that there will be no women getting hurt and no women dying.”

Soon after Swedish announced that it would only perform emergency abortions, a firestorm began, with reproductive healthcare advocates claiming that this was “one religion forcing its beliefs on the health-care system.”

Nine days after they announced the affiliation, Swedish issued a statement that they would finance the creation of a Planned Parenthood center in the Nordstrom Tower, a privately-owned building adjacent to the hospital. At this Planned Parenthood, a full range of reproductive services is available, including elective abortions. According to Dr. Smith, this enables women who elect to have a second trimester abortion (again, usually chosen because a fetal abnormality is discovered) to have part of the termination of the pregnancy at Planned Parenthood, and another part in the hospital. For example, at Planned Parenthood, the fetus may be injected with medication to stop the heartbeat. Once the heartbeat is stopped, the woman is physically transferred and the fetus can then be removed in the hospital. This is clearly not an ideal situation for the patient, and it is not the simplest way to terminate a pregnancy: the one-step (in one location) dilation & evacuation technique is preferred because it is the least risky and complicated method.

According to Dr. Smith, because of the addition of Planned Parenthood and its close proximity to the hospital, there has not been a significant decrease in available reproductive services. However, the affiliation with Providence has clearly made it harder for Swedish physicians to provide excellent—or even standard-of-care—reproductive services: they constantly feel as though they are jumping through bureaucratic hoops to actually avoid

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121 Madrid.
122 “Under pressure on abortion, Swedish backs new Planned Parenthood clinic.”
123 “Under pressure on abortion, Swedish backs new Planned Parenthood clinic.”
providing the best services for their patients. Having medical procedures done in different parts
of the hospital is far from ideal—they would prefer that they were all done in the same place in
order to minimize confusion and complications. In addition to this, some physicians believe that
being forced to abide by the Catholic Church’s policies on reproductive healthcare compromises
their own medical ethics. Some of them simply do not agree with the restrictions, do not want to
work under them, and do not believe they should have to work under a set of rules they consider
fundamentally unethical and wrong.

Objections to the ethical conditions of their work led some physicians I spoke with to
begin questioning whether requiring them to refrain from providing abortions could be
considered an infringement on their personal rights to freedom from religion. They became
physicians under the presumption that they would have to follow the American Medical
Association’s code of medical ethics. They accepted positions at Swedish Hospital with the
knowledge (and taking into consideration) that it was a secular hospital that provided certain
reproductive services. These physicians agreed with the then-secular Swedish Hospital’s
positions on women’s reproductive health. Subsequently, without consulting physicians, the
Swedish Board decided to merge with a Catholic institution and end certain reproductive
services at the hospital, which subsequently terminated the physicians’ ability to perform these
procedures. Although Swedish funded the Planned Parenthood center, certain services performed
by physicians were removed from the Swedish campus, thereby requiring physicians to jump
through various bureaucratic hoops (described earlier) to ensure that their patients could receive
those desired reproductive services. Many physicians resent that they did not sign on for this
when they accepted their jobs at Swedish. They feel as though they are required to adhere to
Catholic mandates in which they do not believe. The fundamental ethical conditions of their jobs, and their identities as physicians, have changed.

Unfortunately for these physicians, there is no simple answer regarding this freedom from religion in such mergers or affiliations. There is not, in my research, precedent for physicians suing hospitals because they disagree with merged hospitals’ ethical guidelines. Typically, if one does not agree with a hospital’s practices (assuming they are legal, of course), he/she either has to stick it out or quit and work elsewhere. Considering precedent, a case based on infringement of employees’ First Amendment rights likely would not be successful, for reasons discussed previously. However, this remains to be seen, and could be a potentially fruitful arena for legal challenges in the future.

**Part I Conclusion**

Several conclusions can be drawn from this examination of the legal issues at stake in Catholic and secular hospital mergers and other problems that arise as a result of these mergers. First, the legal challenges that prove to be relevant in healthcare lawsuits are those that make arguments relating to ethics or values. Most successful challenges to mergers, (meaning that the mergers have either been undone or forced to reinstate reproductive services), have demonstrated that the merged hospitals either failed to provide proper medical care and information, or have demonstrated that the merger violated the public’s right to know (e.g., about a change in mission). These are not arguments related to the proper relationship between religious institutions and the government, but rather they are based upon appeals to ethics or values that the United States government (or specific States’ governments) have deemed meritorious. The second conclusion of this research is that First Amendment challenges to mergers have not been widely advanced, and when advanced have not been successful. The Supreme Court has held that
governments may fund Catholic hospitals and charities, and these government-funded Catholic hospitals are free to eliminate reproductive services if they wish. In such cases, the Court has ruled that government funding of religious hospitals does not establish a particular religion, nor does it represent “excessive entanglement” between the government and religious institutions.

Although this is the state of affairs as of this writing, this could change sometime in the next few years or even months. On November 29, 2013, Tamesha Means, a Michigan woman who had unsuccessfully attempted to receive a therapeutic abortion from a recently Catholic hospital, filed suit against the United States Conference of Catholic Bishops, Catholic Health Ministries Chairman Stanley Urban, and former chairpersons Robert Ladenburger and Mary Mollison. Means’ attorneys allege that the Bishops’ Ethical and Religious Directives (see more in part 2) lead to negligence because they prevent doctors from performing potentially life-saving procedures, such as abortions. This case does not invoke First Amendment protections or arguments about ethics and values; rather, it demonstrates that legal strategies, arguments, and themes related to Catholic healthcare and hospital mergers continue to develop. This issue will be highly relevant to the future of both American law and American public health.
Part II: Ecclesiastical Issues

Part I of this thesis examined legal issues pertaining to Catholic healthcare in general and Catholic and secular hospital mergers in particular. Part II examines the most significant ecclesiastical issues Catholic healthcare institutions face when merging with secular hospitals. I employ a case study method in this analysis, examining the hospital system Dignity Health (formerly Catholic Healthcare West). Teasing out the ecclesiastical and legal complexities involved in the specific case of Dignity Health reveals challenges and patterns that may arise more broadly when Catholic healthcare systems merge with secular providers.

The first section of Part II describes the Ethical and Religious Directives for Catholic Health Care, the primary document that dictates Catholic medical ethics for Catholic hospitals in the United States. I focus especially on reproductive directives, as this thesis primarily analyzes reproductive healthcare. The next section discusses the relatively long history of Dignity Health/Catholic Healthcare West, and provides context for understanding the development of modern ecclesiastical themes within the system. I then describe the uneven application of the Directives among Catholic Healthcare West hospitals, and the confusion this caused for doctors and patients. To illustrate the consequences of this confusion, I present a specific moral quandary that arose at a Catholic Healthcare West hospital, St. Joseph’s of Phoenix, Arizona, and analyze how both the hospital and the bishop of the diocese responded. Finally, I discuss the aftermath of this scandal and Catholic Healthcare West’s disaffiliation with the Catholic Church.

Section 1: Ethical and Religious Directives for Catholic Health Care

The Ethical and Religious Directives for Catholic Healthcare (hereon referred to as ERDs) provide a blueprint for Catholic hospitals in making ethical decisions. The forty-three page document lays out all of the ethical guidelines Catholic hospitals must follow. The most
recent edition of the ERDs discussed here and throughout this section was published in 2009, but the ERDs have a nearly century-old history.

Before the creation of the ERDs, Catholic healthcare organizations followed the direction of the local diocesan bishop in regards to healthcare matters.\textsuperscript{125} The Catholic Hospital Association (now known as the Catholic Health Association of the United States, or CHA) was founded in 1915 to organize Catholic healthcare institutions, and one of the first goals of CHA was to create a standard list of ethical directives for all Catholic hospitals.\textsuperscript{126} The first set of directives was published in 1921 by Rev. Michael Burke, the archbishop of Detroit. Those directives largely discussed surgical procedures, and prohibited the termination of pregnancy and sterilization.\textsuperscript{127} In 1948, a more comprehensive set of ERDs was published by a group of theologians and healthcare professionals affiliated with the CHA. These ERDs moved beyond a list of proscriptions and articulated a weightier set of theological teachings.\textsuperscript{128}

Each subsequent decade brought a new set of directives. The issue of sterilization was particularly contentious among theologians, who eventually had to ask the Vatican for clarification on whether or not Catholic hospitals could provide sterilizations to women for whom pregnancy was life threatening. The Vatican Congregation for the Doctrine of Faith (CDF) ultimately declared in 1975 that no sterilizations could ever be permitted, regardless of the theological opinion put forward to justify such procedures.\textsuperscript{129} The 1994 directives branched out, addressing social issues and accessibility to healthcare, and also presented new authors: the National Conference of Catholic Bishops (later renamed the United States Council of Catholic Bishops).

\textsuperscript{126} Hamel et al.
\textsuperscript{127} Hamel et al.
\textsuperscript{128} Hamel et al.
\textsuperscript{129} Hamel et al.
Bishops) assumed authority for writing the directives.\textsuperscript{130} In 2001, a new set of directives clarified issues regarding cooperation with other hospitals.\textsuperscript{131} The most recent version was published in 2009.

The 2009 introduction notes that the ERDs represent the culmination of centuries of work. They create “a body of moral principles” that has “emerged that expresses the Church’s teaching on medical and moral matters.”\textsuperscript{132} The ERDs are an application of Catholic moral theology to an ever-changing and ever-growing healthcare industry. The ERDs are broken into six parts, each of which addresses particular ethical concerns; these are then broken down into further detail. Part One, titled “The Social Responsibility of Catholic Health Care Services,” discusses the rationale for providing Catholic healthcare. Its directives, which are listed in numeric format, include statements such as, “Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society.”\textsuperscript{133} Part Two, titled “The Pastoral and Spiritual Responsibility of Catholic Health Care,” discusses the role of Catholic ministry in Catholic healthcare. Specifically, certain directives require that Catholic healthcare systems must provide pastoral care and the sacraments to patients. Part Three, titled “The Professional-Patient Relationship,” lays out various ethical rules such as “respect for human dignity,” confidentiality and privacy, the ability for a surrogate or representative to make healthcare decisions for those unable to make them, informed consent, organ transplants, and so forth—many of which are similar to secular medical ethics.\textsuperscript{134}

\textsuperscript{130} Hamel et al.
\textsuperscript{131} Hamel et al.
\textsuperscript{133} “Ethical and Religious Directives for Catholic Health Care Services.”
\textsuperscript{134} “Ethical and Religious Directives for Catholic Health Care Services.”
In the second half of the ERDs (parts 4-6), the rules are notably distinct from secular healthcare ethics, and they are more proscriptive than the prescriptive rules contained in the first half. Part Four is titled “Issues in Care for the Beginning of Life.” It is the longest part of the ERDs. The first paragraph states,

“The Church’s commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and family depends.”

All directives that follow in Part Four are based on this premise of the sanctity of life from its “beginning,” defined as conception. The directives largely restrict what the hospitals can do; for example, hospitals cannot participate in in-vitro fertilization, cannot perform abortions, cannot terminate unviable extrauterine pregnancies, and cannot provide contraceptives. Part Five, titled “Issues in Care for the Seriously Ill and Dying,” prohibits euthanasia and also requires caregivers to use only “ordinary or proportionate” measures to prolong life. Finally, Part Six, titled “Forming New Partnerships with Health Care Organizations and Providers,” prohibits Catholic hospitals from merging with hospitals that compromise the ERDs or engage in any other activities “judged morally wrong by the Church.”

Section 2: Catholic Healthcare West/Dignity Health

The best way to understand how the ERDs are actually applied in Catholic-secular hospital mergers is to examine a specific case. This part of my thesis focuses on a complex, merged hospital system that today is called Dignity Health, but was formerly called Catholic Healthcare West. To begin, I will briefly summarize the lengthy history of this hospital system, which was one of the first hospital systems in the American West.

135 “Ethical and Religious Directives for Catholic Health Care Services.”
136 “Ethical and Religious Directives for Catholic Health Care Services.”
A. History of Catholic Healthcare West/Dignity Health

The history of Dignity Health, based in San Francisco, is nearly as long as the history of the State of California. In 1854, eight nuns of the Sisters of Mercy traveled to San Francisco, where they began administering healthcare for residents suffering from cholera, typhoid, and influenza.\(^{137}\) The Sisters of Mercy is an international religious order of Roman Catholic women founded in Ireland in 1831. Sisters of Mercy came to the United States in 1843, and rapidly began settling throughout the States, creating hospitals and schools.\(^{138}\) In 1857, the Sisters of Mercy opened St. Mary’s Medical Center in San Francisco, the first Catholic hospital on the Pacific Coast. Throughout the rest of the 19\(^{th}\) century, the Sisters continued to open hospitals, expanding to Merced, Los Angeles, Sacramento, and Phoenix, Arizona.\(^ {139}\) At the beginning of the 20\(^{th}\) century, various other congregations of the Sisters of Mercy, as well as nuns from other orders (The Dominican Sisters, the Sisters of Charity of the Incarnate Word, etc.) moved to the area and began forming additional hospitals. In 1986, two congregations of the Sisters of Mercy decided to join their ten hospitals into a single system, called Catholic Healthcare West (CHW).\(^ {140}\) In 1992, the organization’s first non-Catholic hospital, Methodist Hospital of Sacramento, joined CHW.\(^ {141}\) Throughout the 1990s and early 2000s, CHW acquired fifteen non-Catholic hospitals.\(^ {142}\)

From its foundation, the Sisters of Mercy at St. Mary’s Medical Center stressed care for the poor and equal access to healthcare as its primary values. Soon after the formal creation of CHW, the hospital published its first position papers on “commitment to Care of the Poor in

\(^{137}\) “History.” Who We Are. Dignity Health. 2014.


\(^{139}\) “History.”

\(^{140}\) “History.”

\(^{141}\) “History.”

Times of Financial Crisis” (1987), and “Response to the Needs of People Affected by HIV disease” (1989).143 In 1990, the organization publicly advocated health care reform.144 And in the year 2004, the hospital vastly expanded its financial assistance program, offering aid to all patients earning up to “500 percent of the federal poverty level.”145 By the year 2012, CHW had forty hospitals, twenty-five of which were Catholic and fifteen of which were non-Catholic.

B. Reproductive services at Catholic Healthcare West

Catholic Healthcare West has abided by the Ethical and Religious Directives since its inception in 1986. After it began acquiring non-Catholic hospitals, it required these hospitals to abide by a different set of rules, or values, as articulated in a document called the “Statement of Common Values.” Much of this statement reiterates CHW’s commitment to “serving the needs of individuals and communities” and caring for “the poor and the powerless, those of low socioeconomic status, individuals who have had catastrophic illnesses and those needing chronic care services.”146 However, a section titled “Procedures That Are Not Performed,” lists procedures and services that cannot be offered in any of the CHW hospitals: direct abortion, assisted suicide/euthanasia, and artificial reproductive procedures.147 Direct abortion is contrasted with indirect abortion, and CHW explicitly allowed the latter. The author/s of the “Statement of Common Values” identified an indirect abortion as “a termination of pregnancy that is not directly intended and in which the sole purpose is the cure of a proportionately serious pathological condition of the mother, when the treatment cannot be safely postponed until the fetus is viable.”148 In other words, the guidelines of the “Statement of Common Values” allowed

143 “History.”
144 “History.”
145 “History.”
146 “CHW Statement of Common Values.” Catholic Healthcare West. No date given.
147 “CHW Statement of Common Values.”
148 “CHW Statement of Common Values.”

secular hospitals affiliated with CHW to perform medically necessary abortions. Additionally, it is important to note that the “Statement” does not prohibit offering contraceptives or sterilizations.

Despite the fact that the “Statement of Common Values” is mute about sterilizations and contraceptives, some of the hospitals that joined CHW were still required to stop providing these services. In August 1998, CHW acquired West Side District Hospital in Taft, California and renamed the hospital Mercy West Side Hospital. 149 Although the hospital was not technically considered Catholic, CHW discontinued all reproductive services at Mercy West Side. 150 Only five years later, for reasons I could not ascertain, Mercy Westside closed. 151 Another hospital acquired by CHW, South Valley Medical Center, also experienced a loss of all reproductive health services. 152 In August 1999, CHW merged with the Gilroy, California hospital and consolidated it with St. Louise Hospital, essentially combining St. Louise and South Valley Medical Center. 153 Against the “unanimous protest of all the OB/GYNs on staff,” all reproductive health services were cut, not just access to abortions. 154 Women in Gilroy, a largely rural, poor, Hispanic area, had to travel elsewhere to receive most reproductive services. One woman, profiled in a Mother Jones article, had to travel an hour to go to a hospital that would take her insurance. 155 Evidently, at least some of the secular hospitals that merged with CHW were required to abide by the ERDs, although they were supposed to be bound only by the less restrictive “Statement of Common Values.”

151 “History.”
152 “Catholic Health Care State Reports: California.”
154 “Catholic Health Care State Reports: California.”
Other hospitals that merged with CHW were not held to the ERDs and operated with greater autonomy in regards to reproductive care. Exactly how they were able to do this evidently depended on the situation. Some hospitals, as part of the merger, created unique corporate structures that moved “what the Catholic Church considers morally objectionable services into a separate corporation that’s not connected to the merged organization.” This ensured that “Catholic facilities do not govern, manage, or gain financially from objectionable services.” Other hospitals simply were not held to the ERDs as strictly (for reasons I could not readily discern), and if they did not perform abortions before the merger, delivery of other reproductive health services continued without interruption. Sierra Nevada Memorial Hospital in Grass Valley, California is an example of this type of merger. This secular facility wanted to merge with another healthcare system, but explicitly stated from the outset that it did not want to become Catholic. It merged with CHW in 1995 under the agreement that the hospital could continue providing sterilizations and contraceptives. Dr. Joe Lloyd, an anesthesiologist and board member at Sierra Nevada, noted that doctors at the hospital “felt it potentially would be a disservice to limit necessary services.” There was no need to prohibit abortions because Sierra Nevada did not provide them before the merger.

These examples show that the “Statement of Common Values” and ERDs were applied unevenly in hospitals that merged with CHW between 1992-2010. Some secular partners had to comply with both sets of requirements, other partners just with the “Statement.” Exactly why this happened is unclear, although it appears that the hospitals that were not required to comply with the ERDs had to specially negotiate that freedom in the merger agreement. It is difficult to obtain

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157 Bellandi.
158 Bellandi.
159 Bellandi.
detailed information about these partnerships and the rules governing them. The lack of transparency surrounding these mergers could conceivably raise public “right to know” questions for CHW, which is a non-profit, tax-exempt organization. However, none of the merged hospitals that cut services faced legal challenges on transparency (or any other grounds), from their communities, patients, employees, or other parties.

Section 3: St. Joseph’s Hospital in Phoenix

The effects of the ERDs on reproductive health services have not only been challenged by some secular employees and community members; those working solidly within the Catholic system have also resisted applying them at times. These cases are important because they reveal some of the central tensions that exist among Catholic healthcare providers who must apply the ERDs in morally complex situations, such as in a case that arose at St. Joseph’s hospital in Phoenix, Arizona. St. Joseph’s, one of the original Sisters of Mercy hospitals, was part of the original conglomerate of hospitals that formed Catholic Healthcare West. It was founded in 1895, and was originally dedicated to treating tuberculosis patients. An abortion performed at the hospital in 2009 led to its disaffiliation from the Church, and potentially set in motion CHW’s disaffiliation for the Church.

a. The facts of the emergency and the Ethical and Religious Directives

In November 2009, a medical emergency forced St. Joseph’s to make a decision regarding when exactly they must perform abortions under the Ethical and Religious Directives. A 27-year old woman came to the hospital suffering pulmonary hypertension, a life-threatening medical condition. Pulmonary hypertension is an increased abnormal pressure in the arteries of

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160 “Milestones from our Hospitals.” *Who We Are.* Dignity Health. 2014.
the lungs, which carry blood from the heart to the lungs so that the lungs can take in oxygen.\textsuperscript{161} When the pressure in the arteries rises, the heart must work significantly harder to push blood to the lungs. This causes overuse and weakness of the heart, and ultimately the heart will fail if the condition is not alleviated.\textsuperscript{162} Although pulmonary hypertension (PH) is usually diagnosed before a woman becomes pregnant, some women can develop the condition during pregnancy; these women (whose type of PH is registered as “other” in medical studies) have between a 33 and 56 percent mortality rate.\textsuperscript{163} Doctors at St. Joseph’s determined that the best way to ensure the woman’s survival was to terminate the 11-week pregnancy.\textsuperscript{164}

Whether or not the Ethical and Religious Directives (ERDs) allow for termination under these circumstances is somewhat complicated. At first, the issue seems black and white: directive number forty-five states:

> “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, it its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based on the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.”\textsuperscript{165}

This directive clearly draws the line in regards to the termination of pregnancy—Catholic institutions will not perform them. By “material cooperation,” the bishops who wrote the ERDs mean “when a Catholic organization does not intend the immoral object of the principal agent’s


\textsuperscript{162} “What Is Pulmonary Hypertension?”


\textsuperscript{164} Boston, Rob. “Prescription for disaster: hospital mergers and heavy-handed tactics are giving the Catholic hierarchy an increasingly problematic role in American health care.” Church & State. Vol. 64 no. 3, March 2011.

\textsuperscript{165} “Ethical and Religious Directives for Catholic Health Care Services.”
act, yet is involved in circumstances that materially contribute to the immoral action in some causal way.”

However, complicating this apparently airtight anti-abortion mandate (“it is never permitted”), directive forty-seven states:

“Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.”

Here, the bishops seem to indicate that if a pregnant woman has a serious medical condition that requires immediate attention, Catholic hospitals should administer treatment, even if it results in the death of the fetus.

Because these directives could be interpreted as contradictory and did not provide a clear-cut solution for the problem of the woman at St. Joseph’s hospital in Phoenix, Sister Margaret McBride (of the Sisters of Mercy), then the vice president of mission integration at St. Joseph’s, convened an ethics committee to decide what course of action the hospital should take.¹⁶⁶ Convening the ethics board accorded with directive thirty-seven, which states, “An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering education opportunities, and by reviewing and recommending policies.”¹⁶⁷ The ethics committee at St. Joseph’s ultimately decided that the hospital could end the pregnancy within the guidelines of the ERDs because doctors determined that the patient had almost a one-hundred percent chance of mortality, and “the goal was not to end the pregnancy but save the mother’s life,” according to a hospital statement.¹⁶⁸

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¹⁶⁷ “Ethical and Religious Directives for Catholic Health Care Services.”
Although the hospital did not explain its precise line of ethical reasoning after the
decision, it seems likely that they came to two conclusions. First, that the termination was not
actually a “procedure whose sole immediate effect is the termination of pregnancy before
viability” (directive 45). The procedure had two effects: the saving of the woman’s life, and the
termination of the pregnancy. The second conclusion that they likely drew was that pulmonary
hypertension was a “proportionately serious pathological condition” that had to be alleviated,
even though it resulted in the termination of the pregnancy. The president of the hospital, Linda
Hunt, stated, “If we are presented with a situation in which a pregnancy threatens a woman’s life,
our first priority is to save both patients. If that is not possible, we will always save the life we
can save, and that is what we did in this case. Morally, ethically, and legally, we simply cannot
stand by and let someone die whose life we might be able to save.”

After the news came out that a Catholic hospital had performed a medically necessary
abortion, the Catholic Health Association of the United States (hereby referred to as CHA)
issued a statement supporting St. Joseph’s decision. CHA is an official ministry of the Catholic
Church, and is the umbrella organization or trade association for over 600 Catholic hospitals and
1,400 other Catholic health facilities in the United States. Nearly all designated Catholic
hospitals are part of the CHA, although the CHA is not overseen directly by the Church (or by
the US Council of Bishops) but rather by a board of trustees and CEO. The president and CEO
of CHA, Sister Carol Keehan, a member of the Daughters of Charity of Saint Vincent de Paul,
responded in regards to the St. Joseph case that the hospital “correctly applied” the church

169 Myers.
170 “About.” Catholic Health Association of the United States.
guidelines in saving “the only life that was possible to save.” She noted, following the hospital’s direction, that it was a “heartbreaking” and challenging situation.

b. The response of Bishop Thomas Olmsted and an explanation of his theological determinations

The Bishop of Phoenix, however, condemned the actions of the hospital and stripped the hospital of its Catholic status. Following the news that the hospital had performed an abortion, Bishop Thomas Olmsted publicly disagreed with the decision of the St. Joseph’s ethics committee, arguing that the “exceptional cases, mentioned in ERD #47, were not met,” because:

“There was not a cancerous uterus or other grave malady that might justify an indirect and unintended termination of the life of the baby to treat the grave illness … the baby was healthy and there were no problems with the pregnancy; rather, the mother had a disease that needed to be treated. But instead of treating the disease, St. Joseph’s medical staff and ethics committee decided that the healthy, 11-week-old baby should be directly killed.”

Evidently he believed (contradicting established medical opinion) that other treatment options for the “disease” were available, and thus, the termination had not been a necessary treatment for the patient’s pulmonary hypertension. After informing St. Joseph’s administrators that he disagreed with their decision, Olmsted told president of CHW Lloyd Dean that the hospital must “admit to its ethics violation, commit to avoiding abortion under all circumstances, and retrain staff members [about the Ethical and Religious Directives] through an institution of his choosing.”

The hospital, however, refused to admit wrongdoing. The hospital’s medical director, Dr. Charles Alfano, said that “what he [the bishop] wanted us to do was impossible,

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considering the level of care we provide.”\textsuperscript{175} Here, Alfano implicitly acknowledges a contradiction in the Ethical and Religious Directives (or at least, in the Bishops’ interpretation of them). The moral imperative to provide high-level health care to pregnant women makes it impossible to guarantee that the hospital will never again perform another abortion.

For Olmsted, the abortion at St. Joseph’s was the final straw in what he perceived to be a long line of violations of the ERDs by CHW in Arizona. He identified two central sources of ERD violations: first, the form of insurance provided to Arizona’s poor that it accepted, and second, various services performed by the secular CHW hospital Chandler Regional.

Since 1986, CHW hospitals in Arizona have participated in Arizona’s Mercy Care Plan. Mercy Care is a non-profit health-insurance plan that works with Arizona’s Medicaid and Medicare systems (called Arizona Health Care Cost Containment System) to provide additional health care coverage for those eligible for Medicare and Medicaid.\textsuperscript{176} Most states, including Arizona, provide Medicaid family planning eligibility expansions that include birth control and contraceptives.\textsuperscript{177} Because a primary value of CHW is to offer access to healthcare for the indigent, it makes sense that CHW hospitals would take Mercy Care patients. Mercy Care covers prescriptions for contraceptives and also sterilizations, both of which are not allowed under the ERDs. St. Joseph’s Hospital’s CEO, Linda Hunt, explained that all services and procedures not in compliance with the ERDs are “farmed out to a third party,” and not provided at the hospital.\textsuperscript{178} However, according to Olmsted, even providing counseling about these procedures

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\textsuperscript{176} “About Us.” \textit{Mercy Care Plan.} Mercy Care. 2014.


\textsuperscript{178} Clancy.
and organizing them at other hospitals “consists in formal cooperation in evil actions which are contrary to Church teaching.”\textsuperscript{179}

In addition to condemning the Mercy Plan, Olmsted also criticized CHW because Chandler Regional Hospital, a non-Catholic hospital owned by CHW, performed sterilizations and offered contraceptives. His Dec. 21, 2010 letter claimed that he had known this for some time and explained that he had “told CHW leaders that this constituted cooperation in evil that must be corrected; because if a healthcare entity wishes to call itself Catholic (as in ‘Catholic Healthcare West’), it needs to adhere to the teachings of the Church in all its institutions.”\textsuperscript{180} Olmsted asserted not only that because Chandler Regional is affiliated with CHW it must follow the ERDs, but also that CHW’s failure to enforce the Directives at Chandler constituted “cooperation in evil.”

Chandler Regional’s adherence to the ERDs, however, is a more complex issue than the bishop made it seem in his statement. Chandler Regional became part of CHW in 1999. As part of the merger agreement, Chandler Regional was not required to adhere to the ERDs, but rather CHW’s “Common Values for Community Partnership” (a precursor to the previously-mentioned “Statement of Common Values”).\textsuperscript{181} According to these Common Values, Chandler Regional could not perform any abortions, in vitro fertilizations, or euthanasia procedures. It did not, however, proscribe tubal ligations, and the merger agreement specifically allowed Chandler Regional to continue performing these procedures. Physicians at Chandler Regional expressed concern about this before the merger, because tubal ligations are typically performed post-delivery, and it would burden women who gave birth at Chandler to have to schedule the

\textsuperscript{179} “St. Joseph’s Hospital no longer Catholic.”
\textsuperscript{180} “St. Joseph’s Hospital no longer Catholic.”
procedure at a different time and at a different hospital.\textsuperscript{182} In order to ensure the success of the merger, the two groups compromised on this procedure.

Further complicating the matter, the edition of the ERDs published in 1995 and available at the time of the 1999 merger between Chandler and CHW did not include two of the directives added to the later ERD versions (2001 and 2009). The section titled “Forming New Partnerships with Health Care Organizations and Providers” in the newer 2001 edition of the directives added, “Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization” (directive 70).\textsuperscript{183} Also relevant to the dispute was an addition to the 2001 directives, supplementing directive 71, which states, “The diocesan bishop has final responsibility for assessing and addressing issues of scandal, considering not only the circumstances in his local diocese but also the regional and national implications of his decision.”\textsuperscript{184} This seemed to justify Olmsted’s overriding and punishing the hospital administration’s decision. In addition to these amendments to the directives, the introduction to the section says, “the brief articulation of the principles of cooperation that was presented there [in the 1995 directives] did not sufficiently forestall certain possible misinterpretations and in practice gave rise to problems in concrete applications of the principles.”\textsuperscript{185} This represents a tightening of the rules on the part of the bishops in response to earlier mergers in which some hospitals did not have to follow the ERDs. Besides these additions, the newer edition of the ERDs eliminated an appendix in the 1995 edition. The appendix “permitted immediate material cooperation in some circumstances,” and said, “immediate material cooperation is wrong, except

\textsuperscript{182} Larson.
\textsuperscript{183} “Ethical and Religious Directives for Catholic Health Care Services.”
\textsuperscript{184} “Ethical and Religious Directives for Catholic Health Care Services.”
\textsuperscript{185} “Ethical and Religious Directives for Catholic Health Care Services.”
in some instances of duress. The matter of duress distinguishes immediate material cooperation from implicit formal cooperation."\textsuperscript{186} The elimination of this appendix again indicates that the bishops were trying to close loopholes that had previously allowed merged hospitals to provide contraceptives and sterilizations. But, the fact that these loopholes were not closed until after the Chandler-CHW merger indicates that Chandler was abiding by the previous rules and not the most updated ones.

Many of the changes to the ERDs were related to the Principle of Cooperation in Evil. The Principle of Cooperation in Evil is a complex theological concept, but worth briefly discussing here in order to understand Olmsted’s reasoning in disaffiliating St. Joseph’s from the Catholic Church. According to the National Catholic Bioethics Center, these principles were developed in order to help individuals (and more recently, groups or corporations) determine what types of Catholic-secular cooperation are morally acceptable, and how to “properly avoid, limit, or distance themselves from evil.”\textsuperscript{187} The Center notes, “moralists have long recognized that under many circumstances, it would be impossible for an individual to do good in the world, without being involved to some extent in evil.”\textsuperscript{188} Every act has three components: the “moral object,” or the “precise good or evil which characterizes that act”; the intention behind the act; and the circumstances of the act. A cooperator can be part of any of all of these three components.\textsuperscript{189} The principle of cooperation is divided into two main types: formal and material.

Formal cooperation in evil is defined as “assistance provided to the immoral act of a principal agent in which the cooperator intends the evil,” and there are two subgroups of formal

\textsuperscript{187} “What is the Principle of Cooperation with Evil?” National Catholic Bioethics Center. No date given.
\textsuperscript{188} “What is the Principle of Cooperation with Evil?”
\textsuperscript{189} “What is the Principle of Cooperation with Evil?”
cooperation. Explicit formal cooperation occurs when the cooperator “directly approves of (intends and concurs with) the principal agent’s immoral act.” An example of this would be if a Catholic hospital CEO wrote and implemented a policy that allowed for tubal ligations and vasectomies in his/her hospital. Although the CEO would not be actually performing the sterilizations, he does “give assistance to it through the policy,” and “does intend the act to occur on hospital premises and under their auspices.” The second subgroup of formal cooperation is called implicit formal cooperation, and occurs “when the cooperator intends the evil of the principal agent, not for its own sake but as a means to some other end that, by itself, might be morally good.” In this situation, the cooperator may seek a good end but does so at the cost of participating in an immoral act. An example of this would be if a Catholic hospital were to merge with a secular one because it is at risk of becoming economically unviable, and in the merger process, agrees to allow sterilizations occur at the Catholic hospital. Although the end is good—making sure the hospital remains economically viable/profitable—the CEO (cooperator) would be cooperating implicitly in sterilizations that occur as a result of the merger agreement.

Neither form of formal cooperation is permitted in any circumstance.

The other type of cooperation in evil as determined by the National Catholic Bioethics Center is material cooperation. This is defined as “assistance provided to the immoral act of a principal agent in which the cooperator does not intend evil.” The primary difference between formal and material cooperation is intention. As with formal cooperation, there are two forms of material cooperation: immediate material cooperation and mediate material cooperation.

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190 “What is the Principle of Cooperation with Evil?”
191 “What is the Principle of Cooperation with Evil?”
192 “What is the Principle of Cooperation with Evil?”
193 “What is the Principle of Cooperation with Evil?”
194 “What is the Principle of Cooperation with Evil?”
195 “What is the Principle of Cooperation with Evil?”
Immediate material cooperation occurs when “the cooperator does not share the intentions of the principal agent but participates in circumstances that are essential to the commission of an act, such that the act could not occur without this participation.”\(^{196}\) This form of cooperation is explicitly banned. An example of immediate moral cooperation would be if a Catholic hospital/healthcare system offered to provide another hospital with surgical instruments as part of an affiliation or collaboration, and the hospital to which they were giving the instruments provided sterilizations and/or abortions. In this case, there would be no intent on the part of the Catholic hospital to provide sterilizations, but the sterilizations would still occur because of the Catholic hospital’s gift of surgical instruments.\(^{197}\) Mediate material cooperation differs from immediate material cooperation, and occurs “when the cooperator participates in circumstances that are not essential to the commission of an action, such that the action could occur even without this cooperation.”\(^{198}\) The example offered by the National Catholic Bioethics Center is if two hospitals, one non-Catholic that provides sterilizations and one Catholic that does not, agree to wash their lab coats and surgical clothing together in order to save money. In this case, the Catholic hospital’s cooperation does not determine or affect whether the non-Catholic hospital performs sterilizations. This form of cooperation is allowed, as long as it does not create “scandal.”

The Principle of Theological Scandal is the final component of the Principle of Cooperation; Olmsted raised this issue in his statement regarding the disaffiliation of St. Joseph’s with the Catholic Church. The Catechism of the Catholic Church defines scandal as “an attitude or behavior which leads another to do evil,” and says that “anyone who uses the power at his disposal in such a way that it leads another to do wrong becomes guilty of scandal and

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\(^{196}\) “What is the Principle of Cooperation with Evil?”
\(^{197}\) “What is the Principle of Cooperation with Evil?”
\(^{198}\) “What is the Principle of Cooperation with Evil?”
responsible for the evil that he has directly or indirectly encouraged.” According to the National Catholic Bioethics Center, if mediate material cooperation causes scandal that “cannot be overcome,” then it is not morally acceptable. This statement regarding scandal is, however, very vague and never clearly defined.

Olmsted claimed that St. Joseph’s had provided formal cooperation with evil and was also guilty of scandal. He did not explicitly articulate the type of formal cooperation with evil (explicit or implicit) that he believed the hospital had engaged in. However, he did note that CHW had not “addressed in an adequate manner the scandal caused by the abortion.” Because CHW did not address this scandal properly, CHW was, according to Olmsted, responsible for the evil.

Because CHW and St. Joseph’s refused to admit wrongdoing, refused to ensure that another situation such as a medically necessary abortion would never occur, and refused to stop sterilizations at Chandler Regional, Olmsted decided that St. Joseph’s could no longer be affiliated with the Catholic Church. Bishop Olmsted said in a news conference, “It is my duty to decree that … at St. Joseph’s Hospital, CHW is not committed to following the teaching of the Catholic Church and therefore this hospital cannot be considered Catholic.” In practice, this meant that the hospital could no longer call itself Catholic, could no longer have Mass celebrated at the hospital, and was prohibited from “reserving the Blessed Sacrament in the Chapel.” Additionally, St. Joseph’s is no longer part of the Catholic Healthcare Association (previously

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200 “What is the Principle of Cooperation with Evil?”
201 “St. Joseph’s Hospital no longer Catholic.”
203 “St. Joseph’s Hospital no longer Catholic.”
mentioned CHA). According to Olmsted, the hospital can only be called Catholic again if he becomes convinced that the “institution is authentically Catholic by its adherence to the Ethical and Religious Directives of the United States Conference of Catholic Bishops, in addition to the standards of Catholic identity set forth in official church documents, Catholic theology, and canon law.”

**Section 4: Creation of Dignity Health**

Approximately two years after Olmsted revoked St. Joseph’s Catholic status, CHW announced on January 23, 2012 that it was dropping its “formal connection to the Roman Catholic Church” and rebranding itself as Dignity Health (DH). At the time, CHW had thirty-eight hospitals in Arizona, California, and Nevada and was the fifth largest Catholic healthcare system in the United States based on revenue. Its revenue had grown immensely in the years preceding the disaffiliation, despite the fact that it had not recently merged with any other hospitals: in Fiscal Year (FY) 2010, it reported a $485.7 million in net income; in FY 2011, it reported a $917 million in net income, an eighty-nine percent increase. Making a major change in the midst of huge growth seems questionable, from a business model perspective.

CHW/Dignity executives did not do much to illuminate exactly why they chose to disaffiliate with the Church and rebrand themselves. A statement released by the newly formed Dignity Health explained that the group wanted to figure out “how to best extend its health mission,” and that “Dignity Health’s longer term strategic plan is focused on integrated care and enhanced quality that reduces costs.” CEO Lloyd Dean said, “Changing our name to Dignity Health reflects our commitment to excellent care for all in need and to being a leader in quality

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205 “St. Joseph’s Hospital no longer Catholic.” Selvam 6.
206 Selvam.
207 Selvam.
care. The new structure supports our long-term plan to grow and coordinate care, while reinforcing our mission of service to the communities we are so privileged to serve."\textsuperscript{209} In effect, the CEO claimed that changing the name to Dignity and dropping its affiliation with the Catholic Church would help the not-for-profit corporation “grow.” He said this despite the fact that, in recent years, CHW had grown enormously. Implicit in Dean’s statement is the conviction that in order for the healthcare system create new partnerships and grow even further, it had become necessary to separate from the Church. Martin Arrick, a director of Standard & Poor’s Public Finance Ratings Group, which adjusts credit ratings, noted that dropping the Church affiliation would “accelerate merger and acquisition plans.”\textsuperscript{210}

Although entirely avoided in the official press release by Dignity Health, it seems reasonable that the group severed its connection to the Church in part because disaffiliating gave full control of the system to its CEO and those he chose to work collaboratively with him. In a letter leaked after the St. Joseph’s Hospital crisis, Olmsted admonished Dean for making his own decisions and advancing an independent evaluation of the situation. In the letter, Olmsted wrote that by interpreting the morality of the abortion that occurred at St. Joseph’s, Dean “disregards my authority and responsibility to interpret the moral law and to teach the Catholic faith as a Successor of the Apostles,” and also that the “theology of the Catholic Faith, as concretized in the Code of Canon Law, dispels any doubt whose opinion on matters of faith and morals is decisive for institutions in the Diocese of Phoenix.”\textsuperscript{211} According to Olmsted, only he, as “chief shepherd in the diocese,” had the power to “interpret whether the actions of St. Joseph’s and other hospitals meet the criteria of fulfilling the parameters of the moral law as seen in the

\textsuperscript{209} "Catholic Healthcare West is Now Dignity Health."
\textsuperscript{210} Selvam.
Essentially, Olmsted insisted upon asserting canonical authority over the decisions of administrators, health care professionals, and medical experts involved in delivering services through CHW. In disaffiliating with the Catholic Church, Dignity administrators resisted Olmstead’s power and reasserted their authority over the administration of healthcare.

This arrangement would enable the hospitals of Dignity Health to make decisions that they believe are medically and morally sound, that comply with American Medical Association guidelines, and that respect United States laws regarding medical malpractice. As stated previously, doctors and administrators at St. Joseph’s were concerned (among other issues) that treating high-risk pregnancies would periodically make abortions medically necessary. Refusing to provide an abortion when the mother’s life could be saved by the procedure would be considered failing to provide an acceptable standard of care. There are obviously moral implications in this, but also real potential legal ramifications. Refusing to provide lifesaving care makes physicians and hospitals vulnerable to medical malpractice lawsuits, as indicated in Part I of this thesis. Following disaffiliation from the Church, Dignity providers would be free to perform whatever life-saving procedures they deemed necessary.

There were not significant, measurable changes in the values of the hospital after it dropped its association to the Church. Before, CHW’s Catholic hospitals abided by the ERDs and its non-Catholic hospitals generally adhered to the “Statement of Common Values” (with many exceptions and variations, as noted above). Dignity hospitals still do not perform elective abortions or allow euthanasia. However, if hospital physicians believe it is necessary to perform an abortion for health reasons, they are free to do so without fearing repercussions from Church leaders.

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212 Olmsted.
Section 5: Other hospitals wary of joining Dignity

Despite the success and financial clout of Dignity Health, some hospitals are still wary of joining the group because of the “Statement of Common Values.” Although it is disaffiliated with the Catholic Church, public suspicions and resistance remain. Recent events in Ashland, Oregon illustrate this phenomenon.

Ashland is a small town in Southwest Oregon with a population of 20,366 and one hospital system.213 In 2010-2011, Ashland Community Hospital (ACH) faced significant financial problems and began looking to merge with another healthcare system. In the 2010 fiscal year, the hospital experienced a $3.3 million loss due to unreimbursed costs related to Medicare and Medicaid, and because they provided other charity care.214 In order to maintain economic viability, the hospital needed to merge with a larger hospital. At the same time, Dignity was looking to expand—the company wanted to own more hospitals outside California, and announced in early 2012 that it hoped to “triple in size by 2020.”215 Both Dignity and the board of directors at ACH initially believed it would be a good match and in April of 2012 began negotiating terms.

Significant community resistance to the merger developed, however, because of Dignity’s “Statement of Common Values.” A summary of the preliminary agreements between Dignity and ACH indicated that the newly merged hospital would have to abide by Dignity’s “Statement of Common Values.” This was obviously a tradeoff for the many “capital commitments” Dignity agreed to make to ACH—in particular, their agreement to “fund ACH’s annual routine capital needs, on average, in an amount equal to ACH’s capital equipment

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depreciation,” and also funding all of their “strategic initiatives,” like adding more services and general “growth and other capital projects.” Doctors at ACH supported the merger because they believed it would solve their financial problems. Dr. Miriam Soriano, the chief of medical staff, said, “Dignity is vital to having a hospital here. I definitely feel like this is something we must do.” ACH’s CEO, Mark Marchetti, noted that without a partnership, the hospital would face “a significant reduction in services that clearly are not financially sustainable.” Many members of the community, however, were skeptical of the merger and afraid that it would result in a reduction of services. Many signed a change.org position to “Vote NO on Dignity Health’s acquisition of Ashland Community Hospital,” noting that the merger could “have a severe impact on jobs, the quality of care, and the rights of patients and doctors.” ACH doctors rebutted these claims, saying, “as far as the community being concerned about abortion and Death with Dignity, neither of those things pertain to the hospital. Abortion is a total non-issue for us here, and as far as Death with Dignity, you can’t do it in the hospital, it’s built into the [Death with Dignity] law.”

Dignity and ACH negotiated terms for six months, yet eventually were unable to agree on final terms because of the community opposition. Dignity apparently decided to end the acquisition talks, saying only that the “two organizations were not able to reach an agreement on the final closing conditions for the merger and have decided to end negotiations.” Although the details of the failed merger were confidential, many have speculated that the deal fell apart.

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216 “Affiliation Transaction Summary: Ashland Community Hospital-Dignity Health.” Archives. City of Ashland.
219 “Vote NO on Dignity Health’s acquisition of Ashland Community Hospital.” Change.org. Change.org Inc. Date unclear.
220 Wheeler, “Ashland physicians push merger with Dignity.”
due to lack of community support, considering that there were apparently no other issues that the two groups disagreed about. In June 2013 ACH decided to merge with Asante, a secular healthcare provider in Oregon and northern California. This particular situation between ACH and Dignity shows that although Dignity has formally disaffiliated from the Church, the fear of ecclesiastical backlash still exists for hospitals Dignity may want to acquire.

**Part II Conclusion**

Part II of the thesis reveals that oftentimes the biggest problems in mergers between Catholic and secular hospitals do not arise because of legal restrictions but rather ecclesiastical issues. The crux of the problem at St. Joseph’s hospital, which seems causally related to Dignity Health’s subsequent disaffiliation with the Catholic Church, lay in Bishop Olmsted’s ecclesiastical and moral assertion of authority in decisions involving healthcare. The strict nature of the ERDs, as well as the rigid nature in which Olmsted chose to apply them, made it impossible for CHW/Dignity to provide the services hospital administrators and the board believed were consistent with providing good healthcare and maintaining relationships with their non-Catholic hospitals. This could ultimately prove a limitation for the Church in the extent to which they can expand Catholic healthcare services. If the Church continues to ambiguously or rigidly enforce adherence to the ERDs on its partners, and/or demand submission to the opinions of the presiding Bishop, hospital administrators and CEOs may be increasingly unwilling to remain Catholic or to merge with Catholic hospitals.

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223 Wheeler, Sam. “Ashland gives OK to Asante hospital merger.” The Mail Tribune. Local Media Group. 5 June 2013.
Conclusion

This thesis began with questions about the legal and ecclesiastical issues involved in Catholic healthcare and hospital mergers. I wanted to understand how the Catholic Church’s policies on reproductive healthcare have caused legal complications for hospitals, as well as how these policies and their application, coupled with medical emergencies, have created major ecclesiastical issues for the Church and its hospitals. Finally, I wanted to know why these mergers sometimes failed—was it because of legal complications, ecclesiastical crises, or both?

The answers to these questions are inevitably complicated. This research has deepened my appreciation for, and understand of, their complexity. The legal challenges to Catholic healthcare in general and mergers in particular are significant, especially when they involve issues of conflicting values and potential medical malpractice. However, the legal challenges were not as significant as I originally expected. The First Amendment, the typical hot button issue in the mixing of religion and public life, turned out to be largely irrelevant when it came to Catholic healthcare and hospital mergers. This is because other laws, such as conscience clauses, have already been well established to shape the resolution of conflicts over religion in this area. In addition, the Supreme Court has upheld the ability of religious non-profit organizations to receive government funding on the basis that these organizations provide a public good. This realization was fundamentally surprising to me, since I expected the First Amendment to underlie much of the discussion about, and legal struggle over, these issues.

Equally surprising was the fact that ecclesiastical issues are more contentious than legal ones in these mergers and in Catholic healthcare. The complexity of the ecclesiastical issues in the St. Joseph’s case shows how muddled and inflammatory these conflicts can become. In this situation, Bishop Olmsted prioritized the ecclesiastical issues over the potential legal problems.
He effectively said that upholding the Church’s ban on abortion was more important than the potential legal ramifications for refusing to treat a seriously ill patient. Of course, this situation is one in which the saying “hindsight is 20/20” seems appropriate—Olmsted was reviewing the case after the fact, when the patient had not actually died. However, his insistence that Catholic Healthcare West never perform an abortion if a similar situation were to arise indicates this prioritizing of ecclesiastical dogma over potential legal ramifications. It also demonstrates the Church’s insistence on a specific ecclesiastical ideal of “ethics:” one that seems to narrowly privilege the principle of “not killing” an unviable fetus over the possibility of saving an adult woman’s life. Clearly, other (non-ecclesiastical) ethical interpretations of that situation are possible and valid.

This hard-line position, combined with recent amendments to the Ethical and Religious Directives that grant ultimate decision-making authority to Church leaders over medical experts, ensures that the future of Catholic healthcare and hospital mergers will indeed be fascinating. As mentioned in Part I, the Bishops are facing a lawsuit that directly challenges the ERDs on the basis that they require hospitals to provide substandard care. The lawsuit alleges that the hospital in question did not provide adequate care and also did not allow for informed consent. Because the hospital followed the ERDs, the patient named in the lawsuit (Tamesha Means) suffered a dangerous miscarriage resulting in prolonged labor and delivery of a stillborn breech baby. This is the first case in which someone has directly sued the bishops rather than the hospital at which the incident occurred. It is unclear what the outcome of this trial will be, but it should certainly set legal precedents (and open up new legal options) for these types of cases in the future. It represents a direct legal challenge to established ecclesiastical dogmas, and the outcome will have significant repercussions.
Doing research for this thesis and analyzing complex cases challenged some of my previous misconceptions about Catholic healthcare. When I proposed the topic, I approached it with a view of Catholic healthcare that was not particularly nuanced. Initially, I only saw the restrictions on reproductive healthcare. However, in studying the history and implementation of Catholic healthcare more closely, I’ve gained a much fuller picture about the value and importance of Catholic healthcare in the United States. The most important realization is that sometimes, Catholic hospitals are the only ones in town who will take patients who on Medicaid or Medicare. The Catholic mission mandates charity for the needy—the very people other hospitals turn away. Catholic Healthcare West/Dignity Health in Arizona provides an example of this. As discussed in part two, St. Joseph’s Hospital partnered with Arizona’s Mercy Care Plan specifically to provide additional health care coverage for people on Medicare and Medicaid. Catholic hospitals in general tend to accept more Medicaid and Medicare patients, a fact I was unaware of at the beginning of this research. Of course, the fact that many Catholic hospitals have very restrictive policies regarding reproductive healthcare remains troubling, and sometimes this policy hits the poor (like Hispanic women in Gilroy, California) the hardest. My knowledge of Catholic hospitals is nevertheless much more comprehensive and nuanced.

I also began my research with the misconception that all Catholic hospitals follow the Ethical and Religious Directives to the letter and simply never offer any of the services forbidden in the Directives. This did not prove to be true. The Directives are not interpreted or applied uniformly, and the confusion that this can cause is evident in the St. Joseph’s and Chandler Regional Hospital case involving Bishop Olmsted. Had the Directives been applied uniformly throughout the country Chandler Regional Hospital would not have been providing sterilizations and contraceptives. One of the physicians I spoke with at Swedish Hospital noted that hospitals
work with priest ethicists to determine which services the hospitals can and cannot provide. This implies that the Directives are not applied uniformly but rather in context. Again, this offers a more nuanced picture of Catholic healthcare.

A considerable amount of further work could, and should, be done on this topic. One specific line of inquiry that I think is both timely and necessary would be to assess how the Ethical and Religious Directives and Catholic bioethics mesh with secular bioethics. As implied in the title of the thesis, Catholic medicine and ethics raise the precise question of who “do no harm” refers to. The phrase comes from the Hippocratic oath, which includes a statement that loosely translates to “I will do no harm or injustice to them [patients].”224 In cases involving reproductive health such as the crisis that unfolded at St. Joseph’s Hospital, does the “no harm” clause refer to the mother or the fetus? How might secular bioethicists and Catholic theologians and ethicists deal with this question? In their official response to Tamesha Means’ recent legal case against the United States Council of Catholic Bishops (USCCB), the USCCB president Archbishop Joseph Kurtz said that the Church “witnesses against a utilitarian calculus about the relative value of different human lives.”225 That may be so, but sometimes it is still necessary to choose. How does this stance relate to secular medical ethics adopted by the American Medical Association? What other ethical conflicts exist among different healthcare organizations? It would be intriguing to evaluate the medical Directives that have emerged within secular ethics systems and comparatively analyze them.

Another interesting extension of this thesis would be to examine how biomedical and bioethical interpretations shape healthcare in other countries, and evaluate ways in which those

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and how those countries do, or do not, incorporate Catholic bioethics into their laws. Is Catholic bioethics transnational, or are they contained within individual countries? Although the Catholic Church is transnational, different countries incorporate religion, and specifically Catholicism, into their laws and practices in unique ways. The United States government and its institutions inevitably deal with Catholic bioethics differently than Ireland. The death of Savita Halappanavar in Ireland was briefly mentioned twice in this thesis. As she experienced her miscarriage, she and her husband were told by Galway University Hospital’s midwife that her pregnancy could not be terminated because “Ireland is a Catholic country.”

In how many countries is Catholic bioethics civil law? Ireland has since passed a law titled “The Protection of Life During Pregnancy Act” that allows for abortions “where there is a threat to the mother,” or when there is a consensus among doctors that “the expectant mother will take her own life over her pregnancy.” What was the Ireland Conference of Catholic Bishops’ response to this? Have other Catholic countries followed Ireland?

Although it was too soon to address the topic in this thesis, it clearly will be important to study how the Affordable Care Act affects access to medical care, and specifically if it will affect the number of people seeking treatment at Catholic hospitals. Around eight million people have obtained healthcare through the ACA. In addition to this, the ACA expanded Medicaid coverage. This means that many more people will have health insurance and will use healthcare facilities, including Catholic hospitals. It could also mean, though, that people who traditionally might have gone to Catholic hospitals for financial reasons or lack of other options will now be able to go elsewhere. Like so many other unknown aspects of the ACA, this remains to be seen; clearly, I can do more than raise questions and speculate here. On first assessment, expansion of

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coverage to eight million people seems likely bring in new patients to Catholic healthcare systems, even if they have a variety of healthcare options. This is simply because more people will be able to seek medical treatment on a regular basis. And all facilities providing healthcare will be more fully utilized.

Despite their differences, Catholic and secular hospitals share a common fundamental purpose: taking good medical care of people who are ill, injured, or otherwise in need of their services. It is crucial that in order to continue to provide high-quality medical care, these hospitals find common ground despite different ethical frameworks. Some healthcare systems such as the newly reorganized Dignity Health, which are dedicated to the service of some of our society’s most desperate and helpless, can and have modeled collaborative partnership. As indicated in the CHW/Dignity Health case, this process of collaboration takes considerable work and can be highly contentious. However, if the United States is to expand healthcare access to all corners of the country, this collaboration is vital.
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