

Hierarchy Crackdown Clouds Future of Sterilization, EC Provision at Catholic Hospitals

By Rachel Benson Gold

Catholic hospitals have long been part of the fabric of the American health care system. The 618 Catholic hospitals nationwide account for one in six of all community hospital beds. Because Catholic hospitals are bound by rules that severely limit the provision of reproductive health care services, the reach of the Catholic health care system has long been problematic for individuals seeking these services and for providers attempting to meet patients' needs. Recent rapid growth in the Catholic system has exacerbated this long-standing problem while, at the same time, a crackdown by the Catholic hierarchy is making it more difficult for providers to craft arrangements to ensure that needed care will continue to be available.

'Creative Solutions'

Both the number and the reach of Catholic institutions have grown in recent years, as part of an overall trend toward consolidation in the health care marketplace. Catholics for a Free Choice (CFFC) estimates that there were nearly 171 mergers and acquisitions involving U.S. Catholic hospitals between 1990 and 2001. According to the Catholic Health Association, Catholic hospitals now represent the single largest group of not-for-profit hospitals in the nation, caring for 88 million patients a year.

Most often, when mergers and acquisitions have brought together a Catholic and a non-Catholic hospital, the new, combined entity has been required, as a condition of the agreement, to adhere to the require-

ments of the *Ethical and Religious Directives for Catholic Health Care Services*, which are developed by the United States Conference of Catholic Bishops (USCCB) and govern the provision of care in Catholic institutions. The *Directives* specifically ban direct involvement in reproductive health services considered to be morally objectionable, a list that includes contraception, sterilization, abortion and such infertility services as in vitro fertilization and artificial insemination. However, the *Directives* also permit a Catholic institution to have a limited, indirect role in the delivery of some reproductive health services in the context of affiliations with other, non-Catholic providers.

According to CFFC, about half the mergers involving Catholic hospitals have resulted in at least some diminution of reproductive health services. As a result, several of these mergers have become quite controversial, and strong community opposition has even blocked some. In other cases, however, community sentiment has led to the development of creative solutions that allow, in some way, for the retention of at least some reproductive health services.

In most cases, these creative approaches have been used to allow the previously secular party in a merger to continue to provide either sterilization or reversible contraceptive services. For example, when Leila Hospital in Battle Creek, Michigan, was acquired by a Catholic hospital system, it was allowed to retain its sterilization services by creating a separate unit, with its own operating room and board of direc-

tors, within the hospital. Significantly, however, no wiggle room has been allowed when it comes to abortion, which is considered by the Church to be especially loathsome.

Cracking Down

While these arrangements have helped preserve critical access to services, storm clouds have massed in recent years, as the Vatican, directly or through the USCCB, time and again has moved to become directly involved in some of the accommodations being crafted. For example, an arrangement between St. Vincent's Health System and Arkansas Women's Health Center to provide sterilization services was blocked after a finding from the Vatican that the plan was "inappro-

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priate" ("Advocates Work to Preserve Reproductive Health Care Access When Hospitals Merge," *TGR*, April 2000, page 3). Similar attempts to find an accommodation between Brackenridge Hospital in Austin, Texas, and the Seaton Health Care Network, a Catholic chain, provoked the ire of the Church hierarchy and set the stage for a long-running saga over the provision of reproductive health services at that facility (see box, page 12).

The question of the permissibility of these various arrangements came to a head in June 2001, when the USCCB met to consider revisions to the *Directives*. Despite strong objections from the Catholic Health Association, many of whose members feared jeopardizing existing contractual arrangements, the bishops voted to revise the *Directives*,

The Brackenridge Hospital Saga: Seven Years and Counting

The travails of Brackenridge Hospital in Austin, Texas, could be seen as a microcosm of the multifaceted debate over the involvement of Catholic hospitals in the provision of reproductive health care. This seven-year controversy at a single facility embraces all the features of the national debate, including an attempt to craft a creative solution, the direct involvement of the Vatican and a fierce debate over emergency contraception.

The saga began in 1995, when the city of Austin attempted to lease Brackenridge Hospital, a public facility, to the Seton Healthcare Network, a Catholic chain. The original agreement between the city and Seton allowed reproductive health services, except for abortion, to continue at the facility after Seton assumed control. Shortly after the arrangement was crafted, Austin's bishop was summoned to Rome and ordered to end the arrangement. To meet the Vatican's objections, the hospital's lease was amended to ensure that city employees, rather than hospital staff, would provide the actual sterilization procedures and that the city would be financially responsible. About 450 sterilizations were provided annually under this arrangement.

This compromise remained in effect until last year, when the USCCB revised the Directives, seemingly to prohibit exactly the type of creative solution crafted at Brackenridge. With the ink on the revisions hardly dry, Seton announced in June 2001 that it could no longer allow sterilization and other contraceptive services to be provided at Brackenridge, even by city employees.

In response, the city proposed creating a "hospital within a hospital." Under the plan, the city would operate a separately licensed hospital on the fifth floor of Brackenridge and assume all financial responsibility. Deliveries and postpartum sterilizations, along with contraception, would be available. Seton agreed, at least in principle, that its staff would refer patients to the fifth floor when asked about services Seton does not provide.

With the city council poised to vote on the new plan in October, Seton threw a new wrench into the works by announcing that it would allow the provision of emergency contraception, either in its own emergency room or on the fifth floor, only if an ovulation test showed that the woman was not ovulating at the time, a requirement advocates charged would place the services out of reach of precisely the population needing them the most. Seton went so far as to say that it could not even provide "support services," such as water and electricity, to the facility if emergency contraception were provided. Thrown off guard by the last-minute demand, the city council withdrew the plan from consideration.

Four months later, in February 2002, the city and Seton struck a compromise, which allowed emergency contraception to be provided on the fifth floor, but only to women who had been raped; for its part, the hospital relented on the demand for ovulation testing. While the compromise broke the logjam at least enough to allow the council to approve the measure, many advocates were unhappy. Says Peggy Romberg of the Women's Health and Family Planning Association of Texas: "Because of Seton's insistence that the city-owned and operated fifth floor hospital be governed in part by the Catholic directives, the residents of Austin will not have access to the reproductive healthcare services available in other public, tax-supported hospitals in Texas."

essentially putting sterilization on par with abortion as being "intrinsically immoral." This move seemed aimed at greatly circumscribing, if not precluding altogether, the ability of hospitals to make accommodations allowing for the continued provision of sterilization. CFFC estimates that at least 40 arrangements with Catholic facilities that allow for the provision of sterilization could be jeopardized by the revisions.

Barring sterilization services at Catholic hospitals would have serious implications. Sterilization is the single most common form of contraception used by American women, with 28% of contraceptive users relying on that method. Further, about half of all tubal ligations are in-hospital procedures performed immediately after a woman gives birth, according to researchers from the federal Centers for Disease Control and Prevention.

Meanwhile, as the debate continues to swirl over sterilization, a new controversy over the provision of emergency contraception in Catholic hospitals is emerging. In March, the Catholic Health Association issued a statement saying that Catholic facilities may only provide emergency contraception to a woman who has been sexually assaulted if tests indicate that fertilization has not occurred. According to the statement, "A Catholic hospital cannot provide these drugs if their effect would be abortifacient." Emergency contraception, which consists of a concentrated dose of regular oral contraceptives taken very shortly after unprotected intercourse, prevents pregnancy just as oral contraceptives do normally: most often by preventing ovulation or fertilization, or, if fertilization has already occurred, by blocking implantation of the fertilized ovum.

Despite the attempted crackdown by the Church hierarchy, however, the

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question of the degree to which Catholic facilities will be able to participate “indirectly” in sterilization or the provision of emergency contraception is far from being answered. In fact, it is beginning to appear that as in the past, questions are more likely to be resolved in an ad-hoc manner in practice than through blanket policy utterances. Indeed, the Catholic Health Association already has issued a statement “clarifying” that the recent revisions to the *Directives* do not absolutely prohibit creative solutions. “The practical effect of the changes,” says the association, “is to make clear that the Catholic organi-

zation maintains appropriate distance or separation from prohibited procedures....” And the chair of the ethics committee at a Catholic hospital in Spokane, Washington, recently contended that with medical tests unable to determine conclusively, within the crucial 72-hour window during which emergency contraception is provided with the greatest efficacy, whether fertilization has occurred, “the ethical question becomes one of the woman’s and the caregiver’s intent.” Clearly, the final chapter on creative solutions is far from written, but the matter needs to be carefully watched. ☩