

**FIGHTING  
RELIGIOUS  
HEALTH  
RESTRICTIONS**

**Responding to the  
Catholic Bishops'  
Crackdown on  
Hospital Merger  
Compromises  
That Would Save  
Reproductive  
Services**



## **The MergerWatch Project**

The MergerWatch Project was founded in 1996 at the Education Fund of Family Planning Advocates of NYS in Albany, NY, after a religious/secular hospital merger caused the loss of patients' access to contraceptive services at a hospital outpatient clinic in Troy, NY.

MergerWatch staff work directly with community coalitions across the nation to protect hospital-based services that are threatened by proposed business partnerships between secular community hospitals and religiously-sponsored health systems. We seek to preserve patients' access to threatened services at the historically-secular facilities through such means as public education, community organizing and regulatory intervention.

Project staff have undertaken research, policy analysis and strategic work at the state and national levels to provide new tools and information that can be utilized by local hospital merger coalitions. The project co-coordinates, with the National Health Law Program, a National Advisory Board on religious restrictions to health care. Member organizations have specific areas of expertise that can be brought to bear on the problem, or represent those constituencies most affected by the spread of religious health restrictions (such as low-income women, women of color and residents of medically-underserved rural and urban areas).

## **The Emerging Issues Briefing Paper Series**

This paper is one of five developed in 2004 by the MergerWatch Project to inform communities, advocacy groups and medical providers about emerging threats to health care services from religiously-based restrictions.

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By Patricia Miller and Ronnie Pawelko

Since the mid-1990s, women's health advocates across the United States have been fighting to protect consumer access to reproductive services at secular (non-religious) community hospitals when they merge with religiously-sponsored hospitals that use doctrine to restrict services. The services most often threatened in these religious-secular mergers have been continued provision of contraception, emergency contraception for rape victims, sterilizations, abortion, infertility services, and comprehensive HIV/AIDS prevention counseling (that includes recommendations for use of condoms) at the secular hospital.

Baptist, Seventh-Day Adventist and Roman Catholic hospitals are among the health care institutions that prohibit or curtail some services that conflict with religious teachings. Most of the controversy has been focused on mergers involving Catholic hospitals, primarily because there are more Catholic hospitals (nearly 600) than any other type of religiously-sponsored health facility, and they are governed by the most extensive set of religious restrictions.

Working with community-based coalitions, the MergerWatch Project and a group of national women's health advocacy organizations<sup>1</sup> have succeeded in pressuring hospitals to adopt a variety of "creative solutions" to preserve consumer access to contraception and sterilization. Sometimes, these services have continued at the secular hospital if the business partnership is loose enough to permit segregation of the funds and staff used for those services. In other cases, a separately incorporated women's health center has been created to provide the services, either in a stand-alone facility or in an independent unit carved out within the formerly secular hospital.

A particular focus of these creative compromises has been ensuring that women delivering babies have the option of undergoing tubal ligations (female sterilization) immediately after the birth, while still in the hospital. An immediate post-partum tubal ligation eliminates the possibility of an accidental pregnancy for a new mother after she returns home. If the birth is by cesarean section, the tubal ligation can be performed while the woman is still anesthetized. When a hospital's religious doctrine prohibits post-partum tubal ligations, a new mother must wait about six weeks for her uterus to return to normal before she can seek the procedure at an outpatient surgery center. She must then undergo a second anesthesia and arrange for child care while she is having the operation and recovering from it.

# I

## Introduction and Overview

*Hospital mergers and reproductive services*

**Women's health advocates have been fighting to protect consumer access to reproductive services.**

Some Catholic health systems embraced creative compromises out of a pragmatic desire to form financially advantageous business partnerships with secular health care institutions. Special Catholic health care ethicists, such as the Rev. Gerard Magill, were employed by Catholic systems to help resolve moral conflicts and permit partnerships with secular hospitals. “This may shock you, but the Catholic Church is very keen on finding practical solutions to complicated problems. We will not do immoral acts, but we certainly can come to arrangements,” Magill told the *Wall Street Journal* in 1999.<sup>2</sup>

But these promising approaches became threatened by a strong backlash from conservative members of the church hierarchy. The Vatican began reaching out to overturn creative solutions in the United States in the late 1990s. Then in June of 2001 at the behest of the Vatican, the U.S. Conference of Catholic Bishops voted to change their *Ethical and Religious Directives for Catholic Health Care Services* in a way that strongly condemned sterilization and seemed likely to undermine hospital merger compromises that preserve sterilization services.<sup>3</sup>

How did this change come about? What specific action did the bishops take? And, what impact has the bishops’ crackdown had on compromises to protect consumer access to sterilization services?

This briefing paper will review the history of the Catholic *Directives* and explain the bishops’ 2001 vote on sterilization services. It will then examine the impact to date of the bishops’ action on existing creative solutions that had preserved reproductive services following religious–secular mergers. Finally, this paper will review several recent hospital merger compromises and identify new strategies that are being used to protect services.

## II

### **Background: The Directives and Catholic Health Care**

*The Catholic Church prohibits many modern reproductive health services at Catholic hospitals*

When a secular (non-religious) hospital merges with a Catholic hospital, some of the changes are easy to see, such as crucifixes that may be posted in the reception area or in patients’ rooms. Other changes aren’t so readily visible, but can have much greater impact on the community the hospital serves. A woman coming to the hospital to deliver a baby may find that her request to have a tubal ligation (female sterilization) after the baby is born can no longer be honored. Or a woman who has been sexually assaulted may leave the emergency room without being told of an easy, reliable way to prevent pregnancy from the rape by using emergency contraception.

Catholic hospitals are governed by the *Ethical and Religious Directives for Catholic Health Care Services* (the *Directives*), a set of rules developed by the U.S. Conference of Catholic Bishops and approved by the Vatican in Rome. Because the Catholic Church prohibits many modern reproductive health services—including abortion, contraception and sterilization (the most popular form of birth control in the United States)—Catholic hospitals are forbidden to provide these services.

When a Catholic hospital merges with a secular hospital, the formerly secular hospital often becomes a Catholic facility and the *Directives* apply. As a result, a community hospital that had routinely provided sterilizations, abortions for women with medical complications and HIV/AIDS “safer sex” counseling that discussed condom use will be forced to discontinue these services. Other

services prohibited by the *Directives* include in vitro fertilization, male sterilizations (vasectomies) and family planning counseling, as well as the provision of contraceptives. Prompt treatment of dangerous ectopic pregnancies can be affected by restrictions that force physicians to use more invasive methods of treatment or send patients to other hospitals. Provision of emergency contraception (a high dose of regular oral contraceptives taken to prevent pregnancy after unprotected intercourse) to women who have been raped may be eliminated or curtailed. End-of-life choices, such as refusing or removing a feeding tube, may also be affected.

**Prompt treatment of ectopic pregnancies can be affected by restrictions that force physicians to use more invasive methods of treatment or send patients to other hospitals.**

If there are no other hospitals in the vicinity, which is not uncommon outside of urban areas, these reproductive health services are lost to the community. Even if there are other hospitals providing these services, women who turn to hospitals controlled by the Catholic *Directives* are denied the full range of reproductive health choices. This is so despite the fact that these hospitals receive a significant share of their income from taxpayer-funded national health programs such as Medicare and Medicaid and serve people of all faiths.<sup>4</sup> Women enrolled in health maintenance organizations (HMOs) or other health plans with designated provider networks may find that their choices are limited to religious

hospital systems that restrict services, unless the women pay more out-of-pocket to obtain services at providers outside of their health plan's network.

Given the number of mergers that have occurred between Catholic and secular hospitals in the past decade, the stakes for women's health care are high. According to the group Catholics for a Free Choice, there were 171 mergers between Catholic and secular hospitals between 1990 and 2001.<sup>5</sup> Today, Catholic hospitals account for 11 percent of the nation's community hospitals and more than 16 percent of all community hospital beds. Four of the 10 largest health systems in the United States are affiliated with the Catholic Church. Among them is the nation's largest nonprofit health care system, the 67-hospital Ascension Health System, which swelled throughout the 1990s, in part by buying up secular hospitals at an unprecedented rate.<sup>6</sup>

### III

## **The *Directives* Revised: Addressing the Question of Sterilization**

*The Bishops crack down*

The first attempt to develop standards for Catholic hospitals was in 1921, when the Archdiocese of Detroit created a one-page set of rules governing surgical procedures that was adopted by many Catholic hospitals. Among other things, the rules prohibited abortion and contraceptive sterilization. In 1947, a more extensive set of rules, called the *Ethical and Religious Directives for Catholic Hospitals*, was developed. While the *Directives* were widely adopted by Catholic hospitals, they were not official for any given hospital without the approval of the local bishop.

As a result, as time went on and the *Directives* were subject to interpretation by local bishops, a good deal of variance developed in how they were applied, particularly with regard to sterilization and contraception. Many progressive-minded bishops interpreted the *Directives* as allowing the services under certain condi-

tions, such as when a woman would be endangered by a future pregnancy. As a result of these variations in interpretation, in 1971 the National Conference of Catholic Bishops or NCCB (now known as the United States Conference of Catholic Bishops or USCCB) developed revised *Directives* applicable to every Catholic hospital in the country. The 1973 *Roe v. Wade* decision that legalized abortion prompted the NCCB to urge bishops to promulgate the *Directives* out of concern that Catholic hospitals would not be exempt from performing abortions and sterilizations under a new federal “conscience clause” unless they officially banned these procedures.<sup>7</sup>

**The 1994 *Directives* were interpreted as allowing some leeway on sterilization at historically secular hospitals that became affiliated with the Catholic church.**

Despite the attempts of the NCCB to develop a uniform set of standards for Catholic hospitals, debate about allowing sterilization at Catholic hospitals continued. At the request of the NCCB, the Vatican ruled in 1975 that such sterilizations could not be allowed at Catholic hospitals. With some quarters still apparently pushing for leeway on the issue, the debate went back and forth between the Vatican and the NCCB. Partially to settle this issue and to address emerging issues such as partnerships between Catholic and secular hospitals and policies governing end-of-life care, a new, expanded set of *Directives* was issued in 1994. The 1994 *Directives* continued the ban on sterilization. However, an appendix on the principle of “cooperation”—the circumstances under which a Catholic facility may indirectly associate with a prohibited act—was widely interpreted as allowing some leeway on sterilization at historically secular hospitals that became affiliated with the Catholic Church.<sup>8</sup>

By the mid-1990s, partnerships between Catholic and secular hospitals were soaring as excess capacity in the hospital market forced an unprecedented number of hospital buyouts. There were 19 such mergers in 1994 and 24 in 1995 and again in 1996, according to Catholics for a Free Choice.<sup>9</sup> These partnerships (whether mergers between a Catholic and non-Catholic hospital or the purchase of a non-Catholic hospital by a Catholic hospital or health system) raised the issue of how the *Directives* would apply to the formerly secular hospital or the non-Catholic partner. Most commonly, abortions were banned at the non-Catholic hospital because the *Directives* stipulate that Catholic hospitals can never cooperate to any degree with the provision of abortions. Contraceptive sterilization, however, remained a gray area because the procedure was viewed with less moral approbation than abortion. Moreover, a common interpretation of the *Directives* held that Catholic hospitals could be indirectly involved with prohibited procedures, other than abortion, if they would face “duress”—such as the closure of the hospital or the significant loss of revenue—as a result of not entering into a financially necessary business partnership with a secular hospital.

As community and national women’s health activists pushed for the preservation of sterilization services at formerly secular hospitals, many Catholic hospitals compromised on the issue. The business reason for such compromises often was that sterilization services are popular in maternity wards, which are among the most profitable areas of hospitals. These “creative solutions” allowed sterilization services to continue under a variety of arrangements. For example, if a Catholic

and a non-Catholic hospital affiliated or merged only some elements of their governance, but not their actual facilities, sterilizations might be allowed to continue at the non-Catholic facility. In the case of Catholic Healthcare West (CHW), a large, California-based hospital system, some formerly secular hospitals purchased by the system remained non-Catholic and followed the Common Values for Community Sponsorship, a looser version of the *Directives* that allows sterilization while prohibiting abortion, assisted suicide and in vitro fertilization.<sup>10</sup>

Or, if facilities merged or the governance of the formerly secular hospital officially became Catholic, a separate facility might be spun-off either in a stand-alone building or on a separate hospital floor to provide sterilization services. Under

these arrangements, sterilizations were “carved out” with a separate corporate structure and financial stream for the service. Ultimately, it was up to individual bishops to approve any arrangement that allows sterilizations to continue at hospitals in their diocese.

A number of bishops approved such arrangements. At least 40 hospitals affiliated with the Catholic Church were providing tubal ligations as of 2001, according to Catholics for a Free Choice.<sup>11</sup>

But the Vatican was unhappy with these compromises and began to crack down on the arrangements, demanding greater doctrinal uniformity in the interpretation of the *Directives*. In 1997, the Vatican ordered a pending merger between Catholic St. Peter’s Medical Center and Robert Wood Johnson University Hospital halted because sterilizations would have been continued at Robert Wood Johnson, even though the local bishop had approved the arrangement.<sup>12</sup> In 1999, the Vatican halted an arrangement at St. Vincent Doctors Hospital in Little Rock, Arkansas, where doctors performed sterilizations in a room near the labor and delivery ward leased to the Arkansas Women’s Health Center (a loose affiliation of doctors who performed sterilizations at the hospital).<sup>13</sup>

In December of 2000, Bishop James Sullivan of Fargo, North Dakota, ordered Carrington Health Center to stop providing sterilizations. The hospital had performed a small number of sterilizations each year for women who might be harmed by a future pregnancy under a “pastoral exception” issued by a previous bishop.<sup>14</sup>

In 2000, the Vatican officially requested that the USCCB again revise the *Directives* to address the issue of sterilization at Catholic partner hospitals as well as the broader issue of providing banned services when Catholic hospitals merge with secular hospitals. After several drafts, the revised *Directives* were approved by the Vatican in February of 2001 and by the USCCB the following spring. The revised *Directives* took a much firmer line on the issue of sterilizations at Catholic partner hospitals, specifying that:

“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*).”

“Immediate material cooperation” – a key phrase in this new directive — occurs when a Catholic entity, such as a hospital, cooperates with an act considered immoral by the Catholic Church and the hospital’s participation is essential to

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**-US Catholic Bishops**

achieving the outcome. The bishops also eliminated the appendix to the *Directives* that detailed the “principle of cooperation,” which many Catholic hospitals had used to justify cooperation with secular hospitals providing sterilization services. That principle had been interpreted to permit Catholic hospitals to join in a business partnership with a secular hospital providing sterilization services if doing so allowed the Catholic hospital to avoid “duress,” such as the closure of the Catholic hospital due to financial pressures. The Catholic bishops said that only individuals, not institutions, could be under duress. What is allowed under the new *Directives*, however, is “mediate material cooperation,” in which the Catholic entity’s contribution to the outcome is nonessential and the good achieved by the cooperation outweighs any bad effects, such as the closure of the hospital or the loss of essential services.

## IV

### The Immediate Impact of the *Directives*

*Options narrowed*

The immediate practical impact of the revised *Directives*, according to the Catholic Health Association (CHA), the organization that represents Catholic health facilities, is that Catholic hospitals have to further distance themselves from the governance, management and finances of sterilization services at non-Catholic hospitals with which they have business relationships. Both the CHA and the U.S. bishops indicated that some existing arrangements are not acceptable under the revised *Directives*, but initially provided no detail about which arrangements would not be allowed. CHA President Rev. Michael Place said in 2002, “Some current arrangements are being reviewed, and the outcome of those reviews is not clear.”<sup>15</sup>

Archbishop Daniel Pilarczyk of Cincinnati, chair of the U.S. Conference of Catholic Bishops’ Committee on Doctrine and one of two bishops who led the review of the *Directives*, also said the Vatican had found some existing arrangements “unsatisfactory.”<sup>16</sup> For instance, Pilarczyk said that the arrangement at the former Leila Hospital in Battle Creek, Michigan, where sterilizations are provided in a separate four-bed “condominium hospital” may not be acceptable.<sup>17</sup> He told reporters, “Not only can’t you do it, but you can’t help others do it.”<sup>18</sup>

The Leila arrangement is often considered a model compromise by women’s health advocates because services are separated, as required by Catholic rules, but seamless for female patients. The condominium hospital is on the top floor of the former Leila Hospital, now the Battle Creek Health System, which is operated by the Catholic Trinity Health System.<sup>19</sup> The condominium hospital has its own operating room, board and financing stream. This arrangement allows women to undergo tubal ligations immediately following childbirth.

Despite Pilarczyk’s comments, the arrangement at Battle Creek Health System is still operational today.<sup>20</sup> While the revised *Directives* appear to have sunk several partnerships that were on the ropes (see below)—often because of financial or management disagreements that went beyond the *Directives*—there has not been any systematic or widespread attempt to unravel most existing arrangements. Additional clarification from the CHA and the U.S. bishops suggests that carefully structured partnerships will be allowed to continue or be created. According to experts from the National Catholic Bioethics Center, creative solutions to provide sterilization can be acceptable “if a collaborative arrangement such as a joint operating agreement, affiliation, or joint venture is completely segregated from the governance, management, and financing of direct steriliza-

tions provided by the other-than-Catholic partner.”<sup>21</sup> The Battle Creek arrangement appears to meet that standard. In cases where a Catholic system executes a complete takeover of a non-secular hospital, however, there is still little room for compromise on the issue of the preservation of existing reproductive health services, including sterilization.

Examples of acceptable arrangements include the formation of a joint operating company (JOC) by a Catholic and non-Catholic system in which the activities of the JOC are in compliance with the *Directives*, but sterilizations are provided by a corporation separately created, governed, financed and managed by the non-Catholic partner for the purpose of providing sterilizations. Another acceptable arrangement is one in which a Catholic and non-Catholic partner form a JOC that manages the Catholic system’s facilities and provides management assistance for the non-Catholic facilities to secure the financial viability of the non-Catholic partner. Sterilizations could continue at the non-Catholic partner facilities if an agreement ensures that the services are completely separated from the services at the Catholic partner.<sup>22</sup>

According to Catholic ethicists, there are several key points that make creative solutions licit. As noted, the governance, management and financing of sterilization services must be completely segregated from the Catholic partner in the collaborative arrangement. Secondly, the Catholic partner must not propose or design the creative solution; it must be created and initiated by the non-Catholic partner. Finally, sterilization services have to be physically segregated from the Catholic partner hospitals. Therefore, “hospital-within- a-hospital” solutions such as Battle Creek Health System are acceptable as long as the services are provided in the non-Catholic partner hospital.

**Sterilization services have to be physically segregated from the Catholic partner hospitals.**

Another recently announced partnership is in Altoona, PA, where Altoona Hospital and Bon Secours–Holy Family Regional Health System have merged. Each will maintain its separate campus and the *Directives* will apply only at the Bon Secours campus, allowing sterilizations at the Altoona campus.<sup>23</sup>

The situation is more tricky, however, when a Catholic hospital takes over a formerly secular hospital and that hospital takes on Catholic doctrine. For instance, Seton Health Services, a Catholic health system, manages Brackenridge Hospital in Austin, Texas for the city under a 30-year lease. Under an agreement to preserve birth control and sterilization services executed when Seton assumed management of the hospital, city employees were allowed to provide these services in the hospital, which is a key point of access for many low-income women in the area and provides about 400 sterilizations per year.<sup>24</sup>

Shortly before the Catholic Bishops voted in 2001 to promulgate the new *Directives* with stricter language on sterilization, however, Seton Health Services informed the city that it could no longer allow sterilizations or birth control services to be provided at Brackenridge. Instead of responding as many women’s health advocates suggested—by terminating the management contract with Seton—city officials decided to find a way to accommodate the new Catholic restrictions and still provide essential reproductive health services for low-income women.

After months of debate, city officials decided to address the problem by taking back control of the fifth floor of Brackenridge and creating a “hospital within a hospital.” The fifth floor of the facility was transformed into a legally separate entity run by the University of Texas Medical Branch under contract with the city. This new Austin Women’s Hospital provides sterilizations, emergency contraception for women who have been raped, and family planning services. Women who wish to have tubal ligations following childbirth deliver their babies in the Austin Women’s Hospital.

Creating this new unit has cost the city more than \$9 million and the city anticipates ongoing deficits of \$2.8 a year from running the separate hospital, which it will deduct from the \$5.6 million it gives Seton to provide charity care (free care) to low-income uninsured patients at Brackenridge.<sup>25</sup> Although

a costly and complicated solution to the bishop’s action, the new Austin Women’s Hospital is an attractive facility with high-quality equipment and services. In fact, Peggy Romberg, President of the Women’s Health and Family Planning Association of Texas, predicted it would become a popular choice for women to deliver babies.<sup>26</sup> Unlike some previous women’s health centers that were designed to accommodate women giving birth *only* when they intended to have immediate post-partum tubal ligations, the Austin Women’s Hospital was designed as a full-service maternity unit to serve all women who are delivering babies. The revenue from those deliveries will help support the continued existence of the unit, thus

addressing a financial issue that had endangered some earlier compromises. Seton Health’s lease for Brackenridge was recently extended through 2055 and a \$50 million penalty added if the city cancels the lease.<sup>27</sup>

Catholic officials, however, warn that the Brackenridge compromise should not be seen as a model for other hospitals because the forbidden services were allowed to continue in what was essentially a Catholic-governed facility only because of exceptional circumstances. In a letter to U.S. bishops written by Bishop Robert Morlino of Helena, Montana, and Bishop Donald Trautman of Erie, Pennsylvania, who head two key USCCB committees on doctrine and health care, they said that the Vatican considers the “hospital within a hospital” arrangement at Brackenridge Hospital to be “minimally acceptable” because the services are being provided in a Catholic facility.<sup>28</sup> According to the CHA’s Place, such an arrangement “should not be considered an acceptable model or template” for other hospitals. He wrote, “[I]t would seem the ‘condominium’ approach, involving the isolation of prohibited services in a separate entity within a Catholic institution, is problematic.”<sup>29</sup>

According to experts from the National Catholic Bioethics Center, the only reason that the Brackenridge arrangement was given the green light was that Ascension Health, the parent company of Seton, would have faced devastating financial penalties had it completely jettisoned the Brackenridge management contract and some solution was needed to extricate Seton from the earlier arrangement, which was totally unacceptable to the Vatican.<sup>30</sup>

**The new Austin Women’s Hospital is a costly and complicated solution to the bishops’ action.**

## V

### Deals Undone

*Several creative solutions unraveled*

Several other existing or planned creative solutions, mostly involving troubled partnerships, did unravel following the bishops' action. In New Jersey, Our Lady of Lourdes Medical Center acquired Rancocas Hospital in 1998 and committed to using a portion of the non-sectarian hospital's assets for a separate reproductive health facility to preserve sterilization and contraception services. However, when it came time to close the deal in 2002, after the new *Directives* were in effect, Our Lady of Lourdes refused to honor the commitment and halted reproductive health services at Rancocas.<sup>31</sup> In this case the financial viability of the independent center may have been the deciding factor against a creative solution. An analysis of the proposed independent surgery center for sterilizations by an independent consulting firm found that that center's financial sustainability was questionable, and that a \$1.4 million endowment from the hospital for the center would be depleted in a little over five years.<sup>32</sup>

St. Mary's Hospital, one of three hospitals in the Huntington, West Virginia, Genesis Hospital System, moved to disband a four-year-old health system just a few months after the new *Directives* were passed, saying it needed more control of its Catholic mission. Cabell Huntington Hospital and Pleasant Valley Hospital, the other two hospitals in the system, both performed sterilizations.<sup>33</sup> A merger in Owensboro, Kentucky, in which the non-Catholic partner performed tubal ligations in a separate room in the hospital, was also recently dissolved. The Owensboro Mercy Health System bought out partner Catholic Healthcare Partners after refusing its request for more input into appointment of board members. The merger was reportedly financially successful, but the non-Catholic partners said they wanted more "local control" of the system. After the merger was unraveled, full reproductive services were restored at the secular hospital.<sup>34</sup>

## VI

### Sterilization Services Eliminated in New Acquisitions

*Catholic systems refuse creative solutions*

Preserving sterilization services when a Catholic system buys a non-Catholic hospital is more problematic under the new *Directives*. Two recent cases have demonstrated refusal on the part of Catholic systems to agree to arrangements that would have preserved sterilization services in non-Catholic hospitals they were acquiring.

In January of 2002, six months after the Catholic bishops cracked down on compromises that preserved sterilizations, St. Thomas Health Services (part of the Catholic Ascension Health system) purchased Baptist DeKalb Hospital in Smithville, Tennessee. One month later, sterilizations were discontinued at the hospital, despite assurances to doctors prior to the acquisition that sterilizations would be allowed to continue after St. Thomas assumed ownership. A group of 10 doctors from the hospital decided to open an outpatient surgery center where tubal ligations and vasectomies could be performed. After opposition to the center by St. Thomas, the state — which must approve new health care facilities — denied their application to open the center, stating that it would take too much outpatient surgery business away from Baptist hospital.<sup>35</sup>

Sterilizations are performed at other St. Thomas facilities: Baptist Hospital in Nashville and Middle Tennessee Medical Center. In both instances, services are provided in carved-out facilities located on a floor in each hospital. The fact that such an arrangement was not proposed for Baptist DeKalb may indicate a new nervousness on the part of Ascension Health about attempting such arrange-

ments. The failure to craft a compromise in DeKalb County illustrates the problems that occur when compromises are not created. The county now has no facility providing sterilizations. It is unclear if the arrangements at the other two St. Thomas facilities will be allowed to continue.

In 2004, the acquisition of secular West Suburban Hospital in Oak Park, IL, by the Catholic Resurrection Health System eliminated sterilization services at the secular hospital. Local community health activists were unable to preserve access to sterilizations, even though consumer access to contraception, emergency contraception and HIV/AIDS counseling was preserved through a creative solution that spun off three primary care clinics as an independent secular entity prior to the acquisition. Physicians at West Suburban Hospital are now reporting that some patients are arriving at the now-Catholic hospital in labor, with the expectation they will be able to have the sterilization procedure during their stay. In these situations, physicians must explain that the hospital's "conscience" overrides the patient's needs. Although physicians are allowed to transfer such patients to another facility for the procedure, this approach has proved to be unworkable. Because most maternity stays are short, physicians have found that the infant would need to be released from the hospital when the mother is at the transfer hospital having her tubal ligation.

**The acquisition of  
secular West Suburban  
Hospital by Catholic  
Resurrection Health  
Services eliminated  
sterilization services.**

The revised *Directives* also may jeopardize Catholic Healthcare West's novel solution to preserving sterilization services in community hospitals that it buys. Catholic Healthcare West is operating some 14 of its hospitals — such as Sierra Nevada Memorial Hospital in Grass Valley, California, and Chandler Regional Hospital in Arizona — under a looser version of the *Directives* called the *Common Values for Community Sponsorship*.<sup>43</sup> The system maintains that these hospitals are not officially Catholic, because they are the result of mergers with community hospitals, and therefore the *Directives* do not apply.<sup>44</sup> Some of CHW's purchases of community hospitals, such as Sutter Merced Medical Center in Merced, California, were only allowed by state officials to proceed on the condition that sterilizations, family planning and emergency contraception be continued at the hospital.<sup>45</sup> While Archbishop Pilarczyk would not comment specifically on the CHW

arrangement, when asked about the general arrangement in which a Catholic hospital runs a hospital as non-Catholic and provides sterilization, he said, "Theoretically speaking, that is somewhat disturbing."<sup>46</sup>

At least four other examples of this arrangement exist and are still operational today. In Texas, the Catholic Spohn Health System manages the former Bee Country Regional Medical Center as Christus Spohn Hospital and provides tubal ligations at the hospital. Similarly, Covenant Health System in Lubbock, Texas, created by the merger of Lubbock Methodist Hospital System and St. Mary of the Plains Hospital System, provides sterilizations at Covenant Medical Center, the former Methodist Hospital site. In Great Falls, Montana, sterilizations are performed at the Family Birth Center of Benefis Healthcare, a merged facility created by Columbus Hospital and Montana Deaconess Medical Center in 1995. The facility, the only hospital in Great Falls, is a "Catholic-sponsored community hospital."<sup>47</sup> In Duluth, Minnesota, where St. Mary's Medical Center purchased

Miller-Dwan Hospital in 2001, Miller-Dwan is operated as a secular facility and the *Directives* are not applied, allowing sterilization and other reproductive health services to be provided.<sup>48</sup>

Other situations where the revised *Directives* would seem to jeopardize existing arrangements to provide reproductive health services include Catholic hospitals that are providing sterilizations under special arrangements approved by local bishops. When Catholic Healthcare West took over South Valley Medical Center in Gilroy, California, in 1999 the hospital performed some 400 tubals per year. CHW discontinued sterilization at the hospital, which was renamed Saint Louise Regional Hospital and became a Catholic facility. The move was immediately contested because Saint Louise is in an isolated, rural area. Under intense pressure from local physicians and community members, the local bishop eventually agreed that a limited number of “medically necessary” tubals would be allowed following approval by a special committee composed of representatives from the hospital and the archdiocese.<sup>49</sup>

**The local bishop eventually agreed that a limited number of “medically necessary” tubals would be allowed.**

## VII

### **When Compromises Are Challenged**

*Successful strategies to preserve reproductive health services*

As the impact of the more restrictive *Directives* continues to be felt, communities may find themselves facing the loss of reproductive health services such as sterilization, emergency contraception and family planning that they thought had been secured when their secular community hospital was taken over by a Catholic hospital. Recent experience show that changes in negotiated compromises can be successfully blocked.

The most important defense is an informed community and hospital board. Community leaders and hospital board members should be made aware that the promises made by local hospital officials about preserving services through creative solutions can be broken or overturned by the U.S. Conference of Catholic Bishops or the Vatican. The community should be educated about what Catholic ownership means and the hospital board should insist on seeing the fine print in any proposed agreements between the hospitals, including the potential for outside review by church officials to negate the compromises.

#### **Charitable Trust Strategies**

Beyond community education, one of the most promising strategies is to leverage the legal charitable status of a nonprofit community hospital to prompt state review of any reduction in essential services such as reproductive health care. The argument made by women’s health advocates in such cases is that the elimination of reproductive services due to the imposition of religious restrictions may be viewed as a violation of a hospital’s original charitable mission.

Suppose the hospital’s mission statement was “to serve all the people in the community” or “to meet all of the community’s medical needs.” In some cases, the mission might declare that “this is a secular hospital.” If such a hospital adopted religious doctrine and eliminated services needed by some people in the community—women—the hospital could be seen as having violated the trust of people who gave it charitable donations over the years on the assumption that the hospital would remain a secular facility delivering full-service women’s health care.

This argument was used in a Florida case that pre-dated the Bishops' 2001 action, but demonstrated the potential value of the strategy in addressing threats to existing hospital merger compromises. Intracoastal Health System in West Palm Beach had been formed by the 1995 merger of the non-Catholic Good Samaritan Medical Center and the Catholic St. Mary's Medical Center. As part of the arrangement, sterilization services were allowed to continue in the maternity ward of Good Samaritan Medical Center. In 1999, however, Catholic Health East, the parent company of Intracoastal, consolidated maternity services at St. Mary's, effectively destroying the compromise because sterilizations were not allowed at the Catholic facility. The following year, Catholic Health East announced plans to close St. Mary's Hospital and consolidate all services at Good Samaritan—with the *Directives* applying and banning prohibited reproductive health services.

**A judge ruled that since the hospital was built with charitable donations, the state had the authority to approve a change in its mission.**

In the face of community protest over both the planned closure of St. Mary's and the intent to impose religious restrictions at Good Samaritan, Florida Attorney General Bob Butterworth stepped in and asserted that the state had to approve the closure of St. Mary's because it was a charitable trust and any change in its charitable purpose required state approval. A judge ruled that since St. Mary's was built with charitable contributions, the state had the authority to approve a change in its mission.<sup>50</sup> Under a negotiated settlement designed to keep both hospitals open, Catholic Health East agreed to sell the hospitals. The hospitals were purchased by Tenet Health System; maternity care and sterilizations returned to Good Samaritan in the fall of 2001.<sup>51</sup>

Several other successful challenges to a change in a hospital's charitable mission suggest that this is a potentially important tool to block changes in negotiated compromises that would result in a reduction of services available to the community. A review of the use of charitable trust laws in the Palm Beach case by the law firm of Gardner, Carton & Douglas asserts that the "high public profile of sophisticated nonprofit organizations, and their charitable nature, suggest that attorney general review over the business decisions of such organizations is likely to continue apace in the future."<sup>52</sup>

According to the National Women's Law Center (NWLC) which has conducted an extensive analysis on the use of charitable assets laws to challenge the elimination of reproductive health services in secular-religious hospital mergers, the West Palm Beach case is one of several examples of the various uses of charitable assets laws that may be applicable in challenging revisions to negotiated compromises. According to the NWLC, "If an affiliation that reduces or eliminates women's health services is inconsistent with the secular health care provider's charitable mission, it can be legally impermissible for that entity to complete the transition."<sup>53</sup> Charitable asset laws may be used retroactively after the completion of a merger to challenge a proposed reduction in reproductive health services, as was the case in a high-profile New Hampshire merger.

In 1994, the two community hospitals in Manchester, New Hampshire—Catholic Medical Center and Elliot Hospital—merged to create the Optima Health

System. Elliot Hospital was to be maintained as a secular facility not “operated under the auspices or control of any particular religious denomination or any other group.”<sup>54</sup> However, about two years into the merger it came to the attention of Catholic officials that some abortions were being performed at Elliot Hospital in cases of fetal abnormalities or medical complications. As a result, the Optima board banned abortions at all Optima facilities to bring them into compliance with the *Directives*. Community activists and the staff of Elliot Hospital were outraged by the change and asked the New Hampshire Attorney General to intervene. Attorney General Philip McLaughlin concluded that applying the *Directives* to the secular Elliot hospital “radically” changed its mission and identity—a change that had not been approved by the state. Further, he said that the deal should have been reviewed by the public. “A charitable organization must listen to its community; that’s its obligation,” he said.<sup>55</sup> Citing irreconcilable differences over the provision of abortion, the partners dissolved the Optima health system in February of 1999 and Elliot regained its secular nature.<sup>56</sup>

### Certificate of Need (CON) Processes

Another tool that can be used to intervene when a negotiated compromise is threatened is a state’s “certificate of need” (CON) process. Many states require review and approval by state agencies when a health facility wants to add or remove services. CON laws were originally designed as a tool to help control health care costs, by forcing hospitals to demonstrate a “need” to buy expensive medical equipment or add services that might duplicate those of a competitor. More recently, women’s health advocates have used CON processes to prevent the loss of reproductive health services that would result from violations of negotiated hospital merger compromises.

**Women’s health advocates have used CON processes to prevent a loss of reproductive services.**

This strategy was demonstrated in 2001 in a case in Burlington, VT. The community’s three main hospitals—the secular Medical Center Hospital of Vermont and University Health Center and the Catholic Fanny Allen Hospital—had merged in 1995 to form Fletcher Allen Health Care. Each hospital maintained its separate identity and the Catholic *Directives* applied only at the Fanny Allen campus in an arrangement that was hailed as an early compromise to save reproductive services.<sup>57</sup>

In 2001, however, the merged Fletcher Allen system announced plans to move its psychiatric unit from its main (secular) campus to the Catholic Fanny Allen campus. The proposal was opposed by both mental health advocates, who feared that segregating mental health services would stigmatize patients, and by reproductive health advocates, who questioned whether patients would be able to receive services such as contraceptive counseling and birth control at a facility located on a Catholic campus.

The Vermont State Public Oversight Commission held hearings on the proposal as part of the CON process. While Fletcher Allen officials sought to assure the public that patients at the new facility would be able to receive a full range of reproductive services, MergerWatch Director Lois Uttley testified that the very nature of the *Directives* prevented Fletcher Allen from making that assurance.

Based on MergerWatch’s experience as a national advocacy organization that monitors Catholic-secular mergers, Uttley argued that the *Directives* may be revised again and made still stricter, that a new bishop could come in and unravel the arrangement or that the Vatican could overrule the local bishop and demand it be ended.<sup>58</sup> The Public Oversight Committee voted to recommend that the state deny the CON permit and Fletcher Allen withdrew the application. One member of the commission noted that it was the arguments of community activities that swayed his vote. “They had very strong recommendations that this would not result in good care,” David Yacovone said.<sup>59</sup>

**An exit clause can ensure that “broken promises” do not result in a loss of health services.**

### Utilizing Merger “Exit” Clauses

The inclusion of an “exit clause,” a provision in a hospital affiliation agreement that allows hospitals to undo their affiliation under certain defined circumstances, is an important tool that can ensure that “broken promises” or changes in the *Directives* do not result in a loss of health services in a community. For example, in Owensboro, Kentucky, an exit provision allowed a nonsectarian hospital to buy out the shares of its Catholic partner after the Catholic system sought changes in the affiliation agreement. A similar provision was part of a creative solution formed by merging hospitals in Ohio. In a merger between Community and Mercy hospitals in Springfield, a clause in the affiliation agreement allows the nonsectarian partner to purchase the Catholic partner’s shares if changes in the *Directives* make it impossible to continue the creative solution.

### Keys to Successful Challenges

Three elements stand out in successful community challenges to hospitals’ attempts to break the promises they have made in merger compromises:

- Early and consistent opposition and activism. In all of the successful cases, community and national advocates reacted to the situation as soon as possible and succeeded in bringing the case to the attention of the media and state officials.
- Involvement of state officials, especially the attorney general, who in some states may be the only one who has standing to challenge the reduction in services under charitable assets laws. In the Florida, New Hampshire and Vermont cases, the hospitals ultimately backed down from the changes when state officials became involved and a review of the deal ensued.
- The appropriate application of existing regulatory tools. One state may have a strong Certificate of Need process, while another state may have an attorney general willing to use charitable asset review. Activists must consider the state tools at their disposal.

# VIII

## The Future of Compromises in New Mergers

*Creative solutions more difficult, but still possible*

The pace of hospital mergers has picked up again, after having slowed in recent years.<sup>60</sup>

If, as the bishops' comments and actions strongly suggest, the only allowable religious–secular merger compromises will be those that include fully carved-out women's health facilities, it may become much more difficult to preserve sterilization services in future mergers. Such facilities can be expensive to operate if they are segregated from other hospital revenues, especially profitable maternity services. Ensuring financial viability is crucial to maintaining the facility's ability to provide reproductive services. Moreover, such centers must provide maternity care, or be physically contiguous to maternity services, in order to allow women to undergo sterilizations immediately after giving birth.

### A New Model for Creative Solutions

There is still room for creative solutions to preserve sterilization services when the business partnership is not the acquisition of a secular hospital by a Catholic system, but rather a merger or affiliation of equals. A creative solution that was crafted in a 2004 merger between Community Hospital and Mercy Medical Center of Springfield, Ohio, has given advocates a new model that can be used to preserve reproductive health services when secular hospitals enter into affiliations with Catholic hospitals. The merger, which created a new health system called Community Mercy Health Partners (CMHP), included a new creative solution termed the "Reproductive Services Plan." It has two distinct phases that will preserve community access to reproductive health services both before and after a new hospital is constructed. In both phases, a secular entity called Community Hospital Health Services Foundation (CHF) will provide services banned by the *Directives*. The foundation has its own board and will do all of the billing for services it offers.

#### The Springfield

solution is a

"hospital-next-to-a-hospital" model.

In the first phase of the merger, reproductive services will be provided within a space in Community Hospital that is owned, governed and managed by the foundation. In phase two of the merger, the foundation will own a unit that is physically contiguous to the new hospital. Instead of a "hospital-within-a-hospital" model, the Springfield solution is a "hospital-next-to-a-hospital" model. The contiguous foundation unit will be physically adjacent to the new hospital's maternity ward, so transfer from one part of maternity to another where patients will receive services banned by the *Directives* will be seamless for the patient.

An important element of the Reproductive Services Plan is the financial viability of the foundation. It will receive approximately \$5 million for capitalization and will have a source of income. The foundation unit planned for phase two will include a delivery room and an operating room that will be leased back to CMHP when it is not being used by the foundation. A new medical office building will be constructed along with the new hospital; it will be owned by the foundation, which will receive revenue from rents. The foundation will also provide dialysis services, another source of income, and will own and receive revenue from an ambulatory surgery center that is physically separate from the existing and planned hospitals.

The Reproductive Services Plan addresses concerns about problems other communities have experienced when merger agreements did not explicitly provide for the continuation of reproductive services. For example, the Reproductive Services Plan includes an agreement that rape victims will be able to receive emergency contraception in the emergency department and that there will be no limits on treating ectopic pregnancies. The plan also includes an agreement that physicians will not be restricted from counseling or referring patients for services banned by the *Directives*, and the new medical office building planned for phase two will not be bound by the *Directives*.

The potential for future changes to the *Directives* was also incorporated into the agreement through a specifically articulated “exit clause.” If the *Directives* or the interpretation of them are ever changed so that the Reproductive Services Plan can no longer be followed, CHF will have the option of buying out the Catholic partner.

**The secular hospital’s board insisted it would not agree to a diminution in access to reproductive services.**

Several factors were crucial in the creation of the Reproductive Services Plan. The first, and perhaps most important element, in the Springfield solution was the secular Community Hospital board’s insistence that it would not agree to an affiliation if it would result in a diminution in access to the reproductive services Community had offered prior to the merger.

The board held firm to this commitment over a two-year negotiation period, a timeframe that included a period where affiliation talks were called off due to the Catholic partner’s failure to agree to a solution that met the Community Hospital board’s criteria. Community Hospital’s strong financial health was a factor that allowed the board to reject offers, but its perseverance should

nonetheless be an example to other boards that it is possible to enter into creative solutions, even when such solutions are initially rejected.

Equally important to the outcome was the dedication of community activists, who worked with the board to encourage and support them during the negotiations and to provide them with information on experiences of other communities. MergerWatch staff worked closely with community activists and other national organizations to provide the activists with information they used in helping their local hospital board to shape the Reproductive Services Plan.

## IX

### Conclusion

#### *An Uncertain Future*

The impact of the US Catholic bishops’ revision of the *Directives* will be ongoing. Given how the Catholic Church has historically operated, it is unlikely that any blanket guidance will be produced. Instead, each situation will be reviewed individually by the local bishop. This may make it difficult for activists to anticipate which compromises may be in jeopardy and which new ones will be allowed, because an arrangement that is approved in one diocese may not be approved by another bishop, and because Vatican involvement in the cases is uneven.

In general, creative solutions to preserve sterilization involving joint operating agreements and other similar merger structures appear to be possible if the services are completely segregated—financially, physically, and from a management

**Creative solutions  
can be reached  
when hospitals and  
communities insist that  
services be preserved  
in hospital mergers.**

perspective—from the Catholic partner. The solution must be developed and proposed by the non-Catholic partner. How flexible any given Catholic hospital or system will be is somewhat dependent on the hospital's management and the local bishop, but recent experiences illustrate that a proposal that benefits the bottom line of the hospitals or is revenue neutral is more likely to be well-received than one that will cause a deficit. Situations in which Catholic hospitals take over formerly secular facilities are more problematic. While there is no evidence to date of an attempt by the bishops to halt sterilization services that have been preserved at formerly secular community hospitals, this does not mean that such an effort will not be forthcoming in the future.

Catholic ethicists have raised the possibility that the bishops might once again tighten the *Directives* because of still-unanswered questions about the degree of cooperation allowed with forbidden services. When the USCCB eliminated the controversial Appendix to the 1994 *Directives* that some hospitals had used to allow cooperation with sterilization services, a strongly worded draft that explicitly forbids material cooperation was written to replace it, but ultimately not included. Theologian Lawrence Welsh noted, "My fear is that the bishops will have to come back soon, go back and tighten things up further. And one reason is, there isn't an authoritative statement on the principles of cooperation."<sup>61</sup>

While options for compromise have been narrowed by the new *Directives*, especially when a Catholic hospital takes over a non-Catholic facility, creative solutions can be reached when hospitals and communities insist that services be preserved in hospital mergers. When the community demonstrates its will that sterilization and other reproductive health services be provided and there is flexibility on the part of the Catholic partner, there is ample evidence that successful arrangements can be crafted.

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# Additional Resources

## Organizations

### **MergerWatch Project**

*an affiliate of*

#### **Community Catalyst**

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JAF Station

New York, NY 10116

Phone: (212) 261-4314

Fax: (510) 740-3610

Cell: (518) 281-4134

Email: [lois@mergerwatch.org](mailto:lois@mergerwatch.org)

[www.mergerwatch.org](http://www.mergerwatch.org)

### **American Civil Liberties Union**

Reproductive Freedom Project

125 Broad Street, 18<sup>th</sup> Floor

New York, NY 10004

Phone: (212) 549-2633

Fax: (212) 549-2652

Email: [rfp@aclu.org](mailto:rfp@aclu.org)

[www.aclu.org](http://www.aclu.org)

### **Catholics for a Free Choice**

1436 U Street, NW

Suite 301

Washington, DC 20009

Phone: (202) 986-6093

Fax: (202) 332-7995

Email: [cffc@catholicsforchoice.org](mailto:cffc@catholicsforchoice.org)

[www.catholicsforchoice.org](http://www.catholicsforchoice.org)

### **National Health Law Program**

2639 S. La Cienega Blvd

Los Angeles, CA 90034

Phone: (310) 204-6010

Fax: (310) 204-0891

Email: [nhelp@healthlaw.org](mailto:nhelp@healthlaw.org)

[www.healthlaw.org](http://www.healthlaw.org)

### **National Women's Law Center**

11 Dupont Circle, NW

Suite 800

Washington, DC 20036

Phone: (202) 588-5180

Fax: (202) 588-5185

Email: [info@nwlc.org](mailto:info@nwlc.org)

[www.nwlc.org](http://www.nwlc.org)

### **Physicians for Reproductive Choice and Health**

55 West 39th Street, 10th Floor

New York, NY 10018

Phone: (646) 366-1890

Fax: (646) 366-1897

Email: [info@prch.org](mailto:info@prch.org)

[www.prch.org](http://www.prch.org)

### **Religious Coalition for Reproductive Choice**

1025 Vermont Ave., NW

Suite 1130

Washington, DC 20005

Phone: (202) 628-7700

Fax: (202) 628-7716

Email: [info@rcrc.org](mailto:info@rcrc.org)

[www.rcrc.org](http://www.rcrc.org)

## **Additional Resources**

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