

DOES MISSION MATTER?

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INTRODUCTION¹

Catholic health care is a vital component of the nation's health care delivery system. Comprising some of the largest health care systems in the United States, with a presence in all fifty states, Catholic hospitals, skilled nursing facilities, and other types of providers have a long tradition of responding to community needs, and a vital role in directing resources to serve the poor and disenfranchised.²

Catholic health care has matured rapidly over the past fifteen years. From a locally "owned" and organized, often fiercely independent institutional base overseen by a religious community with a strong presence in the local community, Catholic health care today has largely moved to a multi-corporate, multi-state model.³ Unlike its earlier years where the visibility of the religious sponsors—Sisters, Brothers, or priests—was evident throughout the institution,

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¹ This symposium issue raises the important topic of the role of religion in health law and policy. Review of the scholarly literature indicates relatively little discussion on the topic of religion and health law. The law review articles that address the religious aspects of health care focus almost exclusively on the right (or often, the lack of a right) of Catholic hospitals to deny sterilization and abortion services to women. The arguments traditionally made pit two values against each other: freedom of religious expression (by virtue of the Catholic hospital adhering to Catholic doctrine prohibiting such procedures) versus autonomy (with patients "deserving" a right to legally available medical procedures). For many authors, autonomy wins out, as Catholic hospitals are viewed as public supplicants due to their receipt of significant federal funding and tax-exemption, and therefore so vested with a public interest that they must provide services regardless of religious creed. See, e.g., Susan J. Stabile, *State Attempts to Define Religion: The Ramifications of Applying Mandatory Prescription Contraceptive Coverage Statutes to Religious Employers*, 28 HARV. J.L. & PUB. POL'Y 741 (2005); Susan B. Fogel & Lourdas A. Rivera, *Saving Roe Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725 (2004).

² See CATH. HEALTH ASSOC., WHO WE ARE, <http://www.chausa.org/Pub/MainNav/Whoweare/Our+Present/> (last visited May 6, 2006) [hereinafter CHA Statement].

³ An example of such a system is Catholic Healthcare West with hospitals throughout California, Arizona, and Nevada. CATH. HEALTHCARE WEST, <http://www.chwhealth.org> (last visited May 6, 2006).

the significant decline in the number of women and men religious means that today's Catholic hospital is commonly administered by lay individuals, with little sponsor interaction with the average patient or visitor.⁴ Catholic health care systems are more and more likely to be overseen by multiple religious communities exercising their influence on the system, rather than at the patient care level.⁵ Many of these religious communities direct systems in markets in which they no longer have—or never did have—an active presence.⁶ All of these changes make it increasingly difficult for the Church to assure that its religious mission of health care will continue.

Equally important is the harsh operating environment faced by health care providers. Continued reimbursement pressures, coupled with rising costs, are causing many hospitals to make painful choices among service lines which may no longer be financially sustainable.⁷ Investigations at the federal and state level regarding the parameters surrounding the provision of charity care, executive compensation, and community benefit hold special resonance for mission-oriented health care providers.⁸

Given the significant size of Catholic health care, the changes occurring within this sector have not gone unobserved. As systems become more powerful and adopt efficiencies and business strategies necessary to counteract reimbursement pressures, Catholic health care increasingly finds its mission being questioned. In some

⁴ See CHA Statement, *supra* note 2; see also Larry B. Stammer, *Number of Nuns on Brink of Precipitous Drop*, L.A. TIMES, Feb. 21, 1994, at 22.

⁵ For example, Ascension Health has six sponsors, while Catholic Health Initiatives was formed by twelve different congregations. ASCENSION HEALTH, SPONSORSHIP AND HISTORY, http://www.ascensionhealth.org/about/sponsorship_history.asp (last visited May 6, 2006); CATH. HEALTH INITIATIVES, PARTICIPATING CONGREGATIONS, <http://www.catholichealthinit.org/body.cfm?id=37473> (last visited May 6, 2006).

⁶ One good example, out of many available illustrations, involves Ascension Health, the nation's largest Catholic system. The Sisters of St. Joseph of Nazareth historically oversaw a Michigan-based health system—the Sisters of St. Joseph Health System. In 1999 the Sisters joined Ascension Health, and now oversee a system operating in twenty states and the District of Columbia. See SISTERS OF ST. JOSEPH OF NAZARETH, <http://www.ssjnazareth.org/ministries.htm> (last visited May 6, 2006).

⁷ Martin D. Arrick et al., Standard & Poor's, U.S. Not-for-Profit Health Care 2005 Outlook: The Calm Before the Storm, Jan. 10, 2005, available at <http://www2.standardandpoors.com/servlet/Satellite?pagename=SP/Page/FixedIncomeBrowsePg&r=1&l=EN&b=2&s=14&ig=17&f=2> (last visited May 6, 2006).

⁸ See Julie Appleby, *Non-Profit Hospitals' Top Salaries May be Due for a Check-Up*, U.S.A. TODAY, Sept. 29, 2004, at B1; *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. (2005), available at <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=415> (last visited May 6, 2006).

states, Catholic providers have become the target of legislation impacting their ability to follow religious dictates in the provision of health care.⁹ Advocacy groups often lead widespread protests over the expansion of Catholic facilities in their community.¹⁰ Litigation targeting the intersection of religious dogma and patient autonomy has also ensued.¹¹

This confluence of pressures is calling into question whether a Catholic health care mission is sustainable in a pluralistic society, or if changes within the Church and the operating environment will conspire to effectively convert Catholic facilities into non-sectarian institutions. I believe that the continuation of the Catholic mission is important, that it provides a unique and imperative perspective and service, and as I discuss below, that the manner in which the Church and health care providers work through the myriad of challenges that call their mission into question has important implications for the health care delivery system.

To explore these implications, Part I of this article provides a brief overview of the Church's role in the delivery of health care services in the United States and demonstrates that Catholic health care has a dominant role in the delivery of institutional health care and social services in our country.¹² In Part II, the article focuses on the Catholic health care mission. Part II reviews the doctrinal underpinnings of the Church's involvement in health care, focusing particularly on the impact that canon law and church teachings have on the delivery of patient care. Part III addresses the issue of whether contemporary Catholic hospitals truly have a unique religious mission worthy of protection. It does so by examining whether historic changes within the Church, through the transition of mission oversight to the laity coupled with an increasingly hostile business environment and federal and state skepticism of a charitable and/or religious mission, are erasing any genuine distinctions be-

⁹ Recent legislative changes in California and New York, among other states, requiring certain Catholic organizations to provide prescription contraceptive insurance coverage hinge at least implicitly upon the same type of analysis, defining the term "employer" narrowly so as to exclude religiously-based health care providers and social services agencies. See Stabile, *supra* note 1, at 741.

¹⁰ See, e.g., PLANNED PARENTHOOD, CATHOLIC HEALTH CARE PLAN ENROLLS FIRST MEMBERS IN ILLINOIS (Nov. 12, 2004), <http://www.plannedparenthood.org/pp2/portal/files/portal/webzine/newspoliticsactivism/fean-041112-catholic-health.xml> (last visited May 6, 2006).

¹¹ See *infra* Part III.B.2.

¹² See discussion *supra* note 6, regarding the dominance of Catholic health care providers. In twenty states, admissions to Catholic hospitals exceed one-fifth of all hospital admissions in the state. CHA Statement, *supra* note 2.

tween secular and Catholic institutions. Finally, while there are legitimate concerns surrounding the viability of the Catholic health care mission, Part IV concludes that this mission does matter and that its weakening would have a deleterious impact on health care in the United States.

I. RELIGION AND HEALTH CARE

Religion and health care are inextricably intertwined. Greek mythology recognized a goddess who controlled an individual's health.¹³ Both the Old and New Testaments express the importance of serving the poor and disenfranchised as a good to God and society.¹⁴ This spiritual calling no doubt has led to countless acts of charity and healing throughout history.

Patients are often drawn to religiously-based health care providers in times of serious need.¹⁵ Almost fifty years ago, a commentator to the American Medical Association Principles of Medical Ethics opined that

[p]atients may also prefer to obtain care from a facility with a particular mission. In such facilities, patients can obtain care from a staff that is explicitly committed to a philosophy of health care that resembles the patient's own. This may explain why elderly patients often seek nursing homes affiliated with their faith, and why patients who are terminally ill and seeking palliative care choose a hospice. Institutional missions offer the promise that treatment proposals begin from shared fundamental beliefs.¹⁶

In the United States, organized religion recognized early on the need to open health care institutions. The Methodists, Lutherans, Baptists, Latter Day Saints, Catholics, Adventists, and the Jewish community have all had an active presence in health care.¹⁷ The

¹³ “[H]ealth personified is named Hyg[i]eia It is derived from the root word *hugies* or *hygies*, meaning healthy, which is also the root word for hygiene.” Goddess of Health, <http://www.hygeia.com/goddess.html> (last visited May 6, 2006).

¹⁴ See, e.g., *Jeremiah* 8:22 (“Is there no balm in Gilead, no physician there? Why grows not new flesh over the wound of the daughter of my people?”); *Matthew* 25:35–36 (“For I was hungry and you gave me food, I was thirsty and you gave me drink, a stranger and you welcomed me . . . ill and you cared for me . . .”).

¹⁵ Steven H. Miles et al., *Conflicts Between Patients' Wishes to Forgo Treatment and the Policies of Health Care Facilities*, 321 *NEW ENG J. MED.* 48, 49 (1989).

¹⁶ *Id.*

¹⁷ See e.g., for Methodists, THE METHODIST HOSP., <http://www.methodisthealth.com/> (last visited May 6, 2006); for Lutherans, LUTHERAN HOSP., CLEVELAND CLINIC HEALTH SYS., <http://www.lutheranhospital.org/> (last visited May 6, 2006); for Baptists, BAPTIST HEALTH CARE, <http://www.bhcpns.org> (last visited May 6, 2006); for Latter Day Saints, INTERMOUNTAIN HEALTHCARE, <http://intermountainhealthcare.org/xp/public/lds> (last visited May 6, 2006); for Catholics, RESURRECTION HEALTH CARE, <http://www.reshealth.org/> (last

Catholic Church's involvement in health care traces back to Jesus' instructions to the disciples.¹⁸ Catholic teachings take a holistic approach to health care, with a focus on the physical, mental, and spiritual needs of patients and their families.¹⁹

This call to provide healing led the Sisters of Mercy to open the first Catholic hospital in America almost 150 years ago.²⁰ By 1965, more than 13,500 Sisters were directly involved in establishing and operating health care institutions.²¹

Today, the Catholic Church is one of the largest providers of health care services in the United States.²² Nine of the ten largest religiously affiliated health care systems are Catholic.²³ Catholic health care providers constitute six of the ten largest nonprofit health care systems ranked by beds²⁴ and four of the top ten ranked by revenue.²⁵ Ascension Health, which operates sixty-seven hospitals in twenty states, staffing 11,790 patient care beds, is the third largest health care system in the U.S., behind the Veterans Administration and a proprietary chain.²⁶ A 2004 American Hospital Association Annual Survey found that 12.5% of the nation's hospitals were Catholic, constituting 15% of available hospital beds and almost

visited May 6, 2006); for Adventists, ADVENTIST HEALTH SYS., <http://www.ahss.org/about.asp> (last visited May 6, 2006); for Jews, THE MOUNT SINAI HOSP., http://www.mountsinai.org/msh/about_us.jsp (last visited May 6, 2006).

¹⁸ See, e.g., *Matthew* 10:8 ("Cure the sick . . . without cost you have received; without cost you are to give.").

¹⁹ See U.S. CONF. OF CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES Part II (4th ed. 2001) ("Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person.") [hereinafter ERDs].

²⁰ See Mary Kathryn Grant & Margaret Mary Modde, *The Evolution of Catholic Multi-Institutional Systems: Voluntary Multi-Hospital Systems*, 18 TOPICS HEALTH CARE FIN. 24 (1992).

²¹ CHRISTOPHER J. KAUFMAN, MINISTRY OF MEANING: A RELIGIOUS HISTORY OF CATHOLIC HEALTH CARE IN THE UNITED STATES 283 (1995). The year 1965 proved to be the nadir of Sister involvement in healthcare. *Id.* By 1975, the number had dropped to less than 9000. *Id.* It is most probably even lower today. *Id.* While this article focuses on institutional health care, this is by no means intended to downplay the significant role that religious social service, housing, outreach, and the scores of other religiously affiliated programs and agencies play in providing essential services in communities throughout the country.

²² Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patient Rights*, 51 STAN. L. REV. 1703, 1703-04 (1999).

²³ MOD. HEALTHCARE, MODERN HEALTHCARE'S ANNUAL HOSP. SYS. SURVEY (June 7, 2004), <http://www.modernhealthcare.com/mediaindex.cms?type=surveys&industry=Hospital%20Systems> (last visited May 6, 2006).

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

16% of inpatient admissions.²⁷ Total expenses associated with Catholic hospitals exceeded \$69.9 billion; almost 600,000 full-time-equivalent employees work for Catholic health care facilities.²⁸ If viewed collectively,²⁹ Catholic health care facilities comprise the single largest provider of institutional health care in the United States.³⁰

While much of the visibility of Catholic health care is directed toward its hospitals, other types of health care facilities, as well as social service agencies, provide a powerful witness to the role of the Catholic Church in fulfilling its mission of healing. Skilled nursing facilities, clinics and other specialized health care facilities, as well as residences for children, served in excess of 5.2 million individuals.³¹ The Church operates 404 Catholic health care centers treating over four million patients.³² A myriad of other types of facilities also are operated under Catholic auspices. The Church also has a strong presence in non-institutional health care services and support. Catholic Social Services, for example, is one of the largest social service agencies in the United States, serving nine million clients per annum.³³

In short, the magnitude of the Catholic Church's involvement in health care truly is enormous. It is this sheer size and financial power of Catholic health care providers, coupled with the Church's strong parameters around acceptable organizational activities, which causes Catholic health care to be at the forefront of much of the conflict between mission, market and autonomy. In order to obtain a better understanding of this conflict, Part II examines the canonical and doctrinal underpinnings of the institutional actions sanctioned and prohibited by the Church.

²⁷ CATH. HEALTH ASSOC., FAST FACTS: CARE PROVIDED BY CATHOLIC FACILITIES, <https://www.chausa.org/Pub/TopNav/Newsroom/FastFacts/> (last visited May 6, 2006).

²⁸ *Id.*

²⁹ While operated as part of the Catholic Church, Catholic institutions and systems are not under a unified civil law ownership structure. See discussion *infra* Part II.A.

³⁰ See U.S. CONF. OF CATH. BISHOPS, THE CATHOLIC CHURCH IN THE UNITED STATES AT A GLANCE, www.usccb.org/comm/statisti.shtml (last visited May 6, 2006) [hereinafter THE CATHOLIC CHURCH IN THE UNITED STATES AT A GLANCE].

³¹ *Id.*

³² See THE CATHOLIC CHURCH IN THE UNITED STATES AT A GLANCE, *supra* note 30.

³³ *Testimony on Homeless Families Before the Subcomm. on Housing and Community Opportunity of the H. Comm. on Fin. Servs.*, 108th Cong. (2004) (statement of James Mauck, Pres. & CEO of Catholic Charities and Community Services, Archdiocese of Denver), available at http://www.catholiccharitiesusa.org/content_displays/index.cfm?docid=468&fuseaction=PrintArticle (last visited May 6, 2006).

II. CANONICAL AND DOCTRINAL UNDERPINNINGS OF CATHOLIC HEALTH CARE

A. Organizational Structure of Catholic Health Care

The Catholic Church is a hierarchically structured organization, with ultimate authority residing in the Pope.³⁴ As a ministry of the Church,³⁵ and hence an expression of the Catholic religion, Catholic health care organizations are subject to the laws and doctrines of the Church.³⁶ Accordingly, as discussed below, for certain actions undertaken by these organizations, ultimate approval authority rests with the Holy See. Importantly, this authority transcends whatever civil law structures might be used to organize and operate the ministry.³⁷

As a practical matter, the institution's "sponsor" is the Church entity that has direct oversight over mission and ministry. Traditionally the sponsor has been the community of Sisters, Brothers, or priests that founded and operated the institution or system at issue.³⁸ For many years the sponsor's role had been one of high visibility, as the sponsoring congregation often had many of its members working throughout the organization, in direct care and administrative capacities. As congregations have experienced fewer

³⁴ For a thorough review of the Church's role in health care, see Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159, 210 (1997).

³⁵ See Health and Health Care: A Pastoral Letter of the American Catholic Bishops, Nat'l Conf. of Cath. Bishops (Washington, D.C., 1981), available at <http://www.usccb.org/bishops/directives.shtml> (last visited May 6, 2006). See also ERDs, *supra* note 19, at Part I, Directive #1 ("A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.").

³⁶ "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel." ERDs, *supra* note 19, at Part I, Directive #5.

³⁷ In short, Church law ignores the separate incorporation of the entities at issue, taking the position that if an entity is Catholic, it is subject to the authority of the Church regardless of the civil law structures it uses to conduct its ministry. CATH. HEALTH ASSOC. OF THE U.S., *THE SEARCH FOR IDENTITY: CANONICAL SPONSORSHIP OF CATHOLIC HEALTHCARE 24* (1993) [hereinafter *THE SEARCH FOR IDENTITY*].

³⁸ Occasionally, Catholic institutions have been found by dioceses, or more rarely groups of laity. In these situations, the diocese or lay group would generally be considered the sponsor. See, e.g., *DIOCESAN HEALTH FACILITIES SPONSORED BY THE ROMAN CATHOLIC DIOCESE OF FALL RIVER, MA*, www.dhfo.org (last visited on May 6, 2006).

entrants into religious life and an aging of members, however, the sponsorship role has become less apparent.³⁹

The presence and identification of the sponsor is important because it is the sponsor's mission, or "charism," which infuses the organization with its reason for being. It is also through this sponsor that the entity gains recognition by the Church as a "Catholic" organization. Thus, for example, in the general model followed by Catholic health care, the sponsor itself is considered to be a unit of the Church (called a "juridic person"),⁴⁰ and therefore the works that it conducts (and the assets used to conduct those works) are considered to be works of the Church, part of the sponsor's juridic person and, hence, "Catholic."

Indeed, under canon law,⁴¹ religious congregations may only hold assets within their juridic person if these assets are to be used for a purpose deemed proper by the Church.⁴² Book V of canon law, which guides the obtaining and use of property by religious communities, sets forth the canonical framework for the operation of ministries.⁴³ Canon 1254.1 states that "[t]he Catholic Church [has an] innate right. . . to acquire, retain, administer and alienate temporal goods [in pursuit of its proper ends] independently from civil power."⁴⁴ Canon 1254.2 defines these proper ends as the following: "to order divine worship, to care for the decent support of the clergy and other ministers, and to exercise works of the sacred apostolate and of charity, especially toward the needy."⁴⁵ Accordingly, relig-

³⁹ See discussion *infra* Part III.A. on the aging of Sisters. Today, most sponsors serve in a governance or corporate member role, enabling themselves to be in a position of authority and influence with respect to key organizational issues, such as appointment of the Board, approval over significant strategic and financial directions and the like. At the same time, however, effectuating sponsorship at this high organizational level does negatively impact the visibility of the sponsor, often causing patients, employees, and the general public to believe that the sponsor is no longer significantly involved in the ministry.

⁴⁰ Analogous to a corporation under state corporation acts, canon law uses the term "juridic person" to describe entities within the Church which have the authority to operate ministries and hold themselves out as "Catholic." Singer, *supra* note 34, at 217-22. In canonical terms, the sponsor itself is considered to be the juridic person and all ministries it operates are considered to be part of the sponsor's juridic person. *Id.*

⁴¹ Canon law is the law of the Roman Catholic Church as set forth in the Code of Canon Law. NEW COMMENTARY ON THE CODE OF CANON LAW (Latin-English ed. 1983) [hereinafter 1983 CODE]. Canon law dates back to the year 451 C.E.; the Code was last revised in 1983. ADAM J. MAIDA & NICHOLAS P. CAFARDI, CHURCH PROPERTY, CHURCH FINANCES, AND CHURCH RELATED CORPORATIONS: A CANON LAW HANDBOOK 2-3 (1984).

⁴² 1983 CODE, *supra* note 41, at 1451.

⁴³ *Id.*

⁴⁴ *Id.* at c.1254 § 1.

⁴⁵ *Id.* at c.1254 § 2.

ious communities may only hold and use property to enable religious practice, to support the community or clergy or to perform ministerial and charitable works, such as health care.

Canon law further imposes an obligation to properly steward the resources of the juridic person. Canon 1279 charges that the administration of property of the juridic person shall be vested in the individual governing the juridic person (for example, the Superior and Council of the religious congregation).⁴⁶ While canon law does not further define the dictates of “administration,” the contours of this term within Catholic health care have come to mean that certain corporate authorities must be maintained by the sponsor. These “reserved powers” are typically vested in the sponsor through organization of Catholic health care institutions or systems as membership corporations under state nonprofit law, with the sponsor serving in a corporate member capacity and reserving to itself initiation or approval authority over key actions, including mission and philosophy of the organization, board appointment and removal, appointment and removal of the chief executive officer, approval of spending over certain limits, sale/merger/dissolution of the organization and the like.⁴⁷ Rarely, then, can a significant corporate action be taken without sponsor approval.

Sponsors, in turn, are responsible to the bishop in whose diocese they serve.⁴⁸ Bishops are charged with overseeing all matters concerning Church teaching within their diocese.⁴⁹ They also are responsible for directing diocesan activities regarding Church governance, administration of properties and institutions, and coordinating all ministries within the diocese.⁵⁰ Bishops have the authority to declare a particular ministry “Catholic,” and to remove this designation.⁵¹ Beyond formal authority, by virtue of their office bishops are able to assert their concerns and provide direction to Catholic sponsors and institutions within their ambit. In short, bishops serve a pivotal role within the Church to assure that Catholic

⁴⁶ “[T]he administration of ecclesiastical goods is the responsibility of the person who immediately governs the juridic person that owns the goods.” *Id.* at c.1279 § 1.

⁴⁷ Singer, *supra* note 34, at 221 n.355.

⁴⁸ *Id.* at 211.

⁴⁹ *Id.* at 210 n.281.

⁵⁰ *Id.*

⁵¹ *Id.* at 211–12. This authority is seldom used but when it is, it is often in the context of a very public disagreement. For a recent example of its use, witness the dispute surrounding the Catholic Church in the St. Louis diocese. See Suzanne Sataline, *A Catholic Parish Pays High Price For Independence: Dispute With Archbishop Over Property, Control Leads to Excommunication*, WALL ST. J., Dec. 20, 2005, at A1.

institutions are operating in a way that fulfills the Church's mission and satisfies its teaching.⁵²

Ultimately, sponsors and bishops (and hence Catholic institutions) are accountable to the Holy See.⁵³ In practice, the Vatican does not become involved in institutional issues unless required to do so by canon law or in the event that there is a dispute between dioceses. Canon 638 § 3 requires that in certain instances of "alienation"—the sale, mortgage or lease of real property—approval of the Holy See is required.⁵⁴ Currently, transactions exceeding \$5 million require this approval.⁵⁵

Rarely do disputes between dioceses necessitate the involvement of Rome. Nevertheless, because many health care systems now operate in multiple dioceses, and bishops can vary in their interpretations of canon law and Church teachings, conflict can occasionally arise. Many times these different interpretations may not have a system-wide impact, and merely require a particular facility to take action (or not act) in a certain way. When conflicting interpretations have wider repercussions, however, Rome will become involved. For example, when a Catholic health care system decided to enter into a joint venture arrangement with a proprietary chain, and two bishops approved the transaction but a third did not, the dispute was resolved by the Holy See.⁵⁶ The fact that ultimate accountability rests with the Pope is a strong statement that the religious nature of health care is viewed as paramount by the Church.

Canonically, therefore, it is clear that involvement in institutional health care is considered by the Church to be a religious expression of ministry. As such, it may only be legitimately conducted if done so in a manner that aligns itself with a recognized entity within the Church. Apart from the canonical dictates that form a basis for the organization and operation of Catholic health care providers, these providers must also conduct their ministry in accordance with the teachings of the Church. A primary source of these teachings is the Ethical and Religious Directives for Catholic

⁵² Canon 1279 authorizes the bishop to prevent negligent acts of administration by the sponsor. 1983 CODE, *supra* note 41, at c.1279.

⁵³ Canon 1273 provides that the Pope is the "supreme administrator and steward of all ecclesiastical goods." 1983 CODE, *supra* note 41, at c.1273.

⁵⁴ *Id.* at c.638 § 3.

⁵⁵ U.S. CONF. OF CATH. BISHOPS, DECREE OF PROMULGATION, <http://www.usccb.org/norms/1292-1.htm> (last visited May 6, 2006).

⁵⁶ See Bruce Jaspen, *Vatican Allows Columbia, CSA, to Complete Deal*, 25 MOD. HEALTHCARE 45, 3 (1995).

Health Care Services (the “ERDs” or the “Directives”), to which we now turn.⁵⁷

B. Ethical and Religious Directives for Catholic Health Care Services

The ERDs are only one statement among many by the American Catholic Church directed towards the Church’s role in health care ministry. Given the prescriptive nature of the Directives, however, they have garnered the most attention. Originally compiled in an unofficial form in 1947, and then again in 1949 and 1956, the Directives were officially adopted by the bishops in 1971, revised in 1994 and revised once more in 2001.⁵⁸ The purpose of the Directives is twofold: first, “to reaffirm the ethical standards of behavior in health care that flow from the Church’s teaching about the dignity of the human person”; and second, “to provide authoritative guidance on certain moral issues that face Catholic health care today.”⁵⁹ As such, the Directives constitute the fundamental guiding document of moral teaching for institutionally based Catholic health providers.⁶⁰

The Directives consist of six parts, each of which is divided into two sections. The first section of each Part sets forth an introductory narrative, explaining the theological basis for the Directives in that Part.⁶¹ The second section contains the relevant Directives—prescripts that the health care provider must follow if it is to operate as a Catholic facility.⁶²

Part I of the Directives, captioned “The Social Responsibility of Catholic Health Care Services,” explains the Church’s role in health care, including the fact that health care is anchored to a commitment

⁵⁷ The teachings of the Church certainly go well beyond those encompassed within the ERDs. Nevertheless, because the ERDs encapsulate the Church’s position on healthcare, are required to be adopted by Catholic health care facilities, and are the most well-known source of health care doctrine, they will serve as the area of focus for this article.

⁵⁸ Ron Hamel, *A Tour of the ERDs—With a Few Steps Along the Way*, available at <http://www.chausa.org/NR/rdonlyres/D81DBB8B-E216-4DA1-AF89-25382D6487CB/0/TourERD.ppt> (last visited June 14, 2006).

⁵⁹ ERDs, *supra* note 19, at Preamble.

⁶⁰ Hamel, *supra* note 58, at 2. While a product of the U.S. Conference of Catholic Bishops, the ERDs require adoption by each individual bishop in his diocese for them to be binding. ERDs, *supra* note 19. To the author’s knowledge, all bishops have made this adoption.

⁶¹ ERDs, *supra* note 19.

⁶² *Id.*

to promote and defend human dignity.⁶³ The Directives in Part I form the foundation for the remainder of the document, stipulating that institutional health care is a “community” that provides service to those in need which must be guided by the moral teachings of the Church.⁶⁴ Part I further mandates that all Catholic facilities adopt the Directives as policy, and provide education to personnel and medical staff on the ERDs.⁶⁵ Part I also requires that all facilities comply with canon law.⁶⁶

Part II of the Directives speaks to the pastoral and spiritual aspects of Catholic facilities, extending the framework of the institution as an expression of Catholic faith.⁶⁷ It addresses the proper administration of a pastoral care department, as well as baptism in the faith, confirmation, and communion.⁶⁸

Part III addresses the physician-patient relationship. Importantly, Part III states:

[w]hen the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church’s understanding of and witness to the dignity of the human person. . . . This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution.⁶⁹

The Directives in Part III introduce the foundation for, and then Parts IV and V explicitly set forth, the Church’s position on what is often termed “prohibited procedures,” specifically abortion, contraception, sterilization, assisted reproductive technology, and euthanasia.⁷⁰

These positions are well-known.⁷¹ Abortion—the directly intended destruction of a viable fetus—is never permitted, although treatments which are designed to cure a serious pathological condition in the mother may be undertaken, even if the death of the fetus is likely to occur.⁷² Similarly, contraception, including actions in-

⁶³ *Id.* at Part I, Introduction. The Directives flow from the inherent dignity of the individual. “First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity. . . .” *Id.*

⁶⁴ *Id.*

⁶⁵ ERDs, *supra* note 19, at Part I, Directive #5.

⁶⁶ *Id.* at Part I, Directive #8.

⁶⁷ *Id.* at Part II, Directives #10–13.

⁶⁸ *Id.* at Part II, Directives #14–22.

⁶⁹ *Id.* at Part III.

⁷⁰ *Id.* at Parts III–V.

⁷¹ See Stabile, *supra* note 1, at 749–50.

⁷² ERDs, *supra* note 19, at Part IV, Directive #45.

tended to directly result in sterilization, may not be provided or performed,⁷³ although sterilization as a byproduct of treatment for a medical condition is acceptable.⁷⁴ While certain types of assisted reproduction are acceptable,⁷⁵ euthanasia is never allowed.⁷⁶

Part VI is a recent addition to the Directives, added in 2001.⁷⁷ It addresses partnerships between Catholic and non-Catholic health care providers. These partnerships are of relatively recent origin within Catholic health care, whose facilities had historically operated autonomously.⁷⁸ Many Catholic health care systems have embraced partnership as a key organizational strategy. The issue raised here is the impact of these business ventures on the Catholic collaborator's continued ability to follow Church teaching, as well as the appearance of scandal should the venture or the non-Catholic partner be involved in activities contrary to the ERDs.⁷⁹

Prior to Part VI, canonists and ethicists sometimes differed widely in their interpretations of the Church's moral teachings on collaboration with an "evil."⁸⁰ It was often found that the institution was acting under (financial) "duress" when it formed the partnership, and that cooperation with the evil was necessary in order to achieve the greater good (for example, of a continued presence of the Catholic facility in the community).⁸¹ Through these analyses, for example, Catholic facilities might "condominiumize" a facility or surgical suite, housing an entity engaged in the prohibited proce-

⁷³ *Id.* at Part IV, Directive #52. Contraception may be provided in the case of rape so long as conception has not occurred. *Id.* at Part III, Directive #36.

⁷⁴ *Id.* at Part IV, Directive #53.

⁷⁵ *See id.* at Part IV, Directives #38–44. ". . . [A]ssistance that does not separate the unitive and procreative ends of [sexual intercourse], and does not substitute for the marital act itself, may be used to help married couples conceive." *Id.* at Part IV, Directive #38.

⁷⁶ *Id.* at Part V, Directive #60.

⁷⁷ Prior to 2001, the Directives contained an appendix setting forth the bishops' guidance on cooperation with an "evil" under ethical principles assessing the justification for such cooperation under certain instances of duress. After the Vatican's Congregation for the Doctrine of the Faith expressed concern about misinterpretations of the doctrine under the cooperation principle, the appendix was dropped. *See* Ron Hamel, *Part Six of the Directives*, HEALTH PROGRESS, Nov.–Dec. 2002, at 37.

⁷⁸ Singer, *supra* note 34, at 175 (discussing the "merger wave" orchestrated by Catholic health care leaders to consolidate the industry). *See also* Jason M. Kellhofer, *The Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers Between Catholic and Non-Catholic Healthcare Systems*, 16 J.L. & HEALTH 103 (2001-2002); Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1434 (1995).

⁷⁹ ERDs, *supra* note 19, at Part VI.

⁸⁰ Hamel, *supra* note 58.

⁸¹ *Id.*

dure (typically sterilization) while at the same time isolating the Catholic partner from involvement in the activity.⁸²

Part VI injected the bishop directly into the approval process for partnerships which “. . . may lead to serious consequences for the identity and reputation of catholic health care services, or entail the high risk of scandal. . . .”⁸³ Directive 68 directs that the bishop should be involved in the development stage of these partnerships, while Directive 71 specifically counsels the Catholic partner to consider the possibility that scandal can be created through partnering.⁸⁴ Directive 72 requires the Catholic partner to periodically assess its participation in the joint venture to assure that Catholic teachings are being observed.⁸⁵ As the bishop can remove an organization’s Catholic status if he believes that it is not following Catholic teachings,⁸⁶ often concern expressed by the bishop, if not the implicit threat of a sanction, is enough to halt a particular action.

C. The Church and Health Care

It is apparent that Catholic health care is suffused with a religious purpose. Its creation is based upon Church interpretation of a duty to Jesus, and its facilities are required to adhere to formal prescriptions of appropriate canonical, ethical and moral behavior.⁸⁷ As recently as twenty years ago, questions regarding a facility’s Catholicity and the implications of this calling would rarely have been asked. In part this was because of the highly visible presence of Sisters or Brothers in the facility, making the religious nature of the institution readily apparent to even the casual observer.⁸⁸ Too, few Catholic institutions were part of health care systems, and those

⁸² Fr. Thomas Kopfensteiner, *Responsibility and Cooperation*, HEALTH PROGRESS, Nov.–Dec. 2002, at 40.

⁸³ ERDs, *supra* note 19, at Part VI, Directive #67. Each bishop is free to develop his own interpretation of what actions constitute a “scandal” within his diocese. Bishops can and do differ in their interpretations. Singer, *supra* note 34, at 214 n.308.

⁸⁴ ERDs, *supra* note 19, at Part VI, Directives #68, 71.

⁸⁵ *Id.* at Part VI, Directive #72.

⁸⁶ THE SEARCH FOR IDENTITY, *supra* note 37, at 24.

⁸⁷ In the words of Pope John Paul II, “The many initiatives on behalf of the elderly, the sick and the needy, through nursing homes, hospitals, dispensaries, canteens providing free meals and other social centers are a concrete testimony of the preferential love for the poor which the Church in America nurtures.” JOHN PAUL II, POST-SYNODAL APOSTOLIC EXHORTATION ECCLESIA IN AMERICA para. 18 (1999).

⁸⁸ For an excellent treatise tracing the history of Catholic healthcare, see KAUFMAN, *supra* note 21.

systems that existed were of a local or regional nature, likely well-known by the communities served.⁸⁹

Today, many Catholic health care facilities have joined together into larger (often multi-state) health care systems with less visible Sister presence and the development of sophisticated corporate management teams distant from day-to-day operations and local community involvement. Many of these systems enjoy significant market power.⁹⁰ As discussed below, the heightened visibility of these organizations has led to very public questioning of institutional adherence to religious teaching (especially in the area of sterilizations and, to a lesser extent, abortion), posing a significant challenge to the Catholic mission.⁹¹

Other significant challenges to the mission have also arisen, as the law, the competitive environment, and even changes within the Church present their own hurdles to Catholic facilities. Section III discusses these issues, setting the stage in Part IV for a discussion of whether a religious mission is sustainable in a pluralistic society.

III. CHALLENGES CONFRONTING THE CATHOLIC HEALTH CARE MISSION

Catholic health care faces both internal and external challenges to its mission. Internally, significant change is occurring among the sponsors of Catholic health care, calling into question the traditional model of how institutions connect to the Church and communities understand Catholic health care.⁹² Externally, as Catholic health care institutions have consolidated into some of the largest systems in the country, questions have arisen as the impact of these systems is felt by the communities which they serve. In some instances liti-

⁸⁹ *Id.* at 297.

⁹⁰ See *supra* note 3, discussing Catholic Health Care West; see also ASCENSION HEALTH AND CATHOLIC HEALTH INITIATIVES, *supra* note 6. All are examples of systems that enjoy significant market power.

⁹¹ There are many organizations opposed to the Church's position on prohibited health care services. See e.g., EDUC. FUND OF FAM. PLANNING ADVOC., ABOUT THE MERGERWATCH PROJECT, http://edfundfpa.org/mergerwatch/about_mw.html (last visited May 6, 2006); NARAL PRO-CHOICE AMERICA, MISSION, <http://www.prochoiceamerica.org/about-us/learn-about-us/mission.html> (last visited May 6, 2006); PLANNED PARENTHOOD FED'N OF AM., MISSION & POLICY STATEMENTS, <http://www.plannedparenthood.org/pp2/portal/files/portal/aboutus/mission.xml> (last visited May 6, 2006). Further, many Catholics oppose the Church's position as well. See Stabile, *supra* note 1, at 762 n.94.

⁹² See *infra* Part III.A.

gation has ensued,⁹³ while in other areas attempts have been made to circumvent the imposition of the ERDs on the delivery of certain health care services.⁹⁴ Both internal and external challenges are reviewed below.

A. Challenges within the Church to the Catholic Mission

The fundamental dynamic of change within the Church vis-à-vis its health care ministry is the decline in the numbers of Sisters able to serve in a sponsorship capacity.⁹⁵ The decrease is precipitous, and is certain to accelerate. In 1965 the number of Sisters in the United States stood at 179,954.⁹⁶ After Vatican II and its recognition of the role of the laity in the Church, religious congregations underwent a significant decline, as many Sisters chose to leave religious life and live their call to serve the Church in other ways.

By 1975 the number of Sisters had declined to 135,225.⁹⁷ Combined with a decrease in the number of women choosing to join religious life and an accelerating death rate as Sisters' mean ages have increased to at least sixty-nine years old,⁹⁸ this trend has continued. Statistics current as of November 2005 indicate that there are approximately 69,963 Sisters in the United States.⁹⁹ In many religious communities, more than one-half of the Sisters are retired and no

⁹³ See also Jason M. Kellhofer, *The Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers Between Catholic and Non-Catholic Healthcare Systems*, 16 J.L. & HEALTH 103 (2001-2002); Donald H. J. Hermann, *Religious Identity and the Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers*, 34 CREIGHTON L. REV. 927 (2001); Stabile, *supra* note 1, at 749.

⁹⁴ California Women's Contraception Equity Act, CAL. HEALTH & SAFETY CODE § 1367.25(b)(1) (Deering 2005); CAL. INS. CODE § 10123.196(d)(1) (Deering Supp. 2005); New York Women's Health and Wellness Act, N.Y. INS. LAW § 3221(l)(16)(A)(1) (Consol. Supp. 2005); N.Y. INS. LAW § 4303(cc)(1)(A) (2005).

⁹⁵ While there are religious congregations of men which sponsor health care institutions, such as the Alexian Brothers and the Jesuits, and some dioceses also serve as sponsors, notably in Boston, New York and Philadelphia, the overwhelming majority of sponsoring congregations are of women. Male communities are experiencing similar demographic trends as the Sisters. See *Remaining 38 Alexian Brothers Turn to Madison Avenue for New Recruits: Religious Order Operates Health Care Facilities in Five States*, PRNEWswire, June 20, 2003, available at <http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/06-20-2003/0001968854&EDATE> (last visited May 6, 2006).

⁹⁶ U.S. CONF. OF CATH. BISHOPS, FREQUENTLY REQUESTED CHURCH STATISTICS, <http://www.usccb.org/vocations/statistics.shtml> (last visited May 6, 2006).

⁹⁷ *Id.*; Lisa W. Foderaro, *Sisterhood Recruits for a Next Generation*, N.Y. TIMES, Jan. 16, 2000, at 11.

⁹⁸ Foderaro, *supra* note 97.

⁹⁹ THE CATHOLIC CHURCH IN THE UNITED STATES AT A GLANCE, *supra* note 30.

longer actively serving in a ministry.¹⁰⁰ Further, many communities able to attract entrants are either of a contemplative order (with no sponsorship of institutional ministry), or find that new Sisters desire to work more closely with the poor and choose not to become involved in sponsorship or governance.¹⁰¹ The result has been a dramatic need to rethink how mission oversight is effectuated, as the number of Sisters able to fulfill this role declines.

Anticipating the need to transition to a new model of sponsorship, in the late 1980s sponsors began serious conversations among themselves on the need to collaborate within the ministry, resulting in a wave of mergers which created many of the large systems in existence today.¹⁰² While merger activity between Catholic providers has slowed since the early to mid-1990s, it is projected that activity will resume at a quickened pace as the aging of religious congregations continues.¹⁰³

Canon law does enable lay persons to sponsor a health care system or institution, and there are several systems that have availed themselves of this option.¹⁰⁴ Concern amongst Vatican officials regarding the accountability of these lay-sponsored organizations to the Church caused the lay-sponsorship standing approval process to be halted in 2003, although recently approval was granted to Bon Secours Health System.¹⁰⁵ It seems certain that given the demographic trends facing Sisters, Brothers, and priests, additional approvals will be granted.

Catholic organizations have been investing significant energy into developing educational programs for Board members, executives, and others to prepare them to assume a stronger role in mis-

¹⁰⁰ "Of the more than 70,000 women religious [as of 2001] in the country, 53% are now past 70; of the more than 15,000 men, 35% are past 70." OFFICE OF MEDIA RELATIONS, U.S. CONF. OF CATH. BISHOPS, WEST WING STAR MARTIN SHEEN HELPS FUND FOR RETIRED NUNS, BROTHERS, PRIESTS IN RELIGIOUS ORDERS (Nov. 8, 2001), available at www.usccb.org/comm/archives/2001/01-194.shtml (last visited May 6, 2006).

¹⁰¹ Foderaro, *supra* note 97.

¹⁰² Singer, *supra* note 34, at 175.

¹⁰³ Special Comment, *The Multi-State Healthcare Systems: Moody's Expects Further Change Ahead*, MOODY'S INVESTORS SERVS., Nov. 2005, at 5.

¹⁰⁴ Nancy Mulvihill, *Public Juridic Person Ensures Catholic Presence: How One Catholic Healthcare System Assumed a Lay Model of Sponsorship*, 77 HEALTH PROGRESS 25, 26-27 (1996).

¹⁰⁵ Conversation with Sr. Patricia Eck, Board Chairperson, Bon Secours Health System (May 1, 2006). Bon Secours applied to create a Public Juridic Person (PJP) that includes lay members in March, 2003.

sion oversight.¹⁰⁶ Several of these programs are industry-wide, while others have been developed by coalitions of systems or by individual systems themselves. A significant challenge facing these programs is the question of how to train lay leaders in the intricacies of mission fulfillment, especially as sponsors have moved to field a more ecumenical team at the governance and executive level.¹⁰⁷ Equally difficult is that under congregational sponsorship the individuals serving in a sponsorship role were constantly being refreshed, as the religious congregation had an institutional commitment to sponsorship.¹⁰⁸ The question as health care moves to lay sponsorship is how this institutional commitment will be mimicked as lay individuals become charged with educating their successors about sponsorship.¹⁰⁹

The decreased visibility of Sisters, Brothers and priests causes Catholic institutions to appear no different than sectarian facilities, and is no doubt a contributing factor to a sense that the Catholic mission is not fundamentally different than that espoused by any other facility. The ability to transition mission oversight and inculcate religious values into the laity is crucial if the commitment to health care as a ministry of the Church is to be kept alive.

B. External Mission Challenges

1. *Operating Environment*

Institutional health care providers, both secular and religious, continue to face an increasingly hostile business environment.¹¹⁰ While Medicare reimbursement has enjoyed small increases over the past few years, it has failed to keep pace with medical cost inflation.¹¹¹ Increases on the private sector side have also fallen short of

¹⁰⁶ William Cox, Pres. & CEO of Alliance of Catholic Health Care, Address at the Loyola Univ. Chicago 2005 Catholic Health Care Sponsorship Meeting: Catholic Health Care in Transition: Enabling the Mission (Apr. 7, 2005), at slide 31 (on file with author).

¹⁰⁷ See *id.* at slide 50.

¹⁰⁸ See *id.* at slides 51–55.

¹⁰⁹ See generally *id.*

¹¹⁰ See, e.g., James C. Robinson, *Bond-Market Skepticism and Stock Market Exuberance in the Health Care Industry*, 21 HEALTH AFF. 104–17 (2002) (examining the challenges faced by hospitals in the current business environment).

¹¹¹ Congressional Update: Medicare Reimbursement and Pay for Performance, 5 Med. Group Mgmt. Assoc. Connexion 8 (2005) (“[D]ata show that the substantial growth rate, which is linked to measures of the national economy, has not kept pace with inflation related to the delivery of medical care.”).

hospital needs.¹¹² The result has been a slow but continual deterioration in institutional profit margins across the country.¹¹³

Hospital cost increases have been led by the significant growth in pharmaceutical utilization, the development of more refined (and, hence, expensive) equipment, the tremendous expansion in intellectual technology needs (especially electronic medical record and cross-institutional communication systems), higher labor costs, and the significant plant expansion and replacement needs facing the industry.¹¹⁴ Pharmaceutical costs are becoming an ever-larger percentage of the treatment plan, enjoying cost increases in some years that have outstripped the remainder of the treatment regimen.¹¹⁵ In 2000, for example, drug costs associated with hospital treatment totaled \$121.8 billion.¹¹⁶

The quickened pace of developing “next generation” medical equipment has also been a significant driver of hospital cost increases.¹¹⁷ When first developed, magnetic resonance imaging, with its one million dollar plus price tag, was reserved for academic or tertiary medical centers.¹¹⁸ Today no community hospital would be without one.¹¹⁹ Positron Emission Tomography (“PET”) scanners, costing \$1.8 million are now de rigeur, along with Computed Axial

¹¹² KAISER FAM. FOUND., *Trends & Indicators in the Changing Health Care Marketplace*, Exhibit 6.9, available at <http://www.kff.org/insurance/7031/print-sec6.cfm> (last visited May 6, 2006).

¹¹³ Patrick Reilly, *AHA Report Says Hospital Margins are Up for the First Time Since 1996*, 34 MOD. HEALTHCARE 1, 6–7 (2004) (stating that “hospital profits inched upward for the first time in six years”).

¹¹⁴ See, e.g., Arrick et al., *supra* note 7.

¹¹⁵ For example, in 2001, inpatient care spending increased 7.1%, while prescription drug spending increased 13.8%. Press Release, *Spending on Hospital Care Drives Double-Digit Jump in Health Costs; Outpatient Hospital Care Surpasses Drugs as Fastest Growing Cost Component*, HEALTH AFF., Sept. 25, 2002, <http://www.healthaffairs.org/press/sep0203.htm> (last visited May 6, 2006).

¹¹⁶ Jill Carroll, *Health-Care Outlays Accelerated in 2000 with a Jump of 6.9% to \$1.3 Trillion*, WALL ST. J., Jan. 8, 2002, at A4. In 2006, projected pharmaceutical costs had decelerated to 11.8%, from 18.3% in 2003. WORKFORCE MGMT., NEWS IN BRIEF: PHARMACEUTICAL COST INCREASES MAY BE SLOWING, <http://www.workforce.com/section/00/article/24/23/20.html> (last visited May 6, 2006).

¹¹⁷ KAISER FAM. FOUND., *Trends & Indicators in the Changing Health Care Marketplace*, Exhibit 1.3, <http://www.kff.org/insurance/7031/print-sec1.cfm> (last visited May 6, 2006).

¹¹⁸ See *The Role of NSF’s Support of Engineering in Enabling Technological Innovation: III. Magnetic Resonance Imaging*, THE SCI. & TECH. POLICY PROGRAM, available at <http://www.sri.com/policy/csted/reports/techin/mri1.html> (last visited May 6, 2006).

¹¹⁹ SIEMENS, *Community and Rural Hospitals: Top-Notch Diagnostic Technology is Crucial to Delivering Top-Notch Healthcare*, <http://www.medical.siemens.com> (last visited May 6, 2006).

Tomography (CAT), and advanced cardiology services.¹²⁰ Even states with certificate of need requirements, designed to hold medical care cost increases in check by requiring state approval for the purchase of expensive medical technology, are taking a no-holds-barred approach to the routine practice of acquiring the latest, most expensive technology being available in the “average” community hospital.¹²¹

The intellectual technology needs of health care systems and institutions have grown substantially.¹²² Hospitals have expended significant monies to develop fully-networked institutions on the business side of health care, implementing order entry, billing, and collection systems.¹²³ Now, energies (and funds) are shifting to the patient care side, with electronic medical records becoming strongly encouraged by governmental and patient safety groups.¹²⁴ The costs of implementing these systems are extremely significant.¹²⁵

Labor costs comprise approximately 50% of hospital budgets.¹²⁶ While salaries for health care professionals, such as nurses and technologists, have generally moderated over the immediate few years, this follows an expensive run up in costs which the industry is still digesting.¹²⁷ The average salary of a hospital staff nurse increased from \$36,618 in 1992 to \$47,759 in 2000.¹²⁸ Similarly,

¹²⁰ See Christopher Rowland, *Hospitals Seek More Body Scanners*, BOSTON GLOBE, Aug. 26, 2005, available at http://www.boston.com/business/globe/articles/2005/08/26/hospitals_seek_more_body_scanners/ (last visited May 6, 2006).

¹²¹ *Id.*

¹²² See Kelsey D. Patterson, Comment, *Healing Health Care: Fixing a Broken System with Information Technology*, 14 KAN. J.L. & PUB. POL'Y 193, 194 (2004).

¹²³ Timothy J. Mullaney & Arlene Weintraub, *The Digital Hospital*, BUS. WK., Mar. 28, 2005, available at http://www.businessweek.com/magazine/content/05_13/b3926001_mz001.htm (last visited May 6, 2006).

¹²⁴ William Frist, *Why We Must Invest in Electronic Medical Records*, S.F. CHRON., July 24, 2005, at C5, available at <http://www.sfgate.com/cgi-bin/article.cgi?file=/Chronicle/archive/2005/07/24/EDGFVC9JFF1.DTL> (last visited May 6, 2006).

¹²⁵ Karl F. Schmitt & David A. Wofford, *Financial Analysis Reflects Clear Returns from Electronic Medical Records*, HEALTHCARE FIN. MGMT., Jan. 2002, at 2, available at <http://www.imedi.org/docs/Azyxxi/7.%20General%20Info%20on%20Medical%20Records/Healthcare%20Financial%20Management%20VMMC.pdf> (last visited May 6, 2006).

¹²⁶ See Glen Kazahaya, *Harnessing Technology to Redesign Labor Cost Management Reports*, HEALTHCARE FIN. MGMT., Apr. 2005, http://www.findarticles.com/p/articles/mi_m3257/is_4_59/ai_n13621284 (last visited May 6, 2006).

¹²⁷ See Alistair McGuire & Victoria Serra, *The Cost of Care: Is There an Optimal Level of Expenditure?*, 27 INT'L HEALTH (2005), <http://harvardir.org/articles/1328/> (last visited May 6, 2006).

¹²⁸ AM. NURSES ASSOC., TODAY'S REGISTERED NURSE—NUMBERS AND DEMOGRAPHICS (FEB. 2006), <http://www.ana.org/readroom/fsdemogr.htm> (last visited May 6, 2006).

hospital pharmacists enjoyed a 6.6% increase in 2002 alone.¹²⁹ Overall, labor costs rose 21.1% between 2000 and 2003.¹³⁰

Despite—or in some markets perhaps attributable to—these increases, health care has become a major target of unionization efforts, with both the Service Employees International Union (“SEIU”) and the American Federation of Labor and Congress of Industrial Organizations (“AFL-CIO”) engaged in corporate campaigns directed toward large health care systems.¹³¹ Catholic systems have found themselves positioned as targets of these efforts both because of their size and prominence, as well as a belief amongst union leaders that Catholic systems are susceptible to unionization since the social teaching of the Church embraces worker recognition rights.¹³² These efforts have had some success, most notably with Catholic Health Care West.¹³³

Parallel to these reimbursement pressures, the health care environment continues to be highly competitive, as providers chase a dwindling pool of dollars. Beyond intra-institutional competition, hospitals find themselves increasingly in competition with their medical staffs as more care shifts to the outpatient or in-office setting.¹³⁴ Ambulatory surgical treatment centers now account for a growing percentage of all surgeries performed in the United States,

¹²⁹ AM. SOC. OF HEALTH-SYSTEM PHARMACISTS (ASHP), ANNUAL ASHP PHARMACY STAFFING SURVEY, <http://www.ashp.org/emplibrary/staffsurvey2005.pdf> (last visited May 6, 2006).

¹³⁰ RICHARD HAUGH ET AL., HOSP. & HEALTH NETWORKS, SPECIAL REPORT: COST DRIVERS, HOSPITAL & HEALTH NETWORKS (June 16, 2004) (“Unemployment is up and wage increases are down throughout the country, but you wouldn’t know that from health care. Hourly compensation costs for hospital jobs rose 6.4% in 2001, a whopping 10.5% in 2002 and another 4.2% in 2003.”).

¹³¹ Karen Mellen, *Foes Pan Advocate’s Treatment of Poor*, CHI. TRIBUNE, Mar. 12, 2004, at Metro § 1; see also Francine Knowles, *Unions Look to Increase Their Membership; More Organizing Expected as Groups Fight for Dominance*, CHI. SUN-TIMES, Sept. 6, 2005, at Finance § 67.

¹³² See AFSCME COUNCIL 31, THE HIGH PRICE OF GROWTH AT RESURRECTION HEALTH CARE: CORPORATIZATION AND THE DECLINE OF QUALITY CARE (Nov. 2005), <http://afscme31.org/cmaextras/qualityofcare.pdf> (last visited May 6, 2006); Kelly Quigley, *Advocate, Union Playing Hardball*, CHI. BUS., Feb. 20, 2004, <http://chicagobusiness.com/cgi-bin/news.pl?id=11545&rel=1> (last visited May 6, 2006).

¹³³ Arthur Jones, *Unions Gain Ground in Catholic Health*, NAT’L CATH. REP., Dec. 12, 2003, http://nconline.org/NCR_Online/archives2/2003d/121203/121203f.php (last visited May 6, 2006).

¹³⁴ See Nathan Kaufman, *Why Should You Develop A Medical Staff Plan?*, HEALTH FORUM (Oct. 5, 2005), <http://www.trusteemag.com/trusteemag/index.jsp> (last visited May 6, 2006).

and are expected to accelerate the industry's trend of relocating procedures and treatment outside of the acute care setting.¹³⁵

Specialty hospitals, including those focused on cardiac care, cancer, and rehabilitation, when coupled with the growth of free-standing imaging centers and other diagnostic and treatment modalities, place additional pressure on hospital bottom lines as profitable services continue to exit the acute care setting.¹³⁶ Institutions that relied upon these profitable services to generate revenues, which could be used to fund unprofitable offerings, now find themselves faced with very difficult choices.¹³⁷

The capital markets are also taking a stricter view of systems and hospitals, imposing rigorous testing on institutions that seek to borrow funds.¹³⁸ Institutions and systems that fall outside of the top tiers of credit worthiness are experiencing high capital costs as the markets digest the expansion of hospital competitors and the tight reimbursement/high cost environment facing providers.¹³⁹ The need to achieve the highest possible credit rating drives bottom-line oriented business practices that reward tight control of labor, equipment, and supply costs, and pruning of unprofitable service lines.¹⁴⁰ The imperative to adopt these practices at the same level as non-religiously based—indeed, even proprietary—providers, further blurs the line separating Catholic institutions from other providers.

In sum, the business environment continues to present significant challenges to system and hospital operations. For Catholic systems and hospitals, these challenges have a particular impact on the ability of the system and its institutions to fulfill a mission imperative, which may require the continuation of unprofitable services or the expansion of charity care services, while operating in an environment of declining reimbursement and increased costs. The overall result is that health care in the United States is fragmenting into the “haves” and “have nots,” challenging those organizations not

¹³⁵ Bernstein A.B. et al., *Health Care in America: Trends in Utilization*, NAT'L CTR. FOR HEALTH STATISTICS 12 (2003), available at <http://www.cdc.gov/nchs/data/misc/healthcare.pdf> (last visited May 6, 2006).

¹³⁶ KELLY J. DEVERS ET AL., CTR. FOR STUDYING HEALTH SYSTEM CHANGE, ISSUE BRIEF NO. 62: SPECIALTY HOSPITALS: FOCUSED FACTORIES OR CREAM SKIMMERS? (Apr. 2003), <http://www.hschange.org/CONTENT/552/> (last visited May 6, 2006).

¹³⁷ *Id.*

¹³⁸ MOODY'S INVESTOR SERVS., *supra* note 103.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

blessed with strong market share and a highly privately insured patient base to face stark choices between margin and mission.¹⁴¹

2. *Challenges to Restrictions on Prohibited Procedures*

With their increased size and market power, Catholic institutions increasingly find themselves subject to claims that they obstruct access to reproductive health services and interfere with patients' end of life decisions.¹⁴² Confrontation surrounding sterilization, and to a lesser extent abortion, has been the most visceral.¹⁴³

Litigation has surrounded access to sterilization and abortion since *Roe v. Wade*.¹⁴⁴ One of the earliest cases, *Taylor v. St. Vincent's Hospital*, involved a Catholic hospital that refused to allow a sterilization procedure to occur in its facility.¹⁴⁵ Prior to this refusal, the maternity department at the Catholic hospital merged with that of a non-sectarian hospital. The terms of the merger included an agreement whereby a woman desiring sterilization following childbirth would need to be transferred to another hospital prior to the procedure. The Catholic hospital was subsequently forced to perform the procedure despite its moral objections.¹⁴⁶

Since *Taylor*, several courts have decided cases involving providers who restrict the provision of health care based on religious views. In *Doe v. Bridgeton Hospital Ass'n, Inc.*, the New Jersey Supreme Court held that private, non-sectarian hospitals must provide first trimester elective abortion procedures.¹⁴⁷ The court reasoned that due to the hospitals' governmental support and accessibility to the public, "[t]heir actions must not contravene the public interest. They must serve the public without discrimination."¹⁴⁸ Similarly, the California appellate court in *Brownfield v. Daniel Freeman Marina Hospital* addressed a Catholic hospital's refusal to provide emergency contraception to women who had been raped.¹⁴⁹ The court held that, absent the existence of a Conscience Clause, the patient

¹⁴¹ *Id.*

¹⁴² Fogel & Rivera, *supra* note 1, at 727.

¹⁴³ *Id.*

¹⁴⁴ *Roe v. Wade*, 410 U.S. 113 (1973).

¹⁴⁵ *Taylor v. St. Vincent's Hosp.*, 369 F. Supp. 948 (D. Mont. 1973).

¹⁴⁶ *Taylor v. St. Vincent's Hosp.*, 523 F.2d 75, 76 (C.A. Mont. 1975).

¹⁴⁷ 366 A.2d 641, 645 (N.J. 1976).

¹⁴⁸ *Id.* at 645.

¹⁴⁹ 256 Cal. Rptr. 240, 244 (Ct. App. 1989).

retains the right to self-determination in her treatment, and this right prevails over the hospital's religious convictions.¹⁵⁰

Furthermore, Catholic institutions have been challenged on directives regarding end of life care, which critics claim may be adversely affected by religious restrictions. While the ERD's recognize the patient's right to forgo extraordinary means to forestall death, Directive 59 explicitly reserves the right of a Catholic facility to override a patient's decision.¹⁵¹ Recent court decisions favor a patient's right to the withdrawal of death-prolonging treatment over the hospital's religious or moral beliefs.

Several right to die cases exemplify the conflict over health care providers' religiously-based refusals to accede to patient demands regarding end of life treatment. In *In re Beverly Requena*, a New Jersey trial court held that a Catholic hospital could not evict a patient who refused to accept artificial feeding, thus upholding the patient's right to make her own uncoerced health care decisions.¹⁵² On appeal, a significant factor in the court's opinion was that the patient had no notice of a restrictive hospital policy disallowing the refusal of food and hydration.¹⁵³ Despite the religious beliefs of the hospital, the court ordered the hospital to honor the patient's directives.¹⁵⁴

In a similar case, although involving an Adventist institution, a California appellate court held that, despite the hospital's and physicians' religious objections, a competent adult patient has the right to refuse unwanted medical treatment.¹⁵⁵ In this case, the patient knew he would die if the ventilator was disconnected but preferred death to life on a ventilator.¹⁵⁶ The court concluded that "(t)he right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right that must not be abridged."¹⁵⁷

Controversial legislation mandating that Catholic employers cover contraceptives as part of the health insurance offered to em-

¹⁵⁰ *Id.*

¹⁵¹ ERDs, *supra* note 19, at Part VI, Directive #59 ("The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.").

¹⁵² 517 A.2d 886, 891-93 (N.J. Super. Ct. App. Div. 1986).

¹⁵³ *Id.* at 890.

¹⁵⁴ *Id.*

¹⁵⁵ *Bartling v. Glendale Adventist Med. Ctr.*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984).

¹⁵⁶ *Id.* at 221.

¹⁵⁷ *Id.* at 225.

ployees has also come to the fore, presenting a new challenge to Catholic health care providers.¹⁵⁸ At least twenty states have passed laws requiring mandatory coverage of prescription contraceptives.¹⁵⁹ Due to the Catholic Church's strong moral objection to the use of birth control, many mandatory contraceptive coverage statutes include "carve-out" exclusions for religious employers.¹⁶⁰ In New York and California, however, the statutory "carve-out" exclusions define the exception for "religious employers" very narrowly.¹⁶¹

These statutes require all commercial health insurance plans that offer prescription drug coverage to cover prescription contraceptives unless the religious employer is specifically excluded from the statutory mandate.¹⁶² To be excluded as a religious employer, each prong of a four-part test must be met: (1) the purpose of the organization must be to inculcate religious values; (2) the organization must primarily employ persons of the same faith; (3) the organization must primarily serve persons of the same faith; and (4) the organization must be exempt from filing an annual information return with the Internal Revenue Service.¹⁶³ This definition excludes Catholic churches, including seminaries, diocesan chanceries, and parish rectories, from being required to provide contraception coverage for its employees. The definition does not, however, exclude entities such as Catholic Charities, Catholic hospitals, or Catholic universities, "which serve and employ people without regard to religion."¹⁶⁴

As might be expected, litigation attacking the validity of the statutes was brought. In *Catholic Charities of Sacramento v. The Superior Court*, Catholic Charities premised its argument against the statute on the fact that the Act impermissibly burdened its religious freedom.¹⁶⁵ The court rejected that claim, holding that the statute "serves the compelling state interest of eliminating gender discrimi-

¹⁵⁸ For an example of the emerging scholarship in this area, see, e.g., Stabile, *supra* note 1, at 742.

¹⁵⁹ *Id.* at 741.

¹⁶⁰ See, e.g., California Women's Contraception Equity Act, CAL. HEALTH & SAFETY CODE § 1367.25(b) (Deering 2006).

¹⁶¹ *Id.*; CAL. INS. CODE § 10123.196(d) (Deering 2006); New York Women's Health and Wellness Act, N.Y. INS. LAW §§ 3221(16)(A)(1), 4303(cc)(1)(A) (McKinney 2004).

¹⁶² See *id.*

¹⁶³ I.R.C. § 6033(a)(2)(A)(i) or (iii) (2006).

¹⁶⁴ Stabile, *supra* note 1, at 755.

¹⁶⁵ 85 P.3d 67 (Cal. 2004).

nation” and that the Act was narrowly tailored to achieve that purpose.¹⁶⁶

The New York Appellate court decision in *Catholic Charities of the Diocese of Albany v. Serio*, is synonymous with that of the California court.¹⁶⁷ The New York court dismissed Catholic Charities’ complaint regarding the New York statute.¹⁶⁸ The court concluded that the narrow religious employer exclusion protects those who do not share their employer’s religious views and exempts those who do.¹⁶⁹

The First Amendment implications of the statutes are fascinating, as the statutes provide a direct challenge to religious practice of a type never seen before.¹⁷⁰ What these types of statutes also indicate, however, is that society is at least seemingly becoming more comfortable with the notion that religious employers (and the statutes are, in practical effect, largely directed toward Catholic hospitals and social service agencies) are not worthy of the deference they have historically been granted.

3. *Charity Care Litigation*

While not directly a challenge to mission, litigation filed around the country challenging the tax-exempt status of health care systems because of alleged failures to operate in a charitable manner arguably presents a very public attempt to question or define the contours of a charitable or religious mission. Developed by a consortium of attorneys led by Richard Scruggs, who made his fame and fortune spearheading tobacco litigation (and subsequent settlements) on behalf of the states, the litigation was initially filed on June 17, 2004,¹⁷¹ with the filing of thirty-one lawsuits in just over thirty days.¹⁷²

¹⁶⁶ *Id.* at 93.

¹⁶⁷ 808 N.Y.S.2d 447 (N.Y. App. Div. 2006).

¹⁶⁸ *Id.* at 466.

¹⁶⁹ *Id.*

¹⁷⁰ Stabile, *supra* note 1, at 741.

¹⁷¹ Clifford Law Offices, Press Release, *Not-For-Profit Hospital Class Action Litigation*, June 17, 2004, <http://www.cliffordlaw.com/not-for-profit-hospital-class-action-litigation/press-releases/not-for-profit-hospital-class-action-litigation-press-release> (last visited May 6, 2006) [hereinafter *Not-For-Profit Hospital Class Action Litigation*].

¹⁷² Clifford Law Offices, Press Release, *Three of the Nation’s Largest Nonprofit Hospital Systems Charged With Failing to Provide Government Required Charity Healthcare to Uninsured Patients*, July 20, 2004, <http://www.cliffordlaw.com/not-for-profit-hospital-class-action-litigation/press-releases/three-of-the-nation2019s-largest-nonprofit-hospital-systems-charged-with>

Over the course of seven months the litigation grew so that at its peak nearly seventy health care systems or large hospitals had been sued in forty-three states.¹⁷³ Each suit alleges health care providers violate federal law when they “aggressively overcharge” uninsured patients without regard to the patients’ ability to pay. Other claims include violation of contract and consumer protection laws, the use of aggressive billing techniques, and requiring clients to sign a promise to pay prior to receiving treatment.¹⁷⁴ Specifically with respect to tax exemption, allegations were made that because the defendants had failed to provide “sufficient” charity care, they had breached their “contract” with the government which was a condition for obtaining and maintaining tax-exempt status, and that therefore, their exempt status should be revoked.¹⁷⁵ A motion was filed to consolidate the litigation into a class action, which was denied.¹⁷⁶

Ultimately, all but one federal court rejected the suits as failing to present a cause of action on the tax-exemption claim, holding that private litigants do not have the right to sue for enforcement of tax law.¹⁷⁷ Plaintiffs have since refiled many of their claims in state courts, alleging violations of consumer protection laws, health insurance laws, and using deceptive business practices, among other things.¹⁷⁸ Even as the national implications of the lawsuits have faded, the litigation deserves attention because it represents the first instance of a nationwide attack calling into question the viability of mission arguments to sustain favorable governmental treatment of hospitals.

Beyond the direct impact of the litigation, the suits have spawned other actions by the federal and state governments. At the federal level, Congress has been taking a critical eye to reports of

failing-to-provide-government-required-charity-healthcare-to-uninsured-patients (last visited May 6, 2006).

¹⁷³ *Id.*

¹⁷⁴ See, e.g., PREMIER INC., NONPROFIT HOSPITALS AND HEALTH SYSTEMS: CARING FOR OUR COMMUNITIES—A CHARGE TO KEEP, <http://www.premierinc.com/washington/issues/nonprofit/issue-overview.jsp> (last visited May 6, 2006); see also Leah Snyder Batchis, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 507 (2005).

¹⁷⁵ *Not-For-Profit Hospital Class Action Litigation*, *supra* note 171.

¹⁷⁶ Peyton Sturges, *Multidistrict Judicial Panel Rejects Motion to Consolidate, Transfer Charity Care Cases*, BNA HEALTH L. REP., Oct. 28, 2004, <http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-667KU7?OpenDocument> (last visited May 6, 2006).

¹⁷⁷ Batchis, *supra* note 174, at 507–08.

¹⁷⁸ *Not-For-Profit Hospital Class Action Litigation*, *supra* note 171.

excessive executive compensation paid by exempt entities.¹⁷⁹ Enhanced reporting of business arrangements by tax-exempt entities has also been implemented,¹⁸⁰ and hearings have been held examining the basis for granting tax-exempt status to hospitals.¹⁸¹

Various states are also in the midst of investigating hospital charity care policies and pricing strategies, with an eye toward clarifying hospital responsibilities to their communities.¹⁸² In still other instances, specific actions have been brought by states' attorneys general against systems alleging violations of fiduciary principles and tax-exemption standards.¹⁸³ Business practices in the areas of billing and collection and determination of charity care need have been revised to reflect new sensitivity to operating in a charitable manner.¹⁸⁴

Catholic institutions and systems have not been immune from these actions and investigations.¹⁸⁵ No doubt many of these actions will prove to be nonmeritorious. The mere fact that questions are being asked, however, is telling. Twenty or so years ago no one reasonably would have thought of challenging whether a Catholic institution was fulfilling its mission commitments. Today it is hardly shocking that one would do so. To the extent that Catholic hospitals hold themselves out as occupying a special place in society by virtue of fulfilling a higher purpose, it is apparent that society is,

¹⁷⁹ See Appleby, *supra* note 8.

¹⁸⁰ THE URBAN INST., FORM 990 ACCOUNTING AND REPORTING ISSUES (2006), <http://nccs.data.web.urban.org/kbfiles/620/Form990-issues-2006.doc> (last visited May 6, 2006).

¹⁸¹ *Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways and Means*, 109th Cong. (2005).

¹⁸² Carol Pryor & Robert Seifert, *Unintended Consequences: An Update on Consumer Medical Debt*, THE HELLER SCHOOL FOR SOCIAL POLICY & MGMT, BRANDEIS UNIV., http://www.cmwf.org/usr_doc/pryor_medicaldebt_749.html (last visited May 6, 2006).

¹⁸³ For a review of early, landmark cases in the area of attorney general involvement in health care, see *Queen of Angels Hosp. v. Younger*, 136 Cal. Rptr. 36, (2d. Dist. 1977) (action brought by the attorney general of California in 1977 against a Los Angeles Hospital illustrates a strict approach to charitable trust status); *City of Paterson v. Paterson Gen. Hosp.*, 250 A.2d 427 (N.J. Super. Ct. App. Div. 1969) (holding that a hospital originally incorporated to operate within the city limits was not a charitable trust in the strict sense). More recently, in all but one example, actions have been brought in Illinois by local taxing authorities questioning the tax-exempt status of property used by a Catholic hospital, leading to an investigation of the propriety of tax-exemption, billing practices and charitable care policies by the attorney general. See Lucette Lagnado, *Hospital Found 'Not Charitable' Loses Its Status as Tax Exempt*, WALL ST. J., Oct. 30, 2003, at B1; see also Lori Rackl, *Madigan: Hike Charity Health Care: Plan Puts Hospitals' Tax-Exempt Status on Line*, CHICAGO SUN-TIMES, Jan. 23, 2006, at 16.

¹⁸⁴ See Arrick et al., *supra* note 7.

¹⁸⁵ Lagnado, *supra* note 183, at B1.

at best, uncertain as to the contours of that mission promise and, at worst, disbelieving that a special mission even exists.

IV. IMPACT OF MISSION CHALLENGES

There is little doubt that Catholic hospitals face significant challenges to the continuation of their religious mission. The transition of the “moral compass” of Catholic hospitals from religious communities to lay executives and boards of directors presents perhaps the most compelling challenge to the ability of Catholic hospitals to fully act in concert with Church teachings.¹⁸⁶ The likely withdrawal from sponsorship over the next twenty years of many of the religious communities that founded and have guided Catholic health care and its mission—indeed, who are steeped in this ministry and devoted to its fruition—cannot be underestimated.¹⁸⁷ And yet, the fact that the Church and health care leadership—both religious *and* lay—are focused on this transition indicates that protection of a religious mission continues to be viewed as vital and that the intangible aspects demonstrative of a religious mission continue to be present.

Serious arguments can be made that the tangible aspects of a Catholic mission orientation have weakened. Catholic hospitals undertake the same types of bottom-line-oriented business strategies as their secular brethren.¹⁸⁸ Catholic hospitals have violated the antidumping and fraud and abuse laws, and no doubt other laws as well, just like other community hospitals have done.¹⁸⁹ Indeed, there is a significant debate within the health care literature as to

¹⁸⁶ I in no way believe, or intend to imply, that the commitment to follow the ERDs will necessarily weaken under lay sponsorship, although it is possible that the ability to recognize sensitive situations could wane. Rather, I think the more significant threat is the ability of executive management and the Board to remain focused on the “why” of the hospital, to continue a strong preferential option for the poor in the face of mounting business pressures, and to keep alive the historical traditions of the founders when they are no longer present to provide these teachings for themselves.

¹⁸⁷ Catholic health care has embraced ecumenical leadership, with many Catholic systems and institutions managed and governed by non-Catholics. While ecumenicalism brings great strength to Catholic health care because of its attendant diversity, it also creates its challenges as transition to lay control (including non-Catholics) occurs. See KAUFMAN, *supra* note 21, at 307 (“Leadership formation during a period when seventy percent of the administrators of Catholic facilities are laymen and women must be recognized by the Church as vital to its ministry, while the leaders must be accountable to Church reality.”).

¹⁸⁸ And their executives have been questioned for receiving high salaries just like others in the industry. See Appleby, *supra* note 8.

¹⁸⁹ See, e.g. *St. Anthony Hosp. v. U.S. Dept. of Health & Human Serv.’s*, 309 F.3d 680 (10th Cir. 2002) (involving the violation of antidumping law).

whether *any* nonprofit, tax-exempt hospital is worthy of deference to its charitable mission.¹⁹⁰

The industry profile of Catholic hospitals does provide credence to the proposition that, as a whole, Catholic health care is tangibly fulfilling its mission in ways different from non-Catholic hospitals. Data analysis by the Catholic Health Association indicates that Catholic hospitals devote significantly more resources to public health and specialty services than non-Catholic institutions. In twenty service lines, as varied as alcohol and drug treatment, child and adolescent psychiatric services, AIDS and HIV services, hospice, neonatal intensive care, social work, and trauma, Catholic hospitals are service leaders.¹⁹¹ Catholic hospitals also provide a higher percentage of care to Medicaid patients than their share of the total hospital market would otherwise indicate.¹⁹² Further, almost one-third of Catholic hospitals are located in rural areas, often

¹⁹⁰ See, e.g., Jason M. Kellhofer, *The Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers Between Catholic and Non-Catholic Healthcare Systems*, 16 J.L. & HEALTH 103 (2001-2002); Donald H. J. Hermann, *Religious Identity and the Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers*, 34 CREIGHTON L. REV. 927 (2001). Indeed, proprietary hospitals, which may be members of the American Hospital Association, created their own trade association to advocate specifically for the point that their charitable outcomes (community benefit as exemplified by service offerings and “free” care) are not substantively different than nonprofits hospitals. See FED. OF AM. HOSP., www.fahs.com (last visited May 6, 2006); see also MARK A. HALL ET AL., *THE LAW OF HEALTH CARE FINANCE AND REGULATION* 411 (2005) (“Health policy researchers have produced an extensive body of empirical findings that fail to reveal major differences in the cost or quality of care delivered by nonprofits and for-profits.”).

¹⁹¹ See CATH. HEALTH ASSOC. OF THE U.S., *CATHOLIC HEALTH CARE IN THE UNITED STATES* (2005), <https://www.chausa.org/NR/rdonlyres/68B7C0E5-F9AA-4106-B182-7DF0FC30A1CA/0/FACTSHEET.pdf> (last visited May 6, 2006).

¹⁹² In 2005, Catholic hospitals comprised 12.2% of community hospitals in the United States. *Id.* These same hospitals were responsible for 19.3% of Medicaid discharges from community hospitals. *Id.* While hospitals with a high Medicaid caseload are entitled to additional payments under the disproportionate share program, DSH Adjustment, 42 C.F.R. § 447.272 (2006), even these payments fail to remedy the fact that Medicaid generally pays hospitals significantly below their costs. See *Hospitals Face a Challenging Operating Environment*, Statement of the American Hospital Association before the Federal Trade Commission Health Care Competition Law and Policy Workshop (Sept. 9-10, 2002), available at <http://www.hospitalconnect.com/aha/advocacygrassroots/advocacy/testimony/test020909ftc.html> (last visited May 6, 2006) (stating “Medicaid hospital reimbursement rates are generally even lower than Medicare rates, and as a result 73% of hospitals reported negative Medicaid margins in 2000. Hospitals received 82 cents for every dollar spent for Medicaid and charity care patients in 2000.”); see also VA. HOSP. & HEALTHCARE ASSOC., *THE COST OF CARING* (Jan. 2004), available at <http://www.vhha.com/index.cfm?fuseaction=page.viewPage&pageID=230> (last visited May 6, 2006) (stating “Virginia’s Medicaid program pays health care providers well below cost. By design, the Medicaid program pays hospitals about three-fourths of their cost. It also pays nursing homes and doctors well below the cost of providing care.”).

faced with issues of access to care and availability of services not encountered by urban facilities. In many markets, Catholic hospitals are exclusive providers of hospital services, raising the issue, in at least some of these markets, as to whether there would be access to hospital services if the Catholic hospital departed.¹⁹³

Criticism can be levied at the argument that deference to the Catholic mission should be justified by examining Catholic health care in its totality. After all, health care delivery is inherently local, and each institution responds to its particular operating environment and community needs in its own unique way. Each possesses its own culture which guides how mission is defined, reflected, and implemented in the institution. And certainly not all Catholic hospitals are struggling to serve the poor, or even located in markets with high percentages of under and uninsured individuals.¹⁹⁴ Thus, particular communities and states should be free to make their own judgments as to the deference accorded to that mission.

There is merit to this argument and certainly an intuitive appeal to the claim of freedom of choice. At the same time, as health care increasingly adopts a bottom-line orientation, it would seem important to society that institutions exist which are motivated by, *and act out of*, a higher calling. For a particular patient desiring services which conflict with Catholic beliefs, there arguably is a cost associated with Catholic health care. On balance, however, health care is greatly benefited, I believe, by enabling institutions and the individuals associated with them to work out of a religious motive as they provide care of a most intimate nature. Until recently there was respect for the role of religious mission. Nothing has fundamentally changed either internal or external to the Church to merit rejection of this approach.

¹⁹³ It is almost certainly the case that in some markets the Catholic hospital is the sole provider because of its competitive dominance, rather than its desire to serve an otherwise underserved populace.

¹⁹⁴ After all, the major Catholic systems are multi-billion dollar organizations; they did not get that way by being financially unsuccessful.

