Religious Identity and the Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers

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RECOMMENDATIONS AND THE HEALTH CARE MARKET: 
MERGERS AND ACQUISITIONS INVOLVING RELIGIOUSLY 
AFFILIATED PROVIDERS

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A. INTRODUCTION

Throughout the history of the United States, various religious groups have been involved in a broad range of health care activities. Religiously affiliated health care providers combine the objectives of for-profit health care institutions in delivering medical services in an economically efficient manner with those of nonprofit organizations that are concerned with the medical needs of the specific community being served. To this combination, the religiously affiliated health care provider adds the particular goals and mission of its own sponsoring religious group, such as charity care or provision of medical services to those who are financially indigent. While the vast majority of these religiously affiliated institutions serve the public at large without any restrictions on medical service based on religious belief, some sectarian health care entities make their services contingent upon their comporting with the teachings of the supporting religious institution.1 Nevertheless, there is a general consensus among these organizations that their mission includes the assurance that all necessary services are offered, that all needy populations are provided with care, and that a refuge is provided for all those in need of care.2 The objectives of universal access and provision of charity care in community-

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1. For an excellent and thorough discussion of the evolution and impact of religiously-affiliated hospitals in the past and current markets, see Kathleen M. Boozang, Deciding the Fate of Religious Hospitals in the Emerging Health Care Market, 31 Hous. L. Rev. 1429 (1995).

owned nonprofit hospitals have reflected Dr. Albert Schweitzer's formulation of the ideal care-giving tenet of religiously affiliated health care providers: "Here, at whatever hour you come, you will find light and help and human kindness."3

Today, all health care institutions face many economic pressures. Medicare and Medicaid payments comprise more than fifty percent of the income of many hospitals in the United States. In the past few years, particularly after passage of the Balanced Budget Act, Medicare and Medicaid payments to the hospitals have been greatly reduced. Commercial payers, as well as the Medicare and Medicaid Programs, have placed a number of controls and limitations on inpatient hospital visits, and have encouraged the use of office procedures and ambulatory surgery centers to reduce the number and length of inpatient hospital visits. At the same time, there have been many technological advances which require hospitals to invest large sums of money in equipment and the development of employee-intensive procedures to provide the best care to patients. Finally, there is strong competition for managed care contracts. With all of these economic pressures, many institutional health care providers have sought mergers and integration in order to create efficiency by combining departments offering certain services, thus avoiding duplication of programs. The resulting entities can create new services at one campus instead of two, further reduce costs through the consolidation of administrative staff, provide a greater range of services, and attract managed care contracts.

B. GOVERNING STRUCTURE

Until the middle of this century, most religiously affiliated health care facilities were not separately incorporated. Instead, they were part of the organizational structure of the sponsoring religious group, which often included the provision of charitable care as part of its stated purpose. In more recent years, however, various legal developments have produced a need for separate corporate structures for religiously affiliated health care organizations, which are usually created by articles of incorporation or a corporate charter that must comply with state laws governing corporations. The charter states the purposes of the organization, establishes the requirements for membership (or shareholder status), and sets out the constitution of the board. This charter also provides authority for adoption of bylaws, rules, and regulations. Federal law, particularly the Internal Revenue Code and Medicare/Medicaid statues, has had an important influ-

3. Volunteer Trustees, supra note 2, at 1 (citing the inscription of Dr. Albert Schweitzer's lamp at his jungle clinic in Laberene).
ence in the establishment of separate legal initiatives to be administered in compliance with the requirements of the tax law and reimbursement law. Third-party reimbursement has created a need to establish which expenses can be included in the reimbursable cost basis. Creating a separate entity simplifies this process. Another important factor leading to the establishment of separate entities to provide health care services was state certificate-of-need laws which required proposed health care organizations to provide extensive financial disclosure, since many sponsoring organizations did not want to provide full access to their institution's financial records. Perhaps another early important factor leading to separate incorporation of religiously affiliated health care providers has been medical malpractice, which has created the need to isolate assets of the sponsoring group, the necessity of qualifying for malpractice insurance, and a desire to establish adequate risk-management monitoring.

Management of the health care organizations is usually overseen by a board of directors or trustees, many of which are either self-perpetuating or elected by the membership with requirements for members set out in the charter. Some religious sponsors have sought to maintain a level of control over the health care provider by establishing interlocking boards of directors between the provider and the sponsoring religious body or church. Another method of maintaining control uses the category of "membership" in the affiliate's corporate charter. In this process, control over the affiliate is ultimately held by a group designated "the members," constituted of individuals who usually belong to and represent the sponsoring religious organization. In some cases, the religious order sponsoring the health care entity is the sole corporate member. Control through use of powers reserved to the members facilitates significant ultimate decisional authority over matters involving fiduciary responsibility, including sale of corporate assets. Under this arrangement the members have the authority to appoint and remove board members, amend the health care provider's mission, and approve the purchase or sale of major assets. The members also select a board of directors to oversee the administrative responsibilities of the provider organization, and to develop and implement rules to promote the values of the sponsoring group. This board is usually composed of civic, business, and religious leaders along with physicians, ethicists, lawyers, and lay members of the community. Often there is an effort to select individuals for board membership who represent the social makeup of the group receiving services from the provider. The board's authority to govern the health care entity is established by the documents creating the entity and by the general principles of corporate law. The board has ultimate responsibility for the effective operations of the organization and most
often appoints a chief executive officer and other high-level members of the management team who take responsibility for day-to-day management.

The board of directors acts as the governing body of the health care provider, and may ultimately approve or deny any specific proposed treatment protocol. Depending on the sponsoring religious organization, the hospital may or may not provide treatments that some members of the general community may deem essential for quality patient care: for example, abortion, sterilization, or withholding of treatment at the patient's request. It is in the provision of such medical services that there is most often a potential clash of policy when different religiously affiliated hospitals consider merging, or when a religiously affiliated provider becomes associated with a for-profit entity or with another nonprofit institution that lacks any religious affiliation.

Religiously-affiliated health care providers are most often not-for-profit, rather than for-profit or governmental, and private, rather than public, and are often organized as charitable entities in order to qualify for special tax treatment. The law has developed high standards for such charitable enterprises requiring scrupulous compliance with fiduciary standards. However, in some states directors are exculpated from ordinary negligence.

C. CHANGES IN THE HEALTH CARE ENVIRONMENT

Recent developments in the health care industry, as well as changes in demographics and the expressed needs of various social communities, have had a marked effect on the structure of health care institutions. These developments also have changed the way in which health care services are delivered and paid for. The central role that third-party payers have assumed in the provision of health care has compelled all health care providers, both institutions and associated physicians, to streamline services in order to cut costs and remain competitive.

Religiously affiliated hospitals must constantly seek "to adapt to the ever-changing needs of their communities and [to conditions in] the health care market," while struggling to maintain and continue promoting their unique religious identities. This means that health care institutions have had to cope with demands for reform along with the necessity of reducing overhead and controlling costs. This in turn, has led to a large number of closings and mergers among religiously

5. Id. (citing Nanette Byrnes, Anatomy of a Merger, FIN. WORLD, July 5, 1994, at 20. Byrnes noted that "over the past [ten] years the cost pressures of managed care, coupled with chronic over-bedding, have caused an estimated 500 out of 5800 U.S. hos-
affiliated hospitals and nursing homes. While these changes have resulted in limitations on patient choice of providers, some commentators maintain that many of these changes have "increased efficiency" and "eliminated costly duplication of services."

This Article examines the legal implications of religiously-affiliated hospitals joining forces with other institutions whether religiously affiliated or not, whether nonprofit or not. The discussion begins with an overview of developments in the health care system in the United States, and then examines the response of religiously affiliated providers to the changing health care arena, including the various institutional arrangements used to establish cooperative arrangements with other providers. The discussion then focuses on a legal overview emphasizing the tax and antitrust implications of these arrangements. Next, a review is provided of recent federal and state legislation including model legislation and guidelines proposed by grassroots and professional organizations. Finally, this Article identifies conflicts that have arisen as a result of ethical and moral views embedded in the policies of religiously affiliated hospitals, particularly in such areas as reproductive health, the right to refuse treatment or to have treatment withdrawn, physician-assisted suicide, and organ donation and transplantation.

As the influence of managed care limits patient choice of health care providers, patients may also be faced with new restrictions on services available, or on the sites where they may be obtained. This is often a result of participation in managed care and of institutional integration of health care organizations, and it requires policy makers and federal and state legislators to give attention to developing arrangements that balance the religious convictions of the provider with hospitals to close. In big cities such as New York and San Francisco, consultants estimate, at least another [twenty percent] of current capacity will be wiped out within five years." Byrnes, Fin. World, July 5, 1994, at 20-21.


8. Id. at 1433. Boozang stated "[i]t this limitation on choice is especially true when mergers occur between the only two hospitals in a community." Id. (citing David Burda, Agencies Near Decisions on Two Hospital Mergers, Mod. Healthcare, Jan. 17, 1994, at 17 (discussing the Federal Trade Commission and U.S. Department of Justice's concerns regarding the frequency of two-hospital mergers and the possibility these mergers violate federal antitrust laws)).


10. Id. (citing Byrnes, Fin. World, July 5, 1994, at 21).
the treatment expectations present in the secular society regarding the delivery of health care services.11

D. THE EVOLUTION OF THE HEALTH CARE SYSTEM

To understand the institutional arrangements that make up the health care system in the United States, one must study their evolution.12 During the eighteenth and into the nineteenth century, almshouses, the predecessors to our hospital system, cared for the sick, homeless, and poor until their deaths.13 Many of these facilities were established by local governments, while others were run as charity institutions by religious institutions. As the need for such treatment centers became greater, the concept of hospitals providing care to the physically and/or mentally ill began to emerge.14 While these new hospitals received substantial financial support from governmental agencies and religious organizations, wealthy people were largely treated by physicians in their homes or at physicians' clinics.15

By the late nineteenth century, the availability of anesthesia and asepsis motivated privately-treated patients to seek treatment in hospitals and physicians' clinics rather than in their own homes.16 Despite new medical innovations and changing treatments, health care continued to be delivered in two very different ways. One commentator reported that “[l]arger voluntary hospitals, typically supported by philanthropic contributions, served the poorer population, and small, doctor-owned, proprietary hospitals generally catered to self-paying wealthier individuals.”17 By the early twentieth century, physicians and social reformers recognized the need for establishing hospitals adequate to meet the needs of their communities.18 Even with the strong public interest in health care, the number of hospitals was divided between physician-owned or proprietary, and charitable or vol-

15. Id. at 11 (citing Starr, supra note 13, at 145-49.) Crimm noted that by the mid-nineteenth century, most of the care provided in patients' homes or physicians' clinics was similar, if not identical, to the treatment provided in the hospital setting. Id. at 10 n.22 (citing Starr, supra note 13, at 145-49).
17. Id. at 11 (citations omitted).
18. Id.
untary, hospitals. Both types of facilities existed in most regions of the country. The metropolitan cities of the eastern and midwestern United States often had a small number of municipal hospitals, "a few small ethnic and religious hospitals, and some larger nongovernmental, nonsectarian voluntary hospitals operated by voluntary boards of trustees and largely supported by philanthropy." Generally, municipal hospitals provided care to the nonpaying poor while voluntary hospitals, often aligned with medical schools, provided acute care to low-income subsidized patients. The newly developed western states typically provided health care through small proprietary hospitals.

While the institutional structure of the health care sector remained mixed and subject to change, the importance of quality medical care became a vitally important concern. By the 1930s, the number of voluntary nonprofit hospitals began to grow, while the number of proprietary hospitals declined. In the mid-1940s, even more proprietary hospitals closed or were converted into nonprofit institutions. After World War II and until the mid-1960s, "non-government voluntary hospitals accounted for fifty-eight percent of all general acute-care hospitals, while proprietary hospitals accounted for only twenty-four percent." The rapid expansion of not-for-profit voluntary institutions over the span of three decades can be attributed, at least in part, to the 1946 enactment of the Hospital Survey and Construction Act, also known as the Hill-Burton Act. This legislation provided federal funds to subsidize the cost of constructing nonprofit and public acute-care general hospitals, health clinics, and nursing homes throughout the nation.
Access to health insurance was another influence on the growth in the number of voluntary hospitals, and it caused an acceleration in demand for health care. Competing with nonprofit Blue Cross and Blue Shield plans, private commercial insurers began offering lower-priced plans to consumers. The establishment of Medicare and Medicaid was critical to expanding the number of persons able to access health care providers.

Constant changes in the health care system have affected the manner in which religiously affiliated hospitals provide medical services. During the last two decades of the twentieth century, the growth of hospitals aided by a system of reimbursement for actual costs ultimately became a national concern as health care costs spiraled upward. By the 1980s, managed care and the development of reimbursement schedules based on diagnosis represented efforts to contain health care costs. For example, the explosion of managed care in the 1990s has resulted from pressure to increase access to health care services while decreasing costs. Additionally, many nonprofit hospitals, including religiously affiliated hospitals, have been con-

29. Crimm, 37 B.C. L. Rev. at 15.
30. Id. (citations omitted) (discussing the explanations of Steven Golub, The Role of Medicare Reimbursement in Contemporary Hospital Finance, 11 Am. J.L. & Med. 501 (1986)). Golub noted:

World War II also indirectly promoted the popularity of health insurance as an employee benefit, since wartime wage and price controls did not apply to fringe benefits. Hence, between 1940 and 1950, the number of people covered by hospitalization insurance increased from twelve million to seventy-seven million. During the 1940s, as health insurance coverage increased in availability and scope, there was a concomitant rise in the development and use of new medical technology. As a result, both the demand for and cost of health care services accelerated.

Golub, 11 Am. J.L. & Med. at 504 (footnote omitted).
31. Crimm, 37 B.C. L. Rev. at 15. Crimm noted:

Since inception, Blue Cross and Blue Shield, not-for-profit organizations, had offered private insurance with premiums based on the average of the actuarial medical experiences of all employee groups of different companies in an area ('community rating'). Entry of for-profit private commercial insurers into the marketplace profoundly affected the private health insurance industry. These for-profit private insurers offered health insurance at lower premiums than available through Blue Cross and Blue Shield. They based their premiums on the use of medical care in the community ("experience rating"), which provided a broader base to spread their risk of loss, and hence enabled lower premiums to be offered. By the 1960s, Blue Cross and Blue Shield virtually abandoned community rating for experience rating based on similar insurance pools.

Id. at 15-16 n.51
fronted with financial hardship. Moreover, the continuing existence of a significant low-income and indigent population in the United States has increased the need for charity care that generates little or no revenue. Many health care providers have maintained that reimbursement levels under Medicaid and other state public aid programs have failed to cover the full cost of providing patient services. A major effect of managed care has been to reduce the actual level of reimbursement. Consequently, many nonprofit health care providers have argued that they have been left "with little choice but to merge with other not-for-profits or sell their assets to bigger for-profit [entities]." These mergers and sales have resulted in some religiously affiliated providers becoming involved with institutions that deliver "health care services that contravene their ethical, moral, or religious principles." While current law does not require religious hospitals to provide any type of care contradicting their own religion-based policies and protocols, some commentators contend that the extensive federal and state regulation of health care delivery coupled with increased government financing will compel religiously affiliated providers to provide care that is inconsistent with their sectarian principles.

F. TAX STATUS

A primary reason for the corporate structural form of most religiously affiliated health care providers has been the objective of achieving tax-exempt status. Historically, religiously sponsored medical facilities were exempted from federal tax by virtue of their identification with the sponsoring religious group. For example, a March 25, 1946, IRS ruling established federal tax exemption for agencies and instrumentalities including all educational, charitable, and religious institutions operated, supervised, or controlled by or in connection with the Roman Catholic Church in the United States.

Today, however, many religiously affiliated health care organizations are separately incorporated and operated as tax-exempt charities under section 501(c)(3) of the Internal Revenue Code, that requires tax-exempt entities be organized and operated for charitable purposes. In the past, to be considered a charity a health care organi-

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35. Boozang, 31 Hous. L. Rev. at 430.
36. Id.
zation had to provide free care to the indigent. Over time, though, the IRS came to accept the view that providing health care to the public constitutes tax-exempt charitable activity regardless of whether any of it is free. This revised requirement has since been formulated as a community-benefit standard, according to which a health care provider qualifies for the section 501(c)(3) tax exemption if it provides a community benefit and meets the other requirements established by the Internal Revenue Code. A rule against private inurement requires that there be no distribution of profits to private persons.

This discussion is focused on religiously affiliated hospitals. The tax treatment of other health care entities, such as nursing homes and family practice plans that are governed by other rulings and regulations, is beyond the scope of this chapter. The IRS applies one of two tests to determine whether a hospital qualifies as charitable: (1) whether the institution is, to the extent possible, providing free care to those unable to pay; or (2) whether the hospital serves a community purpose by, for example, making emergency-room care available to all members of the community or providing care to anyone able to pay.\[38\]

G. CHARITABLE TRUST STATUS

Prior to the separate incorporation of religiously affiliated health care organizations, hospitals most often were created as trusts for charitable purposes. This form can impose significant legal restraints on changes in organizational form or use of trust assets. For example, in California the state attorney general must approve of the disposition or use of funds from hospital sales or mergers where a trust is involved. However, with the increasing separate incorporations of health care entities, trust issues in relation to hospital governance have largely have been eliminated. Directors of not-for-profit corporations (whether or not called trustees) are not held to the same degree of fiduciary duty as a traditional trustee.

The aspect of charitable trust law that most often comes to bear on the operation of health care providers is the manner in which the organization holds property. Trust property is acquired under terms that provide for safeguarding the principal and using the income for a stated purpose set forth in the trust itself, with the requirement of return or transfer upon certain stated events.

*Queen of Angels Hospital v. Younger*,\[39\] an action brought by the attorney general of California in 1977, against a Los Angeles hospital illustrates a strict approach to charitable trust status.\[40\] The hospital

\[39\] 136 Cal. Rptr. 36 (2d. Dist. 1977).
\[40\] Queen of Angels Hosp. v. Younger, 136 Cal. Rptr. 36 (2d. Dist. 1977)
was incorporated in 1927 under the sponsorship of a Catholic religious order of nuns. In 1971, the hospital's board of directors approved a lease to a proprietary entity and intended to use the lease proceeds to establish and operate clinics in Los Angeles that would provide aid, advice, and free medical care to the poor and indigent. The board also intended to pay an agreed-upon sum to the religious order for the value of past services. However, the court held that the hospital's articles of incorporation and its representations to the public precluded it from abandoning its operation of a hospital in favor of operating clinics. The court reasoned that the issue was whether a specific purpose is authorized by the articles of incorporation, and not whether a new or different purpose is equal to or better than the original purpose. Perhaps most significantly, the court ruled that the board's payment to the religious order was a diversion of charitable assets.

A case more typical of the approach of courts to the issue of the application of charitable trust doctrine to hospitals is provided in *City of Paterson v. Paterson General Hospital*, a New Jersey case that held that a hospital originally incorporated to operate within the city limits was not a charitable trust in the strict sense. Instead, the court denominated the hospital to be a charitable corporation governed by the corporation law and held that since its relocation to another municipality had been authorized by the corporate charter and deemed by the board relocation to be in the hospital's best interest, the change was lawful.

H. RELIGIOUSLY AFFILIATED HOSPITALS' RESPONSE TO THE CHANGING HEALTH CARE MARKET

With the current movement of the health care industry in America toward managed care and increased integration, it is clear that the types of services provided by religiously affiliated hospitals will be affected. Each provider is compelled to deal with the necessary changes in delivering and financing its services, as well as with the ethical, moral, and religious principles that underlie a provider's own purposes. While the 1980s were marked by a high number of mergers between sectarian health care providers, the 1990s witnessed an increasing incidence of mergers between religiously affiliated providers and nonreligious organizations. These mergers are often prompted by the need for health care institutions to establish greater financial

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security and acquire greater technological capacity so that they can deliver appropriate medical services.\textsuperscript{44} Although mergers between any health care institutions inevitably require compromises on the manner in which these institutions will deliver services; mergers between religious and secular entities are often more challenging since some services that the secular provider intends to offer may be strictly prohibited by the religious beliefs represented by the other entity.

An important aspect of health care delivery in the United States that has become firmly established in the last two decades is the recognition of patient autonomy in decision making. This has particular significance in the determination of religion's role in the operation of managed care. After two decades in which families of patients or patients have obtained the right to force withdrawal of treatment over the opposition of the state or provider,\textsuperscript{45} several state courts have imposed relatively stringent requirements on protocols regarding treatment discontinuation.\textsuperscript{46} On the other hand, some physicians are challenging requests of families to continue treatment deemed by the physicians to be futile or inappropriate.\textsuperscript{47} These developments create special problems for religiously affiliated institutions, particularly for sectarian facilities that have joined or been integrated with secular providers.

I. COMBINATIONS AND TRANSFORMATIONS

Sponsoring institutions and religious bodies have expressed varied responses about the results of the combination of two or more nonprofit entities.\textsuperscript{48} Some religious leaders, while encouraging cooperation and affiliation among the health care providers sponsored by their faith, have discouraged or prohibited them from becoming asso-

\textsuperscript{44} Id.

\textsuperscript{45} Boozang, 31 Hous. L. Rev. at 1437. See, e.g., Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 638-40 (Mass. 1986) (granting the patient's wife the authority to order the discontinuation of her husband's nutrition and hydration over the objections of both the hospital and physicians). See also \textit{In re Quinlan}, 355 A.2d 647, 671-72 (N.J. 1976) (giving the adult patient's father the authority to consent to the withdrawal of a respirator over the objections of the hospital, physicians, local county prosecutor, and the state attorney general), \textit{cert. denied}, 429 U.S. 922 (1976)).

\textsuperscript{46} Boozang, 31 Hous. L. Rev. at 1437. See, e.g., Cruzan v. Director, Mo. Dept't of Health, 497 U.S. 261, 279-281 (1990) (recognizing a liberty interest in refusing treatment, but allowing the state to establish procedural safeguards on decisions to discontinue treatment).


\textsuperscript{48} Boozang, 31 Hous. L. Rev. at 1435.
associated with, sold to, or affiliated with those sponsored by other religious sects or for-profit organizations.49

Others have encouraged their affiliated health care institutions to become part of new groupings, so long as that does not violate their religiously based policies and protocols. In other cases, those who control or oversee the operation of health care providers appear ready to tolerate practices originally banned in the former nonprofit institution. Nevertheless, it seems that some practices may simply be beyond the possibility of acceptance. Thus it appears no matter what form of integration the managers of certain entities choose to pursue, in some cases, particularly those involving Roman Catholic-affiliated providers, the accepted policies “can result in the complete elimination of certain services, such as sterilization, in the community.”50

1. THE PROCESS OF COMBINING FORCES

Health care delivery systems are consistently changing in structure and altering the relationships among providers. Similar change is occurring in the nature and availability of the services they provide,

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49. CARDINAL JOSEPH BERNADIN, MAKING THE CASE FOR NOT-FOR-PROFIT HEALTH CARE 16 (Catholic Health Association of the United States 1995).

Healthcare is fundamentally different from most other goods and services. It is about the most human and intimate needs of people, their families, and communities. It is because of this critical difference that each of us should work to preserve the predominately not-for-profit character of our healthcare delivery in Chicago and throughout the country.


50. Boozang, 31 Hous. L. Rev. at 1435. Boozang discussed the Catholic health providers’ awareness of some communities’ concerns about Catholic health providers declining to provide certain female healthcare services. In order to determine both the risks and benefits of joint ventures involving a Catholic healthcare entity, the Catholic Health Association performed a study. The results of which follows:

One of the difficulties Catholic providers face in attempting to be accountable to the community on its own terms is in the area of reproductive health. That is, what some perceive as a community need, or at least what the community expects in family planning services, Catholics are not authorized by the Church to provide. From the perspective of a community where the Catholic facility is the only provider, the facility is often seen as limiting access to needed services. Accountability to the community comes into direct conflict with accountability to the Church if the venture provides reproductive services.

When the joint venture has resulted in a new entity under Catholic sponsorship, with the condition that no contraceptive or sterilization services are offered, physicians are constrained from offering these services within the joint venture’s framework. In some communities it may be virtually impossible to refer their patients elsewhere. These physicians and the women whom they treat in such communities see the Catholic prohibition as an unjust limitation of access.

Id. at 1435 n.24 (citing CATHOLIC HEALTH ASSOCIATION, PHYSICIAN-HOSPITAL JOINT VENTURES: ETHICAL ISSUES 11-12 (1991)).
and the effects are starting to be felt.\textsuperscript{51} For example, the availability of care for the uninsured and indigent is decreasing each year. There were 3,349 nonprofit hospitals in 1985, 3,191 in 1990, and 3,092 in 1995.\textsuperscript{52} On the other hand, for-profit hospitals have steadily increased in number after an initial drop in the early 1980s.\textsuperscript{53}

When a not-for-profit entity is transformed into a for-profit entity, it is often the result of a conversion: a transaction constituting the sale or restructuring of all or substantially all assets of a nonprofit organization into a for-profit company. These conversions generally occur by one of two methods: a joint venture or a sale of assets.

A joint venture occurs when the not-for-profit health care provider, for example a hospital, sells a share of its assets to the for-profit company for a portion of the total value of the assets of the seller. After the sale, the not-for-profit entity retains a certain level of control over the hospital that forms a part of the buying enterprise, while the for-profit investors realize a predetermined amount of the profits earned by the integrated entity. The control the not-for-profit seller retains generally takes the form of a seat on the board of directors of the for-profit entity. Although the board seat appears to provide a secure right to exercise authority over the activities of the institution, this control can be illusory since its effective voting power may in fact be limited.

The other manner in which a not-for-profit entity may convert into a for-profit company is through the sale of all of its assets — often in the form of an outright sale with the proceeds directed to a foundation to continue the charitable purpose of the nonprofit entity, most often through activities related to health care. Due to nonprofit entities' tax-exempt status under the Internal Revenue Code, and because of issues raised in certain cases because of a state's trust law, states attorneys general and other designated regulating bodies have become involved in closely monitoring such sales. The tax status of nonprofit organizations and the tax implications of conversion transactions are discussed later in this article.

2. **The Results of Combining Forces**

The formation of alliances by hospitals and hospital systems with each other and with other organizations results in new structures and

\textsuperscript{51} See generally Marla Rothouse & Elizabeth Kaiser, *Change in Nonprofit Entities* (Health Policy Tracking Service 1999) (editorial note: unable to verify source).

\textsuperscript{52} See generally Rothouse & Kaiser, *supra* note 51.

\textsuperscript{53} See generally *id.* “In 1985, there were 805 for-profit hospitals. By 1990 that number had dropped to 749. In 1994, there were 719 for-profit hospitals in existence, and by December 1995 that number had increased to 752.” *Id.* (citing *Hospital Statistics, 1996/1997* Edition Chicago: American Hospital Association, 1997).
combinations that have certain advantages and disadvantages. Advocates of these conversions claim advantages including efficiency, "cost reduction, enhancement of choice and access to health care, and the resuscitation of distressed entities."54 Opponents argue the "misplaced focus on profits [results in] harm to patients from inappropriate cost cutting, and the increasing danger of harmful anticompetitive conditions."55

Proponents of such transactions often argue that the new alliances between nonprofit hospitals and for-profit companies will instill greater efficiency and create stronger bargaining power.56 One commentator has argued: "[b]y merging and becoming larger, medical corporations can reduce costs through economies of scale [] brought by their larger size. They can also better meet operating costs, accumulate capital with which to purchase equipment, attract patients ("lives"), and negotiate more effectively with third party payers."57

Large hospitals often do experience greater power in negotiating with managed care organizations,58 not simply because they are larger, but because they can deliver services in more locations. This allows the health care provider to decrease costs while maintaining or even increasing access to care. Proponents of these transactions also maintain that combining different types of medical institutions will enable the resulting system to provide a wider range of services.59 Proponents also argue that these new health systems will be able to thrive in the managed-care market because their consolidation reduces administrative costs and increases efficiency by pooling resources.

Opponents of these transactions believe that in these large medical centers or integrated systems, the primary institutional concern becomes maintaining financial viability and profit rather than meeting the medical needs of patients. Critics maintain that hospitals, which for decades have been the cornerstones of the not-for-profit industry, now are converted into for-profit entities and become primarily concerned with pleasing shareholders.60 These critics argue,

56. Id. at 713.
57. Id. at 713 & n.231.
59. Id. at 714. Sander noted that in one healthcare network "an expectant mother ready to enter the hospital, a senior adult [visiting] a rehabilitation center following surgery, or an employer [helping] a chemically dependent employee — can be assured that quality care will be delivered throughout the Columbia network of employees and volunteers." Id. (quoting Columbia/HCA's 1995 Annual Report).
therefore, that proper concern needs to be directed at such problems as: 

"[(1)] cream skimming" of more profitable patients while dumping uninsured patients on nonprofit hospitals; [(2)] access to free care by the uninsured and the indigent; [(3)] accountability to local health needs by companies with out-of-state headquarters; [(4)] the effects on the community when for-profit companies decide to close hospitals; and [(5)] the effect that for-profits will have on the state's nonprofit hospitals and insurers."  

Another concern is that traditional cost-cutting measures of managed care entities will result in misdiagnoses and the denial of access to medically necessary care. By seeking to save money instead of lives, opponents argue, physicians and other health care providers are forced into making medical decisions without the necessary diagnostic information, which will result in lower quality patient care, more severe illnesses, and even patient deaths.

One opponent to the integration of not-for-profit religiously affiliated health care providers with managed care systems and for-profit enterprises has suggested that the basic issue, resulting from the larger anticompetitive situation, is one of saving money at the cost of saving lives: "When firms merge, they are more likely 'to engage in coordinated interaction that harms consumers.' . . . Firms can work together in order to further their own interest in profitability." As a consequence, these institutional transactions increasingly provoke government antitrust scrutiny.

3. ANTITRUST CONCERNS

While a thorough consideration of the implications of these mergers in an antitrust analysis is beyond the scope of this discussion, it is important to understand the government's interests and intent in prohibiting anticompetitive conduct in the health care market. It is under "a very narrow body of federal antitrust law[s]" that the government may challenge the anticompetitive aspects of existing and proposed mergers. The Sherman Act, the Clayton Act and its amendments, the Federal Trade Commission Act, and the Hart-
Scott-Rodino Antitrust Improvements Act,\(^6\) provide the government with the authority to preserve the "competitive vitality" of the hospital-care industry.\(^7\) To prevent an anticompetitive outcome, the government can disallow a proposed merger or force the entities involved to restructure the merger to maintain a level of competition in the relevant market.

When health care institutions seek to merge, they often attempt to establish that the merger will benefit consumers by lowering prices for health services.\(^7\) Critics, however, maintain that any such benefit is realized only by those patients who obtain health care services from managed-care organizations or from coalitions that have enhanced their bargaining positions.\(^7\)

J. TAX CONCERNS

Not-for-profit institutions are granted tax-exempt status under section 501(c)(3) of the Internal Revenue Code by maintaining their charitable purposes.\(^7\) A primary requirement is the prohibition on private inurement. In no case can earnings of the tax-exempt entity be paid out to private persons as dividend, profit sharing, or in any other disguised form of profit. Moreover, section 501(c)(3) classification subjects not-for-profit entities to aspects of the charitable trust laws.\(^7\) These laws, in effect in many states, require that before a nonprofit sells its assets, it must file an application with the appropriate court to change its fundamental purpose in order to become a for-profit entity.\(^7\) Should a nonprofit entity proceed with a conversion without adhering to the established procedural requirements, the state court may prohibit the transaction altogether through an injunction while holding the board of directors liable for breach of their fiduciary duty.\(^7\) Although an individual does not have standing to challenge the sale of the nonprofit's assets, states' attorneys general, as representatives of the public's interests, are automatically made a party to any suit relating to conversions.\(^7\)

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70. Belsley, 90 Nw. U. L. Rev. at 744.
72. Stelwagon, 69 St. John's L. Rev. at 575.
74. Id.
75. Id.
76. See generally Rothouse & Kaiser, supra note 51.
77. See generally id. (citing Robert A. Boisture & Douglas N. Varley, State Attorneys General's Legal Authority To Police The Sale Of Nonprofit Hospitals and HMOs, 13 Exempt Org. Tax Rev. 227 (1996)).
The Internal Revenue Code, and other federal laws, require that all proceeds from the sale of a nonprofit hospital must be used for a charitable purpose. Many states follow the doctrine of *cy pres*, a common-law theory requiring that the proceeds of the sale of a nonprofit entity be used for a purpose as close as possible to the original charitable purpose of the organization. This doctrine allows states to protect funds donated to charitable institutions from being diverted from their charitable purpose, and assures donors that these funds will continue to serve the purpose they originally intended.

If the nonprofit hospital seeks to maintain its charitable status after transferring all of its assets in a merger with a for-profit company, the contractual arrangement of the two parties must grant the not-for-profit entity the ability to pursue its exempt purpose and act only incidentally for the benefit of for-profit partners. For the newly integrated entity, formed by the integration of the not-for-profit and for-profit entities, to remain a section 501(c)(3) organization, the nonprofit entity involved must maintain voting control over the integrated entity and its board must maintain specifically enumerated powers over program changes, disposition of assets, and any management agreement.

On the other hand, if the board of the not-for-profit component of the new entity simply shares power with the board of the for-profit enterprise, the charitable purpose may be thwarted and the tax-exempt status lost. For example, if the nonprofit and for-profit components making up the new entity simply share voting control, the nonprofit component may lack the voting power to initiate community-oriented programs without the agreement of at least one governing board member appointed by the for-profit entity. Further, without the nonprofit component maintaining voting control, a simple majority of the new entity's board may vote, without the possibility of

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78. *Volunteer Trustees*, supra note 2, at 5.
79. BNA, 6 Health Care Pol'y Rep. at 667; *Volunteer Trustees*, supra note 2, at 10.
81. Id.
82. *See generally* Rothouse & Kaiser, supra note 51. Within two legislative sessions, the number of states introducing such legislation more than doubled from fifteen states in 1996 to thirty-five states and the District of Columbia in 1997. In 1997, of the thirty-five states that introduced such legislation, "[fifty] measures moved from their chamber of introduction and [thirty-five] measures were enacted." *Id.* The 1998 legislative session may have had fewer states initiating legislation on the conversion issue, but more than thirty-two states were involved in what amounted to the introduction of eighty-five bills. The states introducing legislation were: Alabama, Arizona, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Maryland, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, and Wisconsin. *See generally id.*
effective opposition, to pursue activities resulting in a benefit to private interests. Such an arrangement cannot claim to be effectively devoted to the exclusive pursuit of exempt purposes and, therefore, cannot claim tax-exempt status.

K. STATE AND FEDERAL LEGISLATIVE OVERVIEW

The large number of not-for-profit health care providers seeking court approval to either join or become for-profit entities has resulted in a similarly large number of state court proceedings. In an effort to facilitate an orderly basis for transformation or integration, many states have enacted legislation establishing procedures for converting not-for-profit entities.83

In December 1997, the United States General Accounting Office ("GAO") reported on the effect of fourteen nonprofit hospital conversions in six states including Alabama, California, Louisiana, South Carolina, Tennessee, and Virginia.84 In discussing the similarities among the conversions, the report noted that the net proceeds of twelve of the transactions went directly to charitable foundations, and that community response to proposed use of the proceeds was obtained through public hearings in six of the fourteen conversions.85 The GAO report also included information about measures taken to grant attorneys general the authority to oversee the transactions in a majority of the conversions and the roles of the IRS, the Federal Trade Commission and the Department of Justice.86

In 1998, the IRS issued a ruling relating to transactions involving not-for-profit hospitals and for-profit entities.87 The ruling focused on two examples of such transactions and established the basis on which a transaction may be designed to allow a nonprofit hospital to maintain its section 501(c)(3) tax-exempt status.88 According to the IRS

83. See generally Rothouse & Kaiser, supra note 51.
88. See generally Rothouse & Kaiser, supra note 51. Within two legislative sessions, the number of states introducing such legislation more than doubled from fifteen states in 1996 to thirty-five states and the District of Columbia in 1997. In 1997, of the thirty-five states that introduced such legislation, "[fifty] measures moved from their chamber of introduction and [thirty-seven measures were enacted]." Id. The 1998 legislative session may have had fewer states initiating legislation on the conversion issue, but more than thirty-two states were involved in what amounted to the introduction of
guidelines, when a nonprofit hospital enters into a venture with a for-profit entity it must maintain control over the new venture, which in turn must give priority to the health needs of the community, rather than to maximizing profits. A process prioritizing community needs can be established in the governing documents of the venture. The underlying assumption is that if the governing documents do not specifically oblige the health care provider to serve “charitable purposes or otherwise provide its services to the community as a whole,” the provider then would be able to turn away patients and stop providing health care services to the community.89

Legislation adopted by state and federal governments has focused on certain key issues, namely: (1) ensuring that patients, particularly those with limited resources or without insurance, still have access to nonprofit hospitals after their integration with for-profit entities; (2) disclosing the terms of sale of nonprofit hospitals to for-profit entities in order to determine any potential conflicts of interest and ensure that the communities’ needs for patient care will continue to be met; (3) determining how to establish the value of the nonprofit hospital before it is converted into a for-profit hospital; and (4) avoiding any conflicts of interest with the nonprofit hospital’s board of directors and those in control of the acquiring entity both during and after the conversion.90

Since a nonprofit hospital’s primary purpose is to serve its community, the issue of maintaining access to health care is an important concern confronting any nonprofit hospital that contemplates conversion into a for-profit entity or integration with a for-profit institution or system. Nonprofit hospitals are often the only places where people who otherwise could not afford medical attention can go to obtain needed health care. To ensure that communities do not lose such important facilities, nonprofit hospitals considering integration with for-profit entities increasingly are being required to assure communities of their intent to use the proceeds from any sale for the community’s benefit, or to guarantee that health care services will continue to be available to needy patients. Thus, in any conversion process, a religiously affiliated nonprofit health care provider will be required to en-
sure that the converted entity will maintain access to charity care for that population of needy patients that it has served in the past.

While transactions involving two for-profit entities are subject to securities regulation and other reporting requirements, not all the details of nonprofit conversions are made available to the public. By the time the community is made aware of a conversion, it is often too late for it to protect itself from any potential conflicts of interest or limitations on access to medical care. Increasingly there is concern that individuals responsible for monitoring religiously affiliated nonprofit institutions may fail to exercise proper oversight, or that they may even become involved in conflicts of interest when offered the prospect of purchase by or integration with a powerful and financially successful for-profit entity. Although the I.R.S. is vigilant on the issue of private inurement, the lack of public reporting makes it almost impossible for the community to monitor whether officers or directors of nonprofit hospitals have been compensated for recommending a sale, and it is difficult to ensure that charitable assets are not being wasted or undervalued.91 While the reasons for secrecy are unclear, many for-profit entities involved in these conversion transactions admit that full disclosure of the terms of the sale would likely impede competitiveness.92

Since the terms of nonprofit hospital conversions are often kept secret, determining the accurate fair-market value of the nonprofit hospital’s charitable assets can be a difficult task. Upon conversion of a nonprofit hospital, the full and fair value of the hospital should be obtained from the purchasing entity with the proceeds being used in a charitable enterprise with a similar purpose.93 Value can be determined by examining either the current or the projected value of the hospital. Current valuation of a hospital, however, often results in undervaluation because many of the hospital’s greatest assets (i.e., education, teaching, research, intensive-care units, and neonatal units) do not necessarily produce a profit, but these are much-needed activities in the community.94 Likewise, basing valuation on a hospital’s potential to earn money can also underestimate its actual value to the community, which is often much higher than its estimated monetary worth. While directors of nonprofit healthcare providers are held to strict accountability on the basis of their fiduciary duty, matters involving transactions that can be viewed as corporate decisions are subject to the less demanding business judgment rule.

91. See generally id.
92. See generally id.
93. See generally id.
94. See generally id.
The nonprofit hospital’s value to the community is also difficult to determine because the evaluation primarily will consider the hospital as a for-profit entity, and give little consideration to the specialty units and other community-focused programs that usually do not earn a profit. Because projected valuations can vary widely, independent experts should be required to provide “valuation reports” which the nonprofit’s board of directors should review thoroughly.

The board of directors of a religiously affiliated not-for-profit hospital must also avoid any conflicts of interest involving a conversion to or integration with a for-profit entity. A potential conflict arises when such directors are offered financial payments or future employment contracts by the for-profit entity as incentives for recommending that the transaction take place. Both federal and state laws prohibit any person from profiting from the operation or sale of a nonprofit hospital. These laws are necessarily broad enough in scope to allow both federal and state governments the authority to enforce the directors’ fiduciary duty to both nonprofit and for-profit hospitals. This duty is predicated on the notion that the directors of an organization caring for the community must act in the best interest of that organization.

In reviewing challenges to director’s acquiescence in these transactions, courts generally adhere to the “business judgment rule,” which grants the directors of both nonprofit and for-profit health care facilities the authority to make decisions on behalf of the facility, assuming they inform themselves of the implications of such decisions and believe in good faith that they are in the facility’s best interests.

The business judgment rule does not, however, grant directors unbridled power to act on behalf of the health care entity. Rather, this rule requires that they act as any “ordinarily prudent person” would in a comparable situation. Thus, when considering a transaction like a sale, conversion, or integration, directors must follow certain procedures including:

- determining that the officers or advisers on whom they rely for information about the transaction do not have any conflict of interest that might color their judgment,
- determining the value of the assets to be sold, and
- duly considering ramifications of the transaction including any *cy pres* implications.

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95. See generally id.
96. See generally id.
97. See generally id. Should a *cy pres* proceeding be required, the “directors of a nonprofit hospital would also have to establish that (a) it has become impossible, or at least impracticable, to accomplish the stated purpose of the hospital, and (b) the proposed alternative use of the charitable assets comes as close as present circumstances
1. PROPOSED LEGISLATION AND GUIDELINES

With an increasing trend toward hospital conversions in recent years, many grassroots, public interest, and governmental organizations have drafted model legislation and guidelines to provide a basis for public and governmental scrutiny. The Volunteer Trustees, Families USA, the American Hospital Association ("AHA"), and the American Medical Association have all published model legislation or guidelines addressing the issue of hospital conversions. Also, the National Association of Attorneys General has promulgated a draft of model legislation on the subject of health care conversions and integration.

The Volunteer Trustees established guidelines for use by state regulators monitoring nonprofit hospital sales to or joint ventures with for-profit enterprises. These guidelines involving application of charitable trust law doctrines focus on three objectives toward which state regulators should aim, including: safeguarding the value of charitable assets, safeguarding the community from loss of essential health care services, and ensuring that the proceeds of the sale are used for appropriate charitable purposes.

In 1997, the AHA, a professional organization, published guidelines relating to actions that hospitals should take when considering or undergoing a conversion. Although these guidelines are not mandatory for members, the AHA strongly recommends that all hospitals follow them when altering any aspect of their nonprofit status. Specifically, the guidelines address the following recommended actions:

(1) responsibility for care of the underserved in the community, and maintenance of essential community services;
(2) identification of options available to the organization and awareness of any legal or operational limitations;
(3) protection of charitable assets;
(4) identification of conflicts of interest;
(5) prevention of any private inurement or personal financial gain by employees or trustees of any not-for-profit entity involved in the transaction; and

permit to fulfilling the original intent of the donor." VOLUNTEER TRUSTEES, supra note 2, at 5-7, 11-13.

98. See generally Rothouse & Kaiser, supra note 51.
99. BNA, 6 HEALTH CARE POL´Y REP. at 667.
100. See generally Rothouse & Kaiser, supra note 51.
102. See generally Rothouse & Kaiser, supra note 51.
(6) education of constituencies, including medical staff, employees and the community, about the proposed changes.\textsuperscript{103}

The National Association of Attorneys Generals' ("NAAG") proposed model legislation focuses on making conversion transactions subject to public view, thus providing an opportunity for comment and criticism.\textsuperscript{104} This proposed legislation focuses on the following:

1. stringent requirements regarding notification to the state's attorney general about proposed conversions,
2. need for the court or attorney general to approve the conversion,
3. requirement that financial and other aspects of the conversion meet the standards set by state public records laws,
4. inclusion of public hearings, outside experts, community assessments, penalties and remedies, and
5. provision of adequate access to care.\textsuperscript{105}

L. THE SPECIAL CASE OF INTEGRATION INVOLVING A ROMAN CATHOLIC-SPONSORED HOSPITAL

Many of the entities in the United States which are referred to as "Catholic hospitals" are organized in the following manner: A religious congregation formed under the auspices of and recognized by the Roman Catholic church sets up a tax-exempt corporation. Often the exemption is obtained by registration in the Official Catholic Directory (this procedure is recognized by the IRS for the establishment of exemption for Catholic hospitals and some other specific Catholic health care corporations). This tax-exempt corporation may either hold title to real estate, the Medicare/Medicaid provider numbers, and the State Board of Health Licenses of Hospitals, or it may be a member of several separate tax-exempt organizations, holding the title to the real estate license and provider numbers of each individual hospital. In either case, it is evident that the control of the property relates back directly to the religious order ("Religious Institute") that is under the direction of the Roman Catholic church.

Under canon law, when a "juridic person" (this would include the religious orders that control hospital property) seeks to make an alien-
Alienation of property of value more than $3,000,000.00, approval of the Holy See is required. Alienation is defined as: "either the conveyance to another party or the encumbrance or placing in jeopardy of any interest in the stable patrimony (immovable goods or fixed capital) . . . ." While the definition is not familiar in civil law, it clearly covers the transfer of assets of a hospital held by Catholic organizations for religious and charitable purposes.

It is important to understand that canonists have stated that for a public juridic person to receive property from a church-affiliated entity without alienation occurring, the transferring entity should maintain certain reserved powers. The major reserve powers recognized by canonists are usually considered to include the power:

- to establish or change the philosophy and mission of the work;
- to change the corporate documents and bylaws;
- to adopt "and remove" the board of directors, and the CEO;
- to lease, sell or encumber corporate real estate;
- to contract debts;
- to establish subsidiary corporations;

and possibly

- to approve capital or operating budgets, or both;
- to appoint the auditor;
- to be involved in mergers, closures, etc., affecting the property or the work; and
- to engage in activities that would entail risk of losing "Catholic identity."

So long as these reserve powers are retained by the newly constituted entity, no alienation is considered to have taken place. The mission of the newly constituted health care provider is understood to remain under the direction or control of the sponsoring religious institute or order. This would not be the case with a simple merger between a Catholic facility and a non-Catholic one. The Catholic cosponsoring organization would maintain a proportionate dollar value of its interest in the resulting entity (i.e., if it contributes fifty percent to the merger it would have fifty percent of control and the right to show such value on its accounting and bond documents). It would no longer, in this canon law view, be the sole possessor of the


reserved powers. Therefore, there would be an alienation of the property.

In order to understand the dynamics that come into play in obtaining church approval of the merger of a Catholic sponsored hospital with a non-Catholic hospital, it is important to understand the procedure that needs to be followed. When a Catholic sponsor makes a request for permission to alienate property to the Holy See, it must submit the following documents:

1. explanation of the just cause (Canon 1293, Section 1);
2. written evaluation (Canon 1293, Section 1);
3. notation as to how other precautions of particular law have been observed (Canon 1293, Section 2);
4. consent of intermediate bodies and counsel, often in the form of minutes of the meeting;
5. statement regarding divisible goods (Canon 1292, Section 3);
6. offer to purchase, if possible (Canon 1293, Section 1);
7. statement of what is to be done with the proceeds (Canon 1294, Section 2);
8. sometimes, a statement regarding observance of the formalities of secular law (Canon 1296); and
9. if the request is from a religious institute, a letter from the diocese bishop stating that he has no opposition to the proposed transfer.

When the property to be alienated, i.e., the assets of the hospital or the hospitals, is located in more than one diocese, a statement of "no opposition" is required from each diocese involved. At that time the bishop or bishops can request an opinion from a canon lawyer that the alienation would be appropriate under canon law.

1. **Specifics to Consider When Seeking Approval of Alienation of Property in Order to Merge a Catholic Sponsored Hospital Facility With a Non-Catholic Sponsored Facility**

While the sponsor of a Catholic facility must be concerned about preservation of its mission and may face some difficulties in working with a non-Catholic facility, there are often strong economic circumstances leading to consideration of these mergers. In fact, in some circumstances the economic survival of the Catholic facility may be at stake. Often both institutions are tax-exempt corporations with a similar mission to provide health care to all persons, including Medicare/Medicaid recipients as well as the indigent. However, while the Catholic facility may be strongly committed to strict observance of the Ethical and Religious Directives ("EDRs") promulgated by the Na-
tional Counsel of Bishops, the secular institution may be equally committed to providing some services not be permitted by the EDRs. This discussion will use the provision of sterilization procedures as an example of such a service. For many health care providers, sterilization by tubal ligation or vasectomy is simply an accepted form of care for individuals who desire to avoid pregnancy. The Roman Catholic church in the United States has been aware of this issue for more than twenty years, as shown in two pronouncements.

First, the National Conference of Catholic Bishops, “Sterilization in Catholic Hospitals,” March 13, 1975, provides that with regard to the administration of Catholic hospitals:

(1) The following is absolutely forbidden: cooperation, officially approved or admitted, in actions which of themselves (that is of their own nature and condition) have a contraceptive purpose, the impeding of the natural effects of the deliberate sexual acts of the person sterilized. For the official approval of direct sterilization and, all the more so, its administration and execution according to hospital regulations are something of its nature — that is, intrinsically — objectively evil. Nothing can justify a Catholic hospital cooperating in it. Any such cooperation would accord ill with the mission confided to such an institution and would be contrary to the essential proclamation and defense of the moral order.

(2) The traditional teaching on material cooperation, with its appropriate distinctions between necessary and freely given cooperation, proximate and remote cooperation, remains valid, to be applied very prudently when the case demands it.

(3) When applying the principle of material cooperation, as the case warrants it, scandal and the danger of creating misunderstanding must be carefully avoided with the help of suitable explanation of what is going on. This sacred congregation hopes that the criteria outlined in this document will meet the expectations of this episcopate, so that having removed the doubts of the faithful, they may more easily perform their pastoral duty.108

Second, the National Conference of Catholic Bishops, “Commentary on: Reply of the Sacred Congregation for the Doctrine of Faith on Sterilization in Catholic Hospitals,” September 15, 1977, provides:

(1) As it was stated in the Roman document, the Catholic hospital can in no way approve the performance of any sterilization procedure that is directly contraceptive. Such contraceptive procedures include sterilizations performed as a means of preventing future pregnancy that one fears might

agravate a serious cardiac, renal, circulatory, or other disorder.

(2) The Catholic health facility has the moral responsibility (and this is legally recognized) to decide what medical procedures it will provide services for. Ordinarily, then, there will be no need or reason to provide services for objectively immoral procedures. Material cooperation will be justified only in situations where the hospital because of some kind of duress or pressure cannot reasonably exercise the autonomy it has (i.e., when it will do more harm than good).

(3) In judging the morality of cooperation, a clear distinction should be made between the reason for the sterilization and the reason for the cooperation. If the hospital cooperates because of the reason for the sterilization, e.g., because it is done for medical reasons, the cooperation can hardly be considered material. In other words, the hospital can hardly maintain under these circumstances that it does not approve sterilization done for medical reasons, and this would make cooperation formal. If the cooperation is to remain material, the reason for the cooperation must be something over and above the reason for the sterilization itself. Since, as mentioned above (#2), the hospital has authority over its own decisions, this should not happen with any frequency.

(4) As was stated in the Roman document, the Catholic health facility must take every precaution to avoid creating misunderstanding or causing scandal to its staff, patients, or general public by offering a proper explanation when necessary. It should be made clear that the hospital disapproves of direct sterilization and that material cooperation in no way implies approval.

Direct sterilization is a grave evil. The allowance of material cooperation in extraordinary cases is based on the danger of an even more serious evil, e.g., the closing of the hospital could be under certain circumstances a more serious evil.¹⁰⁹

Each of these commentaries contains a general statement exemplifying the standards that are used in analyzing whether the proposed integration of a Catholic and non-Catholic facility creates a permissible or impermissible cooperation with a forbidden practice. In recent years, canonists have examined potential mergers between Catholic-sponsored hospitals and non-Catholic-sponsored hospitals which have engaged in activities prohibited by the ERDs. Canonists have used the standards set forth by the National Conference of Catholic Bishops to examine the nature of the cooperation between Catho-

lic and non-Catholic facilities to determine whether the Catholic facility's intention creates a "formal" or "implicit formal" cooperation, both of which would be prohibited. Formal cooperation exists when the Catholic institution intends the wrongdoing (that is, it agrees with the activity). Implicit formal cooperation exists when it denies agreement with the intention yet offers no other opposition to the prohibited activity.110 If the canonist concludes that the latter is not the case, then he or she must seek to determine whether the Catholic facility is engaging in "immediate material" cooperation — that is, pursuing the same action as the wrongdoer even if for a different reason, as is permitted only if the facility is acting under duress.111 If the action is not one of "immediate material" cooperation, then the canonist may seek to determine whether it is "mediate material" cooperation — that is, the facility is doing something clearly distinguishable from the wrongdoing, such as serving food to patients in a health care facility without awareness that forbidden procedures are being performed there. The canonist will also seek to determine whether the cooperation is proximate to the activity or merely remote, and whether it is contingent or necessary to another purpose, as in a Catholic facility engaging in a merger as the only means of continuing its existence in an area that would otherwise be deprived of a Catholic institution. In applying all of these standards, the canonist must next determine the level of scandal, or awareness of the forbidden practice, that would be created by the facility's cooperation leading others to believe the practice is permissible, and possibly becoming involved in such conduct themselves.

While not all canon lawyers will reach the same conclusions in their analysis of a specific proposed merger of a Catholic hospital with a non-Catholic hospital, many canonists view such a merger as occurring as a result of duress or necessity when the intention of the Catholic institution is to preserve a Catholic community presence that would not otherwise be possible, so long as the Catholic provider does not formally cooperate in actions that are impermissible under the Ethical and Religious Directives. In such an arrangement, the Catholic hospital sees to it that such activities are "carved out of the transaction."

In examining "carve outs," it must be determined whether the Catholic facility is participating in (1) governance (that is controlling and supervising the operation); in (2) management (by supplying the

111. Boudeur, available at www.chausa.org/CALANDER/9904CALA.ASP.
personnel that are providing the service); and in (3) deriving revenue from the service.\textsuperscript{112}

A "carve out" occurs when prohibited services are provided not within the integrated facilities, but in a newly established facility operated by the non-Catholic partner. For example, in a "carve out," sterilizations would be performed not in the merged facilities by the merged entity, but rather, outside of the merged facilities or in an area immediately adjacent to them which would be under the complete control of the non-Catholic facility's parent and separate from the operation of the merged company. The non-Catholic parent would supply and control all personnel, separately bill for all such services, and obtain all revenue resulting from provision of the service.

Even in such a proposed "carve out," it is necessary for the canonists to determine whether or not the activity of the Catholic facility would create scandal. In the "carve out" described above, one could state that the Catholics examining the merger would not be prone to consider the Catholic-sponsored health care provider as having sanctioned or approved the sterilization procedures, because they would be performed exclusively in an adjacent area that does not bear the name of the Catholic facility, and because anyone receiving such services would be billed by the parent of the non-Catholic facility rather than by the newly merged entity.

M. GENERAL DISCUSSION OF DIFFERENCES ABOUT PERMISSIBLE TREATMENTS AMONG RELIGIOUSLY AFFILIATED HOSPITALS

1. Missions and Values

Most religiously affiliated hospitals seek to be multifaceted institutions serving the objectives of their sponsoring organizations and the needs of their communities. The mission statements of these institutions often stress the importance of providing disease management and prevention, continuing patient and physician education, encouraging applied and clinical research, and improving the communities in which they serve. Although some also express a commitment to further the teachings of the particular sponsoring religious organization, most are limited to advocating the promotion of patients' spiritual well-being.

With the growth of managed care, most mission statements of health care organizations now include phraseology relating to provid-

\textsuperscript{112} Id.
ing treatment in the most efficient, cost-effective manner possible.\textsuperscript{113} Though some statements do not include this language explicitly, the interest in allocating resources fairly and efficiently is clearly implied.\textsuperscript{114} The mission statements of most religiously-affiliated health care institutions usually include such language, and in fact only show their differences in reference to their commitments to a sponsoring religious organization.\textsuperscript{115} These latter statements require adherence and implementation by the medical staff, employees, and management of the hospital.

As discussed above, integration and conversion of health care providers may have serious tax implications. The provision of certain medical services may, however, occasion some of the most serious conflicts affecting members of the communities served by these providers. Conflicts involving maintenance of religious integrity and the provision of access to certain medical services can often result in the elimination of options for some patients. Due to the various and constantly changing demographics of many communities, it is not possible to delineate the consequences of a specific merger without examining the community and health care institutions involved. It is possible within the scope of this discussion, however, to provide a limited examination of the extent to which various religious philosophies differ with regard to the provision of patient care or to specific medical treatments or practices.

It should be clear that economic pressures and demand for medical services have forced many nonprofit health care providers to seek out associations with other health care entities, whether they be non-


\textsuperscript{114} See, e.g., Our Mission and Values, Glendale Adventist Medical Center, at http://www.adventisthealthsocal.com (last visited Mar. 11, 2001). For example, the mission statement of Glendale Adventist Medical Center in California states:

- Glendale Adventist Medical Center is caring people . . .
- Working together with our community to promote healing, health and wellness for the whole person.
- Committed to Servanthood as exemplified by the life of Christ.
- For our guests, this means that the management, medical staff and employees of Glendale Adventist Medical Center will:
  - Place the needs of patients first,
  - Respect and protect their rights,
  - Allocate and use resources effectively for their benefit,
  - Provide service with the highest level of competency and caring.


\textsuperscript{115} For examples of mission statements, visit the following websites: http://www.njc.org/ham.html (last visited February 24, 2001); http://www.njc.org/market/html/NJCMre.html (last visited February 24, 2001).
profit or for-profit institutions, in order to stay in business.\textsuperscript{116} Although such consolidation of costs and sharing of resources and revenues often appears to have beneficial economic consequences for the community being served, it can also result in some medical services being limited or even eliminated.\textsuperscript{117}

2. Reproductive Health Issues

When health care entities consider a merger, the provision of reproductive services can be a very controversial topic. Given the large numbers of Roman Catholic-affiliated health care providers, as described above, the teachings of the Catholic church often become an issue in any attempt to merge a Roman Catholic-affiliated entity (most often a hospital) with another health care provider.\textsuperscript{118} The ERDs for Health Care Services created by the National Conference of Catholic Bishops serve as a guide for bishops to follow in overseeing the operation of Catholic hospitals within their dioceses.\textsuperscript{119} Although each bishop is encouraged to follow these directives, guidelines have had different interpretations and applications depending on the particular bishop or hospital board involved.\textsuperscript{120} Differences among dioceses may reflect personal predilections of the officials involved, but more likely are a result of "geographic, population and economic market realities."\textsuperscript{121}

Since the directives are simply an attempt to "give moral direction to what [the bishops] see as an intensely moral enterprise," in many areas they are often vague, open to interpretation, or in need of a definition of terms.\textsuperscript{122} On the issues of abortion and assisted suicide, the directives appear quite clear, but the document does not address fully such issues as the "morning-after pill," sterilization, or contraception.\textsuperscript{123} The directives strictly forbid any action directly intended to terminate a pregnancy or destroy a viable fetus, because such action infringes on "natural" reproductive events.\textsuperscript{124} This ban on "infringement" also appears to apply to reproductive-assistance measures, such

\begin{itemize}
\item \textsuperscript{116} Jane Hochberg, Comment, The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights, 75 OR. L. REV. 945, 949 (1996).
\item \textsuperscript{117} Hochberg, 75 OR. L. REV. at 949-50.
\item \textsuperscript{118} Id. at 950.
\item \textsuperscript{119} Carol Bayley, Ph.D., Address at the National Health Lawyers' Association Conference, Mergers and Acquisitions 2000: Tomorrow's Deals Today (Jan. 16, 1998).
\item \textsuperscript{120} Hochberg, 75 OR. L. REV. at 951.
\item \textsuperscript{121} Bayley, supra note 119.
\item \textsuperscript{122} Id.
\item \textsuperscript{123} Id.
\item \textsuperscript{124} Hochberg, 75 OR. L. REV. at 953-54. See also National Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services 45 (1994) [hereafter Religious Directives].
\end{itemize}
as in-vitro fertilization, as well as to permanent or temporary contraceptive practices.125

Under Jewish law, abortion or contraception may be used when required to protect the life of the mother.126 According to Jewish medical ethicists, the actions taken for the protection of life may come at any time in the woman's lifetime. Thus, "before the fact, [women] must protect themselves by contraception or, after the fact [women may protect their lives] by abortion, because protection of [a mother's life] comes first."127 Jewish law emphasizes pikkuah nefesh, the need to protect women "against any threat to their health before or after the event, and to give necessary healing at all times."128 Unlike the Roman Catholic view, Judaism welcomes the option of in-vitro fertilization as an alternative way to fulfill the mitzvah of giving birth. According to the position taken by Jewish ethicists, reproductive technologies are merely a means to assist a couple in their roles as partners with the divine in creation of new life.129 If needed, multifetal pregnancy reduction is permitted under Jewish law, but only when it maximizes the chances of survival for the mother and minimizes the risks to the other fetuses.130

The Lutheran Church, Missouri Synod takes a view comparable to that of Roman Catholics, holding that abortion is contrary to divine law and is an option only when necessary to save the life of the mother.131 By contrast, the United Methodist Church and the Presbyterian Church do not prohibit the practice of abortion. The United Methodist Church recognizes a woman's rights to terminate pregnancy, and encourages and coordinates support for safeguarding the legal option of abortion.132 The Presbyterian Church has been unable to give moral guidance on the issue of abortion, leaving the moral decision in the hands of each woman.133 The Presbyterian Church sug-

125. Hochberg, 75 OR. L. REV. at 951-55.
128. Id.
gests, however, that the decision to abort a fetus be the choice of last resort.

3. **RIGHT TO DIE**

Both the Roman Catholic church and the Evangelical Lutheran Church in America ("ELCA") accept that patients have the right to refuse burdensome treatment when its benefits do not significantly outweigh the risks of further suffering. Along similar lines, the ELCA does not require physicians and other health care providers to administer certain methods of medical treatment when they "will not contribute to an improvement in the patient's underlying condition or prevent death from that condition." These churches, like the law courts, recognize the importance of patient autonomy over hospital and physician interests in the refusal of futile treatment. It should be understood that even those religiously affiliated hospitals that have protocols prohibiting the withholding or withdrawal of treatment may be constrained in applying their policies when patients lawfully refuse treatment. For example, in *Bartling v. Glendale Adventist Medical Center*, the California appellate court held that the right of a competent adult patient to refuse medical treatment is constitutionally guaranteed. In order to preserve the patient's right to self-determination, the court stated that if a patient requests treatment or services contrary to the hospital's mission, the hospital may seek to transfer the patient to another health care facility willing to comply with the patient's desires. However, if the transfer cannot occur immediately, the hospital must grant the patient or his/her agent the authority to refuse treatment.

4. **PHYSICIAN-ASSISTED SUICIDE**

While only Oregon currently has legislation providing for physician-assisted suicide, this issue is likely to provide the basis for future conflicts between religiously-affiliated providers and their patients if additional states follow the apparent suggestion of the United States

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Supreme Court and adopt legislation recognizing the practice. As with the right-to-die issue, physician-assisted suicide may also require the balancing of patient autonomy with the rights of religiously affiliated health-care providers to determine which treatments and services are compatible with their beliefs and policies. Although many religions do not require the use of extraordinary measures to prolong a patient's life, most religions do "object to the active hastening of death." It strictly prohibits patients the right to refuse treatment when there is no hope for recovery, but directly opposes all suicides no matter how extreme the patient's suffering.

According to the Union of Orthodox Jewish Congregations of America, Jewish law forbids assisting in a suicide, even for a terminally ill patient, since such assistance is deemed to undermine the sanctity of human life. Many religions' views on assisted suicide correspond with the Catholic and Jewish teachings; for example, the ELCA believes physicians and other health care providers are obliged to relieve suffering through the "aggressive management of pain, even when it may result in an earlier death." However, the ELCA prohibits any "deliberate action of a physician to take the life of a patient, even when this is the patient's wish."

5. **Organ Donation and Transplantation**

Although many religions have not discouraged organ donation, most faiths maintain it is a matter of personal choice. Even so, it should be noted that less than ten percent of Americans are aware that their religions clearly encourage the practice and even urge it.

For example, the Catholic church takes the position that dead bodies should always be treated respectfully and does not encourage...
the practice of cremation. However, current Roman Catholic doctrine views organ donation as "meritorious." Catholics view organ donation as an act of charity, fraternal love, and self-sacrifice, and regard transplants as morally and ethically acceptable. Similarly, the Jewish faith takes the view that people are "partners with God in creating and maintaining life. What is ordinarily problematic and prohibited not only becomes permissible, it's encouraged." Thus, Judaism teaches that if needed to save or maintain life, a dead body should be harvested for any usable organs. Judaism teaches that saving a human life takes precedence over maintaining the sanctity of the human body.

Like Catholicism and Judaism, most religions support organ donation and transplantation. Members of the Amish community will consent to transplantation if it is for the health and welfare of the recipient. Buddhists treat organ donation as a matter of individual conscience. Hindus are not prohibited by religious law from donating. Moslems were formerly barred by the Moslem Religious Council from receiving donated organs, but the Council has recently ruled that transplantations may be allowed as long as donors provide consent in advance. Jehovah's Witnesses do not encourage organ donation, but neither do they strictly forbid it so long as all organs and tissue are completely drained of blood before transplantation. Most Protestant sects encourage and endorse organ donation, so long as those procuring organ donation give proper respect to the potential donor's conscience and the right to make decisions regarding his or her own body.

N. RELIGIOUS BELIEFS AND PROVISION OF HEALTH CARE SERVICES

Issues involving organ donation and transplantation, women's reproductive health, the right to die, and physician-assisted suicide are examples of the potential clash between patient demand for medical services and the restrictions on providing them that arise in religiously affiliated health institutions. These conflicts become more complex in mergers between nonprofit and for-profit entities, or between nonprofit hospitals with different religious affiliations. To ensure patient access to quality health care services, religious institutions seeking to merge or convert will increasingly need to strike a balance between patient demands for specific services and the

148. Id.
149. Id.
150. Id.
151. Id.
152. Boozang, 31 Hous. L. Rev. at 1474.
rules of sponsoring religious institutions that prohibit such services. One commentator has stated the bottom line in this area: "[t]o the extent that the religious health providers see no possibility of compromise, they must either seek an exemption from civil authorities or withdraw from their health care ministry."153

Actions taken by a religiously affiliated health care provider, whether to provide or not provide certain services, directly affect patient care and autonomy in medical decision making. Limiting the options available to patients implicates not only their philosophical notions of autonomy and personal choice, but also their common-law right to informed consent.

Religiously affiliated hospitals and their sponsoring organizations must determine the "extent to which they are morally able to compromise" their philosophical positions in order to adapt to the evolving health care market through the process of integration with other providers or participation in managed-care plans.154 In addition, health care policy makers and legislators must assess the extent to which the health care system will accommodate the beliefs of the sectarian provider and the limits on services stipulated by those beliefs.155 It is clear that all parties involved must work at providing health care that allows for access to the highest level of patient care while preserving the religious integrity of the sectarian providers.156

There is no simple approach to determining the terms of a merger between a religiously affiliated health care provider and another religiously affiliated, secular nonprofit, or for-profit entity. The merging parties must remain sensitive to the needs of the communities they serve. If the community mandates services that are disagreeable to either party, the parties should consider seeking different partners with which to merge. Certain practical commitments to the provision of specific services must be shared in order for the merger to be appropriate.157

The constant changes in the health care market will continue to make it increasingly difficult for health care organizations to accommodate both sectarian and secular interests.158 As the difficulties persist, conflicts will undoubtedly occur.159 Many analysts and health care institutions remain hopeful that mergers or other similar trans-

153. Id.
154. Id. at 1441.
155. Id.
156. Id.
158. Boozang, 31 Hous. L. Rev. at 1441.
159. Id.
actions involving secular and sectarian facilities will "satisfy the competing needs of theology and economics."\footnote{Id. at 1440.}

Regardless of the arrangement, it is important to remember that religious institutions seek to enter the health care market fundamentally to provide charitable care to their communities. Religiously affiliated hospitals have contributed greatly to the success of our current health care system, and now they must explore ways in which they can continue providing their much-needed assistance into the next century.