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Unholy Alliance

The controversy over the Catholic Church and health care goes beyond birth control.

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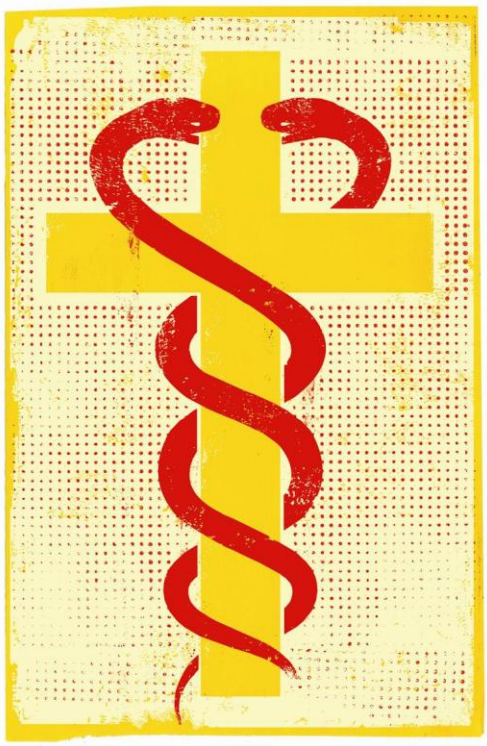

When the Obama administration decided that birth control coverage would be mandatory for all insurance policies, even those provided to employees by large religious institutions, the outcry from Catholic leaders and social conservatives surprised a lot of people. But conflicts between health care and religion, particularly Catholicism, are not news in many parts of the country. Just ask physicians in Sierra Vista, Arizona.

Sierra Vista is a rural community about 80 miles southeast of Tucson and about 20 miles north of the Mexican border. It has one hospital: the Sierra Vista Regional Health Center. In 2010, administrators announced that their secular institution would be joining the Carondelet Health Network, a system of Catholic hospitals. The intention was to make the hospital more financially viable, the administrators explained, but it would also entail some changes: The obstetrics service would have to abide by care directives from the Catholic Church. Although the merger would not be official for another year, staff would begin observing Catholic medical guidelines right away.

The hospital did not perform elective abortions, which is typical for small conservative communities. But the obstetricians were accustomed to terminating pregnancies in the event of medical emergencies. And just such a case presented itself one November morning, when a woman, 15 weeks pregnant, arrived at the emergency room in the middle of a miscarriage. According to a deposition later obtained by *The Washington Post*, the woman had been carrying twins and passed the first fetus at home in the bathtub. When she arrived via ambulance, she was

stable and not bleeding. But the umbilical cord from the first fetus was coming out of her vagina, while the second fetus was still in her uterus.

Robert Holder, the physician on duty who gave the deposition, said the odds of saving the second fetus were miniscule. Doctors would need to tie off the umbilical cord and put the woman at severe risk of infection. After discussing the options, the family, with some difficulty, opted for a medical termination. But, under the new rules, Holder had to get approval from a nurse manager and eventually a more senior administrator. When Holder briefed the administrator, she asked whether the fetus had a heartbeat. It did, he said. "She replied that I had to send the patient out for treatment," Holder later recalled. He arranged for the woman to get the procedure at the nearest major medical institution—in Tucson. According to his account, the 90-minute trip put her at risk of hemorrhaging and infection, which did not happen, and "significant emotional distress," which did.

Holder said that an official from Ascension Health, which oversees Carondelet, told him earlier that the rules permit terminating a pregnancy when a spontaneous abortion seems inevitable. (Officials from Ascension and Sierra Vista were not available for comment.) But Bruce Silva, another obstetrician on staff and an early skeptic of the merger, told me that confusion over the rules was common. "We couldn't get a straight answer," Silva says. "There was so much gray area. And sometimes you need to make these decisions quickly, for medical reasons." Even when the new rules were clear, Silva adds, they sometimes prevented physicians from following their best clinical judgments, not to mention their patients' wishes. A prohibition on tubal ligations, a surgical form of sterilization that severs or blocks the fallopian tubes, meant women had to go elsewhere for this procedure. However, physicians routinely perform this operation as part of a cesarean section, either when patients have requested the procedure or when it's medically recommended, in order to avoid a second invasive surgery and the attendant medical risks. "I had a patient who was blind. She and her husband were working but poor, and she was diabetic, too," Silva told me. "She was having her second baby, and that's all she wanted and she's got these medical issues. She asked for a tubal ligation. And I can't do it."

CATHOLIC HOSPITALS have been a bulwark of U.S. health care since the early twentieth century, when orders of nuns from Europe came to tend to the immigrant communities powering the industrial revolution. Many of these hospitals provided care to people of all faiths. But their first order of business was to help fellow Catholics, particularly those of the same ethnicity, who required care—and, frequently, last rites—delivered in a language they understood. In this respect, the Catholic institutions were like religious hospitals from other faiths that provided services for their own followers, whether it was Lutheran hospitals that could communicate with patients in their native German or Jewish hospitals that provided only kosher food on the wards.

Today, Catholic hospitals supply 15 percent of the nation's hospital beds, and Catholic hospital systems own 12 percent of the nation's community hospitals, which means, according to one popularly cited estimate, that about one in six Americans get treatment at a Catholic hospital at some point each year. We now depend upon Catholic hospitals to provide vital services—not just direct care of patients, but also the training of new doctors and assistance to the needy. In

exchange, these institutions receive considerable public funding. In addition to the tax breaks to which all nonprofit institutions are entitled, Catholic hospitals also receive taxpayer dollars via public insurance programs like Medicare and Medicaid, as well as myriad federal programs that provide extra subsidies for such things as indigent care and medical research. (Older institutions also benefited from the 1946 Hill-Burton Act, which financed hospital construction for several decades.)

But sometimes the dual mandates of these institutions—to heal the body and to nurture the spirit, to perform public functions but maintain private identities—are difficult to reconcile. That was the issue with the recent contraception controversy. The whole point of the new health care law is to make insurance a public good to which every citizen is entitled, regardless of where he or she works. And, because employers have traditionally been the source of insurance for most working Americans, the law effectively deputizes employers to provide this public good. In some cases, that means forcing religious institutions to pay for benefits—such as birth control—that violate the terms of their faith. Even Sister Carol Keehan, president of the Catholic Health Association and a staunch supporter of health care reform, protested the contraception rule, arguing, "The explicit recognition of the right of Catholic organizations to perform their ministries in fidelity to their faith is almost as old as our nation itself."

This tension has implications that go far beyond birth control. In 2004, during the Terri Schiavo controversy, Pope John Paul II decreed that Catholic health care providers had obligations to provide food and water intravenously—even to patients in vegetative states, as long as doing so would keep them alive indefinitely. The U.S. Conference of Catholic Bishops interpreted that as a mandate to provide life-sustaining treatment except in cases where treatment would be "unduly burdensome to the patient"—prompting ethicists at different hospitals to debate when, and whether, that prohibited physicians from removing feeding tubes for patients with no hope of recovery. When President Obama early in his term announced a new policy for stem-cell research, leaders of Catholic hospitals hinted their institutions were not likely to allow such projects, clinical value notwithstanding.

Still, reproductive health is the area that has given rise to the most public controversies. In 2007, a physician wrote an essay in the *Journal of the American Medical Association* about a woman, also pregnant with twins, whose pregnancy was failing, threatening infection that could jeopardize her ability to have future children and perhaps her life. Distraught, she and her husband decided to terminate the pregnancy—only to learn the Catholic hospital would not perform the procedure. The physician, Ramesh Raghavan of St. Louis, knew about the case because he was the husband.

A few years later, according to an article in *Ms.* magazine, a New Hampshire waitress named Kathleen Prieskorn went to her doctor's office after a miscarriage—her second—began while she was three months pregnant. Physicians at the hospital, which had recently merged with a Catholic health care system, told her they could not end the miscarriage with a uterine evacuation—the standard procedure—because the fetus still had a heartbeat. She had no insurance and no way to get to another hospital, so a doctor gave her $400 and put her in a cab to the closest available hospital, about 80 miles away. "During that trip, which seemed endless, I

was not only devastated but terrified," Prieskorn told *Ms.* "I knew that, if there were complications, I could lose my uterus—and maybe even my life."

Probably the most notorious incident occurred in 2009, when a 27-year-old woman with "right heart failure" came to the emergency room of St. Joseph's Hospital and Medical Center, a Catholic hospital in Phoenix, while eleven weeks pregnant. Physicians concluded that, if she continued with the pregnancy, her chances of mortality were "close to 100 percent." An administrator, Sister Margaret McBride, approved an abortion, citing a church directive allowing termination when the mother's life is at risk. Afterward, however, the local bishop, Thomas Olmsted, said the abortion had not been absolutely necessary. He excommunicated the nun and severed ties with the hospital, although the nun subsequently won reinstatement when she agreed to confess her sin to a priest.

THERE'S REASON to think these kinds of conflicts are becoming more common. Like every other industry in health care, hospitals are consolidating to strengthen their financial positions or merely to survive. "There are a lot of rural places that now have only a Catholic hospital," says Lois Uttley, director of MergerWatch, a research and advocacy group based in New York City. "We hear regularly from doctors there who are just distraught at not being able to provide the care they want." Silva, from Sierra Vista, notes that such arrangements can be particularly tough on poor patients: "If you're wealthy, you go up to Tucson and you get a hotel. But a lot of people can't even pay for the gas to get up there."

Catholic ownership of a hospital can mean different treatment for the patients—a recent study in the journal *Women's Health Issues* found Catholic-run hospitals tended to offer different counseling and different medical remedies than secular institutions—but it can also mean different training for the doctors. Standards for training obstetricians and gynecologists include instruction on medical contraception and tubal ligations, as well as abortion techniques (although residents may opt out), but most Catholic teaching hospitals will not provide it. "Residents will have to take the time to do it as an elective, and sometimes they just end up taking one or two lectures a year on it, which really isn't adequate," says Debra Stulberg, a family physician and assistant professor at the University of Chicago Medical School.

Sometimes, the tensions are too great to resolve. The deal to bring Sierra Vista under Carondelet fell apart, following protests that Silva, working with MergerWatch and the National Women's Law Center, helped lead. In December, the governor of Kentucky, acting on the recommendation of his attorney general and in response to community lobbying, rejected a proposed merger that would have put two major hospitals under the control of a Colorado-based Catholic hospital system. Not long after, Catholic Healthcare West, a network of 38 hospitals, voluntarily severed ties with the Church and renamed itself "Dignity Health."

But sometimes institutions have been able to reconcile religion and medicine with creative solutions. When a secular hospital in Kingston, New York, merged with a Catholic institution, in effect reducing the community's hospitals from three to two, administrators set up a separate maternity unit in the parking lot. It provides a full range of reproductive services, including

abortion. In Troy, New York, leaders of a newly merged secular-Catholic hospital came up with a different solution: The maternity unit operates on the second floor, as a "hospital within the hospital"—complete with its own financial operations.

These distinctions may seem artificial or meaningless, which is precisely what some people have said about President Obama's proposal for contraception coverage. Under that proposal, insurers are supposed to provide coverage of birth control directly to the employees of institutions who believe contraception is a sin. Although it satisfied some of the critics, like Sister Carol, it infuriated critics like columnist Charles Krauthammer, who called it "an accounting trick." But what's the alternative? For better or worse, the government depends on Catholic hospitals to provide vital services—and the hospitals depend on the government for money to provide them. Convoluted solutions may be the only way for this convoluted mix of public purpose and private institution to survive.

Jonathan Cohn is a senior editor at The New Republic. *This article appeared in the March 15, 2012 issue of the magazine.*
