11.2.6 – Mergers of Secular & Religiously Affiliated Health Care Institutions

The merger of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity.

Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.

Physician-leaders within institutions that have or are contemplating a merger of secular and faith-based institutions should:

(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the same breadth of services and care previously offered will continue to be available to the community.

(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same breadth of services and care remain available to the community.

(d) Recognize that physicians' primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

Individual physicians associated with secular and faith-based institutions that have or propose to consolidate should:

(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.

(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

AMA Principles of Medical Ethics: VII,VIII,IX

Background report(s):

CEJA Report 2-A-18 Mergers between secular & religiously affiliated health care institutions

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS[1*]

CEJA Report 2-A-18

Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Peter H. Rheinstein, MD, JD, MS, Chair)

Mergers between secular and religiously affiliated hospitals are changing the landscape of health care across the United States. This report by the Council on Ethical and Judicial Affairs (CEJA) offers ethics guidance to address the challenges such mergers can pose for patients, physicians, health care institutions and the communities they serve.

RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS

The concept of the hospital as a facility providing inpatient care for the sick originated with the Catholic Church, with the original and enduring dual mission of healing the body and promoting spiritual well-being [1]. The mission of today's Catholic Health Association remains focused on the needs of those who are "poor, underserved, and most vulnerable" [2]. Although hospitals established by Protestant denominations and Jewish-identified facilities remain important segments of U.S. health care, Catholic facilities predominate among religiously affiliated institutions—U.S. Catholic Health Care is the largest nonprofit care provider in the country [2].

Since the 1990s, mergers between secular and religiously affiliated hospitals and health care institutions have been reshaping the landscape of health care in the United States, for both patients and physicians. Driven by economic considerations and changes in health policy, notably in recent years emphasis on accountable care organizations and bundled payments [1,3], mergers have enabled facilities in some cases simply to survive and in others to thrive within their communities. Consolidation has enabled hospitals to control a greater share of their local markets and to negotiate effectively with insurers [4].

Religiously affiliated hospitals and facilities benefit from the tax-exempt status of the religious institutions they represent and from other tax subsidies that derive from their mission to serve the poor and provide charitable care [5]. Although the majority of religiously affiliated hospitals remain nonprofit, the number of for-profit hospitals affiliated with religious institutions increased by 22 percent between 2001 and 2016 [6]. Religiously affiliated health care facilities—which encompass clinics, hospitals, and long-term care facilities—are also important employers. According to the Catholic Health Association, as of 2017 member facilities employed more than 500,000 full-time and 200,000 part time staff [2].

[*] Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council

In some communities, religiously affiliated health care institutions may be the only providers [6]—as of 2015, 132 of the nation's approximately 1,300 critical access hospitals were members of U.S. Catholic Health Care [2]. In some areas, more than 40 percent of short-term, acute care beds are in Catholic facilities [6]. Nationwide, one in every six patients now receives care in a Catholic hospital [2].

THE DILEMMA OF MERGERS

The consolidation of a religiously affiliated institution with a secular health care facility raises challenges for all stakeholders—the facilities, their communities, their patients, and the physicians and other professionals who provide care. All religiously affiliated institutions seek to remain faithful to their defining mission and values, which can place them in tension with their secular counterparts. Catholic facilities, however, are embroiled in an increasingly public debate about the implications and effects of entering into arrangements with secular institutions as they seek to retain their identity and mission and still survive in the health care market place. Thus they offer a window through which to understand the ethical dimension of health care mergers.

As the Ethical and Religious Directives that govern care in Catholic health care facilities observe:

> New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.
>
> On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles (§VI)[7].

From this perspective, in the contemporary health care market place Catholic hospitals "are caught in an impossible bind" [1]. Like other hospitals, financial pressures drive them to consolidate with other institutions to become more economically efficient. Yet "competing in the aggressive world of the medical business industry" can put Catholic hospitals' historical commitment to the poor at risk [1]. At the same time, gaining financial security may risk "imperceptibly compromising their traditional Catholic witness" when compromises are made with respect to Directives [1].

From the perspective of those they serve, a merger or consolidation may help guarantee the continued presence of health care in a community, but may also limit the range of services available to patients when the consolidated entity adheres to the Directives. Certain treatment choices for care at the end of life, reproductive health care services, and, by some reports, certain services for transgender individuals may all be affected [4,8,9]. Limitations on women's health services have been a focus of concern for obstetricians and gynecologists associated with or employed by religiously affiliated hospitals [10], with reports of conflict over both elective and clinically indicated surgical sterilization [11,12], and management of miscarriage [13]. Restricted access to services can have a disproportionate impact on poor women, and women in rural areas where religiously affiliated institutions are the only providers of care [14].

From the perspective of physicians and other health care professionals affiliated with or employed by the entity that results from a merger can challenge professional commitments. A merger that results in loss of access to services for the community and requires physicians to follow the religious guidelines embodied in the Directives may result in "conflict with prevailing medical

standards of care and ethical principles of health care professional" [15]. Physicians and other health care professionals who are not members of the faith tradition may find themselves contractually prohibited from providing care that is otherwise legal and, in their professional judgment, clinically appropriate and ethically permissible under the norms of medical professionalism.

THE RESPONSIBILITIES OF LEADERSHIP

As challenging as mergers between secular and religiously affiliated health care facilities may be for individual patients and physicians, addressing dilemmas of mission is pre-eminently a responsibility of hospital leadership.

For Catholic facilities merging with secular facilities (or facilities associated with other religious traditions), a touchstone is the principle of cooperation [16,17]. The principle, it is argued, is a necessity for business relationships in a pluralistic world, providing a way to address the reality that, for the faithful, "it is almost impossible to bring about good without brushing up against or even becoming somewhat involved in the wrongdoing of others" [16]. The principle of cooperation is understood "as a *limiting principle*, to avoid cooperating in evil" (original emphasis) [17].

The essential goal is to ensure that institutional arrangements allow the facility and its staff to "remain as removed as possible" from violations of the Directives and "not [to] contribute anything essential to make possible the wrongdoing's occurring" [16]—e.g., essential employed staff or equipment for the performance of what under the Directives is an immoral procedure [17]. Whether services that would be otherwise prohibited by the Directives will or may be available through the merged entity is importantly a function of how caregiving is organized in the resulting composite system. The approval of the diocesan bishop is required for mergers involving facilities subject to his governing authority, and the diocesan bishop has final authority for assessing whether a proposed merger constitutes morally licit cooperation (§VI) [7].

Analogous discussions of the ethics of trusteeship, such as that offered by The Hastings Center, offer secular insight for thinking about the responsibilities of leaders in health care institutions. Trustees of not-for-profit health care organizations "regularly make decisions that affect the lives and well-being of a large number of people who are relatively powerless, relatively vulnerable, and in need of services or assistance" [18]. In light of the mission of such organizations, service on a board of trustees entails fiduciary duties to founders, benefactors, and donors and responsibility to ensure that the organization realizes the public benefits for which it enjoys tax exempt status.

Trustees are held to principles of fidelity to mission; service to patients, ensuring that the care is high quality and provided "in an effective and ethically appropriate manner"; service to the community the hospital serves, deploying hospital resources "in ways that enhance the health and quality of life" of the community; and institutional stewardship. They have a further responsibility to ensure that when there is conflict over fundamental values and principles, "all points of view are heard and taken seriously, that reasonable compromise is explored, and that consensus has time to form" [18].

The Principles of Integrated Leadership for Hospitals and Health Care Systems, developed in collaboration by the American Hospital Association (AHA) and the American Medical Association (AMA), address responsibilities of hospital leadership in the context of rapidly evolving models of integrated physician-hospital health care systems [19]. In addition to governance and management structure and leadership development, guidance identifies "cultural adaptation" as a key element for success, observing that:

> Culture is the way an organization, institution or integrated health system does business, in a way that is predictable, known to all and consonant with the mission and values of the organization, institution or integrated health system. The creation of a common shared culture that includes an integrated set of values is important to serve as a guide to the entity and will serve as a touch point to help resolve the inevitable conflicts that will arise [19].

The AHA-AMA's principles for *Integrated Leadership for Hospitals and Health Systems* urge integrated health systems to cultivate the characteristics of adaptive institutional culture, including a focus on the health of the entire population served; agreement to a common mission, vision, and values; mutual understanding and respect; and a sense of common ownership of the entity and its reputation [19].

INSIGHT FROM THE CODE OF MEDICAL ETHICS

As frontline clinicians, physicians (and other health care professionals) regularly confront the effects on patients' lives and well-being of the institutional arrangements through which care is delivered. They have a responsibility to advocate for the resources patients need, as well as to be responsible stewards of the resources with which they are entrusted [20]. They must be able to make treatment recommendations in keeping with their best judgment as medical professionals [21]. And they are expected to uphold the ethical norms of medicine, including fidelity to patients and respect for patients as moral agents and decision makers [22].

Existing guidance on exercise of conscience by individual physicians suggests essential responsibilities of leadership in health care as well [22]. These include responsibility to engage in thoughtful consideration of the implications of institutional arrangements—whether arrangements sustain or risk undermining the personal and professional integrity of staff, cause moral distress, or compromise the ability to provide care. Leaders in health care institutions must be mindful that arrangements do not discriminate against or unduly burden individual patients or populations of patients, and of the burden arrangements may place on fellow professionals. And they must accept responsibility to take steps to ensure that services will be available to meet the patients and community the institution serves.

RECOMMENDATION

In light of this analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted, and the remainder of this report be filed:

> The merger of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity.
>
> Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.
>
> Physician-leaders within institutions that have or are contemplating a merger of secular and faith-based institutions should:

(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the same breadth of services and care previously offered will continue to be available to the community.

(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same breadth of services and care remain available to the community.

(d) Recognize that physicians' primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

Individual physicians associated with secular and faith-based institutions that have or propose to consolidate should:

(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.

(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

(New HOD/CEJA Policy)

Fiscal note: Less than $500

REFERENCES

1 Guinan P. Catholic hospitals, are mergers the way to go? *Linacre Quarterly.* 2014;81(2):107–110.

2 Catholic Health Association. *U.S. Catholic Health Care 2017*. Available at https://www.chausa.org/store/products/product?id=3455. Accessed August 30, 2017.

3 Hill EL, Slusky DJG. Medically Necessary But Forbidden: Reproductive Health Care in Catholic-owned Hospitals, March 2017 [discussion paper]. Available at https://economics.ku.edu/sites/economics.ku.edu/files/files/Seminar/papers1617/april%2026.pdf. Accessed August 4, 2017.

4 American Civil Liberties Union. Health Care Denied, May 2016. Available at https://www.aclu.org/mwg-internal/de5fs23hu73ds/progress?id=XGdSUFilEMNhTLIOIDDkVgjFI1WeJSEtthzNOu9Q8G0. Accessed August 4, 2017.

5 Mencimer S. Charts: Catholic hospitals don't do much for the poor. *Mother Jones.* 2012;Dec 18. Available at http://www.motherjones.com/politics/2013/12/catholic-hospitals-arent-doing-much-poor/. Accessed August 3, 2017.

6 Uttley L, Khaikin C. Growth of Catholic Hospitals and Health Systems. *MergerWatch 2016*. Available at http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=7BGsnPyq440GPR0AyWEgqOThYQ8%3D. Accessed August 4, 2017.

7 U.S. Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Services, 5th ed*. Washington, DC: USSCB 2009. Available at http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. Accessed April 23, 2017.

8 Stulberg DB, Lawrence RE, Shattuck J, Curlin FA. Religious hospitals and primary care physicians: conflicts over policies for patient care. *J Gen Intern Med.* 2010;25(7):725–730.

9 Somashekar S. Transgender man sues Catholic hospital for refusing surgery. *Washington Post.* 2017;Jan 6. Available at https://www.washingtonpost.com/news/post-nation/wp/2017/01/06/transgender-man-sues-catholic-hospital-for-refusing-surgery/?utm_term=.08d436ce9705. Accessed August 3, 2017.

10 Stulberg DB, Dude AM, Dalhquist I, Curlin FA. Obstetrician-gynecologists, religious institutions, and conflicts regarding patient care policies. *Am J Obstet Gynecol.* 2012;207(1):73.31–73.e5.

11 Egelko B. Legal case tests religious hospitals' right to deny procedures. *San Francisco Chronicle.* 2015;Aug 25. Available at http://www.sfchronicle.com/health/article/Lawsuit-tests-religious-hospitals-right-to-6461051.php. Accessed August 1, 2017.

12 Stulberg DB, Hoffman Y, Dahlquist IH, Freedman LR. Tubal ligation in Catholic hospitals: a qualitative study of ob-gyns' experiences. *Contraception.* 2014;90(4):422–428.

13 Freedman LR, Landy U, Steinauer J. When there's a heartbeat: miscarriage management in Catholic-owned hospitals. *Am J Public Health.* 2008;98(10):1774–1778.

14 Sloboda M. The high cost of merging with a religiously-controlled hospital. Berkeley J Gender, Law & Justice 2013;16(1):140–156.

15 Uttley L, Reynertson S, Pawelko J, et al. Merging Catholic and non-sectarian hospitals: NYS models for addressing the ethical challenges [briefing paper]. *Merger Watch 2014*. Available at http://static1.1.sqspcdn.com/static/f/816571/23042588/1372882137057/Models+of+Catholic-secular+hospitals+mergers+in+NYS.pdf?token=WMgcWaEMDP2zcdqKtRUngnSaaRQ%3D. Accessed August 3, 2017.

16 Hamel R. Cooperation: a principle that reflects reality. *Health Progress.* 2012;Sept-Oct:80–82.

17 Cataldo PJ, Haas JM. Institutional cooperation: the ERDs. *Health Progress.* 2002;Nov-Dec:49–60.
18 Jennings B, Gray BH, Sharpe VA, et al. Ethics and trusteeship for health care [special supplement]. *Hastings Center Report.* 2002;Jul-Aug:S1–S27.
19 American Hospital Association, American Medical Association. *Integrated Leadership for Hospitals and Health Systems: Principles for Success, 2015*. Available at http://www.aha.org/content/15/ahaamaintegrleadership.pdf. Accessed August 30, 2017.
20 American Medical Association. *Code of Medical Ethics*. Opinion E-11.1.2, Physician stewardship of health care resources. Available at http://static1.1.sqspcdn.com/static/f/816571/23042588/1372882137057/Models+of+Catholic-secular+hospitals+mergers+in+NYS.pdf?token=WMgcWaEMDP2zcdqKtRUngnSaaRQ%3D. Accessed August 8, 2017.
21 American Medical Association. *Code of Medical Ethics*. Opinion E-11.2.1, Professionalism in health care systems. Available at http://static1.1.sqspcdn.com/static/f/816571/23042588/1372882137057/Models+of+Catholic-secular+hospitals+mergers+in+NYS.pdf?token=WMgcWaEMDP2zcdqKtRUngnSaaRQ%3D. Accessed August 8, 2017.
22 American Medical Association. *Code of Medical Ethics*. Opinion E-1.1.7, Physician exercise of conscience. Available at https://www.ama-assn.org/sites/default/files/media-browser/code-of- medical-ethics-chapter-1.pdf. Accessed August 8, 2017.