ABSTRACT

Appeal to Conscience Clauses in the Face of Divergent Practices
among Catholic Hospitals

Sandra S. Hapenney, Ph.D.

Committee Chairperson: Francis J. Beckwith, Ph.D.

Conscience clauses are laws enacted by federal and state governments to protect health care providers from participating in those medical practices they consider morally objectionable. This study examines the practices of Catholic hospitals and their adherence to the Ethical and Religious Directives (ERD) for Catholic Health Care Services issued by the U.S. Conference of Catholic Bishops. If divergence of practice exists among Catholic hospitals, such diversity may pose judicial and political problems for providing protection under the conscience clauses.

Catholic hospitals in seven states—California, Illinois, Indiana, New Jersey, New York, Texas and Washington—were studied to determine if diversity of practice existed in the provision of direct female sterilizations. Inpatient discharge data was requested for three years (2007-2009) from the 1,734 hospitals, secular and Catholic, within the states. Of these hospitals, 239 Catholic hospitals were identified of which 176 provided obstetric services. The records of these 176 hospitals were searched for those containing the diagnostic code from the ICD-9-CM coding system for sterilization for contraceptive

management. Eighty-five or 48% of these hospitals provided a total of 20,073 direct sterilizations in violation of the ERD.

An analysis of Catholic hospital systems owning hospitals within the seven state study area illustrated that 69.0% of the hospitals were members of 26 various Catholic hospital systems. Ten systems operating in the seven states also have hospitals outside the study area. Within these 10 systems, 64.2% of the hospitals in the study area performed direct sterilizations. An analysis of the Catholic dioceses in the study area revealed that 69.8% of the dioceses had hospitals which provided direct sterilizations. Thus, diversity of practice resulting from varied interpretations and applications of the ERD exists among hospitals, and within hospital systems and dioceses. An analysis of the conscience clauses illustrates that Catholic hospitals are in jeopardy of defending themselves against judicial challenges and could strip themselves of the ability to mount a political front to aid in defending the conscience clauses.

Appeal To Conscience Clauses In The Face Of Divergent Practices Among Catholic Hospitals

Revision 1 (See p. xi for a description of revisons)
March 29, 2012

by

Sandra S. Hapenney, B.A., M.P.H., M.A.

A Dissertation

J. M. Dawson Institute of Church-State Studies

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ACKNOWLEDGMENTS

Our goal in life is to always seek the truth and this I have tried to do. There are many people along the way who have helped me in this endeavor. My dissertation advisor, Dr. Beckwith, helped me stay on path towards this end and complete this study, and I am greatly indebted to him. I would also like to thank all the faculty and staff at the Institute for Church-State Studies, especially Dr. McDaniel and Dr. Marsh who stood behind me and supported my research. There are many others such as my dissertation committee members who advised me in their respective areas of expertise to whom I wish to express my gratitude. Two others who worked behind the scenes were instrumental in this dissertation and receive my greatest thanks. They are my husband, Dan, and my son, Jim. Dan was always encouraging and listened to me hours on end as I struggled with various issues. Regarding Jim, my computer skills are vast, but miniscule compared to his, and he supported and advised me every step of the way as I waded through over 47 million patient records to finalize this study. There are many others who sustained me with their advice and prayers who are too numerous to list, but I want them to know that they too were very instrumental in my completion of this effort. My thanks go out to each and every one of them.

CORRECTIONS

After the dissertation was completed, but prior to its inclusion in the UMI database of dissertations, a version of the data was made available on the Internet (catholichospitals.org). Questions were raised regarding procedure codes reported for some of the Indiana hospitals. An initial review by the author found that there had been an error in processing the procedure codes for the Indiana hospitals that resulted in the erroneous reporting of sterilization procedures for five hospitals. The author also found that the diagnostic V25.2 codes were inflated by five out of the 171 reported in Indiana. They were corrected and a later independent review by the Baylor Graduate School confirmed these corrections. The processing error arose because the Indiana data was provided in a different format than the other states (as originally noted on page 60). The table containing the procedure codes for Indiana was removed from this section.

With the cooperation of the author, in a further effort to validate the data calculations for the other states, there was an independent review done by a faculty member of the Computer Science Department. They found some discrepancies in the state of California (an under reporting of 14 V2.5 codes) and these were corrected. The number of hospitals reporting V25.2 codes did not change.

These errors though regrettable do not affect the thesis or the conclusion of the present dissertation. The procedure codes in Indiana were reported, but not used in developing the rationale of the thesis (as originally noted on page 56). Consequently, these errors do not create a false reporting of the degree of diversity among Catholic hospitals.

Revision 1 Changes

Hundreds of individuals have read the full text of the dissertation available online at catholichospitals.org. A few individuals have sent me questions about some issues they discovered in the document. Upon investigating these issues, I have revised the document to include these minor changes. I truly appreciate receiving feedback from these individuals and welcome any other comments from readers.

1. St. James Mercy Hospital was reported as being in the diocese of New York. Instead it is in the diocese of Rochester. As a result, the diocese of New York has no hospitals with patient records reporting V25.2 codes. Changes were made on p. 71, Table 16, and p. 74, Table 19.

2. St. Joseph's Hospital Health Center in Syracuse is independently owned and is not affiliated with Catholic Health Services of Long Island. None of the hospitals owned by Catholic Health Services of Long Island reported V25.2 codes. Changes were made on p. 71, Table 16, and p. 73, Table 18.

3. Holy Family Hospital in Spokane was listed twice in the table for hospitals in the state of Washington. This was a formatting error and did not affect any of the total numbers. The change was made on p. 82, Table 23.

CHAPTER ONE

Introduction

"Conscience clauses" are laws enacted by federal and state governments to protect health care providers, both individuals and institutions, who refuse to participate in a variety of medical practices the providers consider morally unacceptable. The present study examines appeals to the conscience clauses and the practices of Catholic hospitals in seven states. The study concludes with a consideration of the effect of divergence of practice among Catholic hospitals on judicial appeal to the conscience clauses and on political efforts to strengthen the clauses.

In 1973, Senator Frank Church introduced the first federal legislation regarding conscience clauses. Congress passed the Church Amendments, as they became known, specifically protecting the conscience rights of health care providers from forced involvement in abortions and sterilizations. During subsequent years, many states implemented similar conscience protection laws for these and other medical services. As of 2008, forty-six states and the District of Columbia had statues protecting physicians from a broad array of consequences for refusal to participate in abortion procedures, and Illinois, Mississippi, and Washington allowed refusal of any medical service to which the physician is morally opposed.[1]

[1] Holly Lynch, *Conflicts of Conscience in Health Care*, (Cambridge: MIT Press 2008) 20.

Some advocacy groups such as the NARAL Pro-Choice America and Planned Parenthood[2] advocate against such conscience clause laws because they consider the provision of the medical treatments in question to be a human right of the patient. They argue that providers have a duty to provide these procedures or medications upon request and that the procedures should be readily available wherever patient care is provided. The conscience appeal of Catholic hospitals and clinics is particularly worrisome to these advocates because of the large number of Catholic facilities across the United States, and because Catholic facilities may be the only providers in some areas.

Official Catholic positions regarding health care have been precisely defined under doctrinal authority. The Catholic Church has declared some procedures—such as direct abortion, direct sterilization, and euthanasia—to be immoral because they harm the body and violate human dignity. Thus, for a Catholic, participation in the provision of such procedures is a deadly sin, a grave offense against God and a crime against humanity. In some cases for individuals, such actions would result canonically in automatic excommunication from the Church.[3] Additionally, Catholic health care systems that provide morally objectionable treatments may be subject to intervention by ecclesial authorities, closing of facilities, or the loss of their affiliation with the Church.

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[2] NARAL Pro-Choice America was formed in 1968 as the National Association for the Repeal of Abortion Laws. It is a non-profit organization which sponsors lawsuits and lobbies for laws to increase the availability of all forms of abortion and "reproductive rights." Planned Parenthood has evolved since its establishment in 1921 by Margaret Sanger in New York into to a large worldwide collective group of organizations providing women's medical care and lobbying for women's "reproductive rights."

[3] Canon Law, the body of law and regulations of the Catholic Church, governs the Church and its members. Canon 1398 states that "A person who procures a completed abortion incurs a *latae sententiae* excommunication." *Latae sententiae* is an automatic excommunication. Persons assisting in abortion also incur a *latae sententiae* excommunication. Canons 751 and 1364 refer to the denial of some truth believed divine by the Church. These also result in *latae sententiae* excommunication. Libreria Editrice Vaticana, *Code of Canon Law* (Washington, D.C.: Canon Law Society of America, 2003).

Scholarly journals, press reports, and statements from Church authorities raise questions about the uniformity with which Catholic health care providers interpret and adhere to the Church's teaching. Until recently, it has been difficult for interested groups to evaluate actual practices of Catholic hospitals because individual patient records are protected by confidentiality laws. Secure techniques for data collection and processing of hospital data evolved within the last two decades which allow research without compromising patient confidentiality. As a result of this evolution, many state departments of health began rigorous collection and examination of patient data to ensure accountability among providers in the areas of patient management and fiscal responsibility. The data being collected is made available under certain conditions to insurance providers and researchers.

By studying patient level data of Catholic hospitals, the actual practices of the individual hospitals may be revealed. If the data reveals a significant divergence in interpretation and application of Church teaching among Catholic hospitals, this would indicate that, practically speaking, no uniform Catholic practice exists. The absence of a unified Catholic practice would raise the question: can an institution or an individual claim Catholic identity as a legal basis for conscientious objection?

This dissertation seeks to determine the uniformity of practice among Catholic facilities based upon official Catholic hospital norms. Patient level inpatient discharge data for three years was obtained from seven states. Although there are many diagnoses and medical procedures within the patient records which could be examined for hospital adherence to the Catholic practice as presented in the Ethical and Religious Directives

(ERD) for Catholic Health Care Services of the U.S. Conference of Catholic Bishops,[4] this research focuses on procedures for direct sterilization. A direct sterilization is one that induces sterility when no underlying or pathological illness is present and is an explicit violation of official Church teaching. The research will examine diagnostic and procedural codes for direct sterilization and the frequency of their reported occurrence.

This dissertation will conclude with a consideration of the effects of divergent practices on the appeal to existing conscience clauses by Catholic institutions. Catholic hospitals have other possible legal recourses to defend their position (such as the invocation of the free exercise clause of the first amendment) but, in the interest of precision, the scope of the present study is restricted to the conscience clauses.

Catholic Health Care in the United States: Past and Present

The Catholic Health Association of the United States of America (CHAUSA) stated that in 2009 there were 636 Catholic community hospitals in the U.S.[5] Based upon the 2009 American Hospital Association Annual Survey, this represents 12.7% of all hospitals and 15.8% of all patient admissions in the United States.[6] The establishment and growth of Catholic health care has a rich history beginning in the early 19th century. Prior to the industrialization of the United States, hospitals generally were not necessary. In agrarian societies, families and communities took care of the sick and dying. With rapid industrial growth and the large influx of immigrants, care of the sick changed

[4] USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: United States Conference of Catholic Bishops, 2009)

[5] Catholic Health Association of the United States, "Fast Facts 2009" http://chausa.org/Pages/Newsroom/Fast_Facts/ (accessed March 26, 2011)

[6] Ibid.

dramatically in the early 1800's. In 1823, Catholic sisters first began staffing hospitals in the continental U.S. These women brought with them a unique charism —a willingness to assume a caretaker role for unknown persons, and to do so with love and compassion. Women joined the religious orders primarily for spiritual reasons. They sought to achieve spiritual perfection by manifesting their love of God in the midst of their own hardships and suffering, and to lead others to discover the love of Christ in suffering. Thus, they sought to integrate their care for the sick and dying with their spirituality. With no formal medical training programs in existence, the sisters tackled their challenges, learning and developing the practice of nursing from experience in their own hospitals.[7]

By 1922, Catholic religious sisters operated 675 Catholic acute and specialty hospitals in the United States. The sisters became adept managers and entrepreneurs as they experienced the changing nature of medical care during the twentieth century.[8] CHAUSA, formerly (CHA) Catholic Hospital Association, founded in 1914 as an association of Catholic hospitals to further medical advancements and training, became a united voice for the hospitals. According to CHAUSA, in 1966 there were 803 [9] Catholic general hospitals with religious sisters operating the majority of them.

The year 1965 marked a turning point in the practice of medicine in the United States affecting not only Catholic hospitals, but all health care providers. President Johnson signed into law The Social Security Amendments of 1965 [H.R. 6675] that

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[7] Barbra Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865-1925* (Columbus: Ohio State University Press, 2005) 16-18, 36.

[8] Ibid., 186.

[9] Ursula Stepsis, CSA, and Dolores Liptak, RSM, ed., *Pioneer Healers,* (New York: Crossroad), 179.

established the Medicare and Medicaid programs. With federal funds insuring elderly, disabled, and unemployed adults, as well as children in poverty, health care spending as a percentage of Gross Domestic Product (GDP) significantly accelerated. In 1960, it was 5.2% and by 1980 it was 9.1%. As a result, cost containment in health care became a priority for the federal government resulting in numerous attempts through legislative actions to cut health care expenditures. The Comprehensive Health Planning and Service Act of 1966 [P.L. 89-749] was established to ensure the availability, accessibility, affordability, and quality of health care for all those needing health services, but also to attempt to control the number of excess hospital beds and the purchase of expensive equipment which could be underutilized. The Health Maintenance Organization Act of 1973 [P.L. 93-222] allowed grants and loans to provide, start or expand a health maintenance organization (HMO). These organizations are referred to as managed care providers. They differ from traditional health care insurance in that the organization contracts with hospitals, physicians, and other providers to provide care according to specific guidelines and procedures established by the HMO. A patient chooses a primary care physician who acts as a gatekeeper to the other services. The patient or the patient's employer pays a set monthly amount for the service. HMOs were supported because at the time they limited spending for health care and appeared to provide better access for more people.

Further legislative activity in 1974 enacted the National Health Planning and Resources Development Act [P.L. 93-641]. Replacing the Comprehensive Health Planning and Service Act, it established state and local Health Systems Agencies providing them with greater control in restraining growth in the expansion of hospitals by

limiting excess beds and the purchase of expensive diagnostic equipment within a given area.[10] Then in the 1980s, the federal government began to place caps on reimbursements for health expenditures while HMOs or managed care plans began controlling the length of hospital stays to control rising costs. Whereas legislation and other activities may have slowed the rise in health care as a percentage of the GDP, surplus hospital beds and increased cost of medical technology caused a continuing increase in the percentage of GDP for health care as compared to other areas of spending in the U. S.[11] The growth of health expenditures slowed in the 1990's due to the increased legislative efforts, but still reached 16.2% of the GDP by 2008.[12]

The legislative activity of the last three decades of the 20th Century resulted in a flurry of activity by hospitals as they attempted to control costs and maintain solvency. Large HMOs and other managed health care plans replaced most traditional health insurance and received federal incentives to reduce costs for Medicare and Medicaid recipients. These changes in insurance shifted the balance of power away from the hospitals that previously had been setting their own fees and instead supported the organized purchasers of services.

Some hospitals closed while others merged with different institutions. Large hospitals systems with overhead efficiencies and improved bargaining power with

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[10] Sandra Hapenney, "The Impact of P.L. 93-641, the National Health Planning and Resources Development Act, upon Health and Mental Health Programming," *Evaluation and Program Planning* 1, no. 1: (January 1978): 79-81.

[11] Richard A. Rettig, "Medical Innovation Duels Cost Containment," *Health Affairs* 7 (Summer, 1994): 27. Rettig discusses at length the issues of cost containment efforts especially as it relates to the need for continual technological innovations.

[12] Centers for Medicare & Medicaid Services, "Overview National Health Expenditure Data, 2010" https://www.cms.gov/NationalHealthExpendData/ (accessed 12 July 2010).

managed health care plans emerged. Catholic hospitals had advantages over others non-profits in establishing large systems because Catholic hospitals possessed similar missions and affiliations through CHAUSA. Catholic hospitals quickly began to merge with other Catholic hospitals, and underperforming hospitals were either sold or closed to create some of the largest and most economically efficient non-profit hospital systems in the U.S.[13]

The largest non-profit hospital system in the nation, Ascension Health, best illustrates the changes in Catholic hospital management and the growth of Catholic hospital systems. Ascension Health system was formed in 1999 by creating a co-sponsored Catholic health ministry between the Daughters of Charity National Health System (DCNHS) and the Sisters of St. Joseph hospitals. The DCNHS was established in St. Louis in 1986. The initial hospitals run by the Daughters of Charity began sharing services with other hospitals as early as the 1940's to increase efficiencies in their ministries. By the time of the merger with the Sisters of St. Joseph in 1999, they included nearly 80 hospitals, nursing homes, outpatient clinics and other healthcare facilities in 15 states. The Sisters of St. Joseph joined the merger with 30 hospitals, and nursing homes, outpatient clinics and other healthcare facilities spread throughout lower Michigan.[14]

By 2009, sixty Catholic health care systems comprised eighty-nine percent of all Catholic hospitals in the U.S, but the ownership and status of some Catholic hospitals are changing frequently. From 2008 to 2009, there was a decrease of sixty-three Catholic

[13] On the list of the 20 largest non-profit hospital systems given on *Becker's Hospital Review* as of October 2010, Ascension Health Systems and Catholic Health Initiatives were ranked as the top two non-profit systems followed by Catholic Healthcare West.

[14] This information was obtained from the Ascension Health website, http://www.ascensionhealth.org (accessed January 1, 2011).

hospitals.[15] Some hospitals were closed, others were sold and some were sold to for-profit systems. For example, Resurrection Health Care in Chicago operated seven hospitals in addition to surgery centers, nursing homes, and numerous other health facilities in 2009. Within the last year, Resurrection Health sold two of its underperforming hospitals to Vanguard Health Systems, a for-profit system based in Nashville. Vanguard also made plans to purchase another Catholic hospital, Holy Cross, in Chicago at the end of 2010. Vanguard has committed to maintaining the Catholic identity of the hospital and conforming to the ERD.[16]

New York City Catholic hospitals demonstrate other issues Catholic hospitals face. There were eight Catholic hospitals in New York City in 2007, but by the end of 2009, all but one had closed. According to the article, *Then There Was One*, by Daniel Sulmasy, O.F.M., M.D. in *America*, there were a number of reasons causing the demise of the facilities. The foremost problem is the harsh market environment for hospitals today especially in New York City. The pressure by managed care to reduce length of patients' hospital stays resulted in a high number of excess beds in the City. The management of the hospitals was weak and there was not enough philanthropy to help them survive even in their attempt to downsize. Sulmasy also stated that the

[15] Catholic Health Association of the United States, "Fast Facts 2009" http://chausa.org/Pages/Newsroom/Fast_Facts/ (accessed March 26, 2011)

[16] Yue, Lorene, "Holy Cross Hospital Selling to Vanguard Systems." *Crain's Chicago Business*, December 15, 2010. http://www.chicagobusiness.com/article/20101215/NEWS03/101219917/holy-cross-hospital-selling-to-vanguard-health-systems#axzz19tU25NNR (accessed 1/2/2011, 2011).

ecclesiastical leadership was not effective in aiding the hospitals and that Catholics no longer had strong attachments to Catholic healthcare, but had become more secularized.[17]

Coupled with the changes occurring in Catholic hospitals since the mid twentieth century, internal ecclesiastical problems emerged in maintaining the Catholic identity of the hospitals. The US Conference of Catholic Bishops (USCCB) and the Vatican repeatedly acted since the 1960's to prohibit in Catholic facilities procedures such as tubal ligations (direct sterilizations considered immoral by the Catholic Church). The US Bishops prepared the first *Ethical and Religious Directives* (ERD) for Catholic Health Care Services to clarify moral from immoral procedures in 1971.[18] During the 1970's, specifics of these ERD were often questioned and challenged by some hospitals and medical ethicists, particularly those who were dissenting from Catholic moral teaching.[19] Hospitals employ their own ethicists who sometimes attempt to redefine terminology rather than depend upon already accepted ethical systems and terminology. In 1975, the Vatican issued *Responses to Questions Concerning Sterilization in Catholic Hospitals* affirming the United States Bishops'1971 ERD specifically relating to direct sterilizations.[20] The Vatican continued to confirm the directives and to insist that the

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[17] Daniel P. Sulmasy, "Then There Was One," *America*, March 16, 2009. http://americamagazine.org/content/article.cfm?article_id=11513 (accessed December 17, 2010)

[18] USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, (Washington, DC: United States Conference of Catholic Bishops, 1971)

[19] An exhaustive analysis of the actions by the U.S. Bishops during this time period is provided in a detailed dissertation titled "A Theological Analysis of the Ethical and Religious Directives for Catholic Health Facilities in the United States" by Clarence Deddens (Pontificia Studiorum Universitas A S. Thoma AQ. in Urbe, 1980). (Deddens, Clarence, M. Div., M.A., S.T.D.)

[20] Sacred Congregation for the Doctrine of the Faith, *Responses to Questions Concerning Sterilization in Catholic Hospitals*, Vatican City: Libreria Editrice Vaticana, 1975. May be accessed online http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19750313_quaecumque-sterilizatio_en.html.

norms be enforced without reference to the dissenters' ethical theories and terminology. In 1993, Cardinal Ratzinger (now Pope Benedict XVI) issued *Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters* again affirming the Church's position on tubal ligations by giving specific answers to cases in which questions were raised regarding situations in which direct sterilization had been considered as an option.[21] In 1995, Pope John Paul II with the encyclical *Evangelium Vitae (The Gospel of Life)* reaffirmed the dogmatic prohibitions against contraception, direct sterilization, direct abortion and euthanasia.[22] The ERD were updated by the USCCB and reissued in 1995, and with the assistance of Cardinal Ratzinger a fourth edition was issued in 2001. The bishops then issued a fifth edition in 2009.[23]

The ERD clearly prohibit procedures at Catholic hospitals such as contraception, direct sterilization, and direct abortion (ERD 45, 52, and 53).[24] Such procedures are not permitted even if a current or future pregnancy might endanger the life or health of the mother. ERD 5 also requires that all doctors and staff at a Catholic hospital uphold the ERD as a basis for medical privileges or employment. Furthermore, Catholic health systems interacting with non-Catholic agencies must avoid all "immediate material" cooperation with immoral procedures and all forms of cooperation with induced abortion

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[21] Congregation for the Doctrine of the Faith of the Holy See, *Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters,* (Vatican City: Libreria Editrice Vaticana, 1993). May be accessed online at http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_31071994_uterine-isolation_en.html.

[22] John Paul II, *Encyclical Letter*: *Evangelium Vitae,* Vatican City: Libreria Editrice Vaticana, 1995. May be accessed online at http://www.vatican.va/edocs/ENG0141/__P15.HTM.

[23] USCCB, *Ethical and Religious Directives for Catholic Health Care Services, 5th ed*. (Washington, DC: United States Conference of Catholic Bishops, 2009)

[24] Each directive within the ERD is numbered and in common usage is simply stated as ERD followed by the number of the directive.

(ERD 70 and 45). Partnerships with non-Catholics also must respect Catholic teaching and discipline (ERD 68).

While the ERD are commonly understood to be binding on hospitals, this is not strictly true under Canon Law. The ERD are national guidelines developed by the USCCB and recommended for implementation by each diocesan bishop for the hospitals in his diocese.[25] The ERD do not include any requirements for reporting violations to the ethical board of the hospital or the diocesan bishop, nor is there any mechanism for ensuring how the guidelines are interpreted by hospitals. This means for example, that a hospital could perform direct sterilization simply by internally interpreting the procedures as indirect sterilizations.

This issue of uniform interpretation and practice of the ERD at Catholic hospitals has drawn increased scrutiny by professionals and the news media in the last few years. In 2005, a Task Force of the Catholic Medical Association[26] devoted to the ERD exposed several issues regarding the changing nature of Catholic hospitals. The Task Force report states that there is much pressure to include provisions for "immoral reproductive services" in contracts for mergers and acquisitions between Catholic and non-Catholic health providers. The Task Force further asserts that a primary area of concern in the

[25] In the United States, as a rule, each state is divided into dioceses which are territories over which a bishop has ecclesiastical jurisdiction. Diocese boundaries and choice of bishops are determined by the Pope.

[26] The Catholic Medical Association (CMA) is an organization of Catholic physicians founded in 1912. They support one another and Catholic facilities in maintaining their Catholic identity and support of official Church teaching. CMA began publishing a quarterly journal, *Linacre Quarterly*, in 1932 dedicated to medical ethics.

contracts is the provision of female tubal ligations which are frequently offered during an inpatient stay after childbirth. [27]

In July of 2008, *Our Sunday Visitor Newsweekly* (OSV), a national Catholic newspaper reported on allegations of widespread practice of tubal ligations in Catholic hospitals in Texas. The author, Ann Carey, based her reporting on a compilation of statistics from the Texas inpatient hospital public use data files completed by a group of medical researchers investigating the occurrence of direct sterilizations and legally induced abortions occurring from 2000-2003. [28] Their data was published anonymously on Wikileaks.org[29], and indicates over 9,600 women were explicitly diagnosed for direct sterilization during the time period. Ms. Carey reported that the study added clarity to information available to the public at a healthcare consumer website (www.txpricepoint.org) also reporting numerous sterilizations at Catholic hospitals in Texas. The story was picked up by many major Catholic news agencies around the world.

According to an independent group of researchers responding to the Wikileaks article, "The directives, however, suffer from crippling defects: no consequences for violations, no means of reporting violations, and no independent oversight."[30] The independent group stated that the Wikileaks data established that 23 of 40 Catholic

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[27] Task Force on the Religious and Ethical Directives of the CMA. "Report of the Task Force on Ethical and Religious Directives," *Linacre Quarterly*, (May, 2005): 184.

[28] Ann Carey, "Texas Bishops Examine Reports of Ethical Lapses at Catholic Hospitals," *Our Sunday Visitor*, July 1, 2008.

[29] WikiLeaks is a not-for-profit media organization. Their goal is to publish on the internet important news and information to the public. Their uniqueness is their ability to publish information from authors who need to remain anonymous due to threats from loss of jobs or life.

[30] Wikileaks. "US Catholic Healthcare Systems Betray Their Mission: Scope of the Violations and Response to the Crisis." http://wikileaks.org/w/images/Review-Narrative2.pdf (accessed Nov. 4, 2009).

hospitals in six systems in Texas explicitly provided prohibited procedures. They also noted that this signaled a potential nationwide failure to ensure compliance with the directives.

Two other authors writing about Catholic hospitals expose potential problems involving major Catholic hospital systems. Leonard Nelson, in *Diagnosis Critical*, examines two specific Catholic hospital systems, Providence Health System and Ascension Health, and reflects upon their struggle to maintain Catholic identity. Nelson states that in some instances these systems have entered into arrangements through mergers and acquisitions of non-Catholic facilities which have put them in the position of providing procedures in violation of the ERD.[31] William Bassett in an article in the *Journal of Contemporary Health Law Policy* expresses his concerns that the legal requirements being imposed by mergers and acquisitions may undermine the prohibition of immoral procedures in Catholic hospitals. Basset reports that while some hospitals are making great attempts to maintain their allegiance to the moral teachings of the Catholic Church, others are capitulating to local pressure to devise options for the provision of illicit procedures. [32]

In 2010 an issue arose that illustrated not only the problem of some Catholic hospitals performing illicit procedures, but also the problems that arise from divergent interpretations of the ERD. Bishop Thomas J. Olmsted of the Diocese of Phoenix, Arizona earlier in that year excommunicated a religious sister at St. Joseph's hospital, a

[31] Leonard J. Nelson, *Diagnosis Critical: The Urgent Threats Confronting Catholic Health Care* (Huntington, IN: Our Sunday Visitor Publishing Division, 2009), 113, 116-117, 124-130.

[32] William Bassett , "Private Religious Hospitals: Limitations upon Autonomous Moral Choices in Reproductive Medicine," *Journal of Contemporary Health Law Policy* (Summer, 2001): 445.

member of the Catholic Healthcare West system, for assenting to a direct abortion in violation of ERD 45. In an open acknowledgement of contrary interpretations of the ERD, Daughter of Charity, Sr. Carol Keehan, CHAUSA president and CEO, stated that the hospital was in compliance with the ERD concerning the abortion. [33] In subsequent investigations of St. Joseph, the Bishop learned that the hospital had violated other provisions of the ERD and had been performing direct sterilizations. As a result, he removed the Catholic status of the hospital. The Bishop explained his actions by issuing a statement on December 21, 2010.[34]

This dissertation seeks to establish a more precise picture of Catholic medical practice in several states to determine if indeed the provision of practices prohibited by the ERD is as nationally widespread across the nation as suggested in the analysis from Texas, the evaluations of Nelson and Basset, and news reports. To narrow the scope of the research, this dissertation will examine the provision in Catholic facilities of specific procedures for direct sterilization. The consequence of this research is of pressing concern as the significant discrepancy of practice among Catholic institutions could affect the ability of Catholic health care providers to appeal to the existing conscience clauses in U.S. and state laws. A diversity of practice has the potential to affect judicial challenges against individual Catholic hospitals or systems of Catholic hospitals, and to affect the ability of Catholic institutions to present a united political position on issues affecting conscience clause legislation.

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[33] Filteau, Jerry, "Catholic Health Association Backs Phoenix Hospital." *National Catholic Reporter*, December, 22, 2010

[34] Rob DeFrancesco, "St. Joseph's Hospital No Longer Catholic." Diocese of Phoenix. http://www.arizonacatholic.org/wp-content/uploads/2010/12/NEWS-RELEASE-PHOENIX-DIOCESE-122210.pdf (accessed 21 January, 2011).

Literature Review of Conscience Clauses

The "conscience clauses" are those clauses enacted by the U.S. Congress or state legislatures to protect the human rights of health care professionals and entities from forced involvement in health care activities that may violate their moral beliefs. Many institutions and persons who favor health care as a "right," and who believe that professionals and hospitals have a duty to provide all legally permitted services (including morally controversial ones) stand in opposition to these clauses.

This following review investigates the historical development of the conscience clauses and the opinions of scholars regarding the necessity of the clauses. Some scholars are directly opposed to the clauses, while other scholars support their existence in various forms. The recently enacted health care reform acts[35] will most likely affect the current conscience clauses. The courts and the legislature will then have new challenges as they attempt to uphold religious freedom in the face of cultural challenges regarding what are being termed women's "reproductive rights."

Conscientious Objection in United States Law

American law first recognized conscientious objector status in relation to the draft for military service in various Selective Service Acts.[36] Persons seeking conscientious objector status not covered by the Acts challenged the Selective Service Acts in court. After two notable cases, United States v. Seeger [380 U.S. 163 (1965)] and then in Welsh

[35] P.L. 111-148, the Patient Protection and Affordable Care Act was signed into law by President Obama on March 23,2010 and is accompanied by the P.L. 111-152, the Health Care and Education Reconciliation Act of 2010 which amended P.L. 111-148 and was signed into law on March 30, 2010. Together, they are generally referred to as the health care reform acts.

[36] The first of these was the Selective Service Act of 1917 which initially defined conscientious objector status. This was followed by the Act of 1948 and then updated again in 1967.

v. United States [398 U.S. 333 (1970)], many individuals could qualify as conscientious objectors for the military draft based upon their moral objection to participating in wars.[37] Supreme Court decisions had already begun to extend conscientious objection to other situations. For example in Sherbert v. Verner [374 U.S. 398 (1963)] the Court decided for Sherbert when she applied for unemployment compensation because her employer placed her on a six day shift which required her to work on Saturdays. As a Seventh-day Adventist, her religious beliefs prevented her from working on Saturdays and she felt compelled to quit her job when her employer would not accommodate her beliefs.

Justice William Brennan, writing for the majority, warned that the religious requirements of a minority religion can easily be "trod upon" by the practices of the majority unless the nation offers specific protections.[38] Brennan argued that in cases in which the state places a substantial burden on a person's free exercise of religion, religious practice must be accommodated—even if it means offering some individuals special advantages—unless there exists "a compelling state interest" for not doing so.[39]

Two additional major U.S. Supreme Court cases extended the definition on conscientious objection supported by religious freedom. The first was *Thomas v. Review Board of Indiana Employment Security* [450 U.S. 707 (1981)] in which a Jehovah's Witness quit his job because building tanks violated his religious beliefs. He applied for unemployment compensation and was turned down. The Supreme Court sided with Thomas. The second case, *Frazee v. Illinois Department of Employment Security* [489

[37] Ronald B. Flowers, To Defend the Constitution: Religion, Conscientious Objection, Naturalization, and the Supreme Court. ATLA Monograph Series, 48. Lanham, Md: Scarecrow Press, 2003. 75.

[38] *Sherbert v. Verner* 374 U.S. 398 (1963).

[39] Ibid.

U.S. 829 (1989)] involved a case in which the appellant was refused unemployment compensation because he refused to work on a Sunday. In its decision supporting Frazee, the court referred to its finding in Thomas. It stated that

> Undoubtedly, membership in an organized religious denomination, especially one with a specific tenet forbidding members to work on Sunday, would simplify the problem of identifying sincerely held religious beliefs, but we reject the notion that to claim the protection of the Free Exercise Clause, one must be responding to the commands of a particular religious organization. [489 U.S. 829 (1989)]

Because of this decision, lower courts have taken a hands-off approach in which "an employer contends that an employee's beliefs are motivated by personal preference, rather than religious conviction."[40] As a result, conscientious objection eventually applied broadly to any individuals legally compelled to participate in any work or join a group where they would be required to participate in actions contrary to their religious beliefs. However, the Sherbert test was applied in *Employment Division v. Smith* [498 U.S. 872 (1990)] to find in "a compelling state interest" when two employees were terminated due to the religious use of peyote in religious ceremonies. Since the State of Oregon had a statue in place which prohibited the use of peyote by anyone, the law superseded the religious rights of the individuals.

Conscience Clauses in U.S. Health Care

The issues of conscientious objection in health care provision are more complicated than those in selective service cases, but could end up being related to the employment provisions. The issue first arose in 1972 in a local court case involving a

[40] Michael Wolf, Bruce Friedman, and Daniel Sutherland, *Religion in the Workplace: A Comprehensive Guide to Legal Rights and Responsibilities* (Chicago: Tort and Insurance Practice, American Bar Association, 1998), 31.

couple suing a private Catholic hospital, St. Vincent's in Billings, Montana, to force the hospital to perform a tubal ligation after a planned Caesarean section. The tubal ligation would be in violation of the hospital policies. St. Vincent's adhered to the ERD for Catholic Hospitals issued by the U.S. Conference of Catholic Bishops which states that Catholic hospitals may not perform tubal ligations, abortions and other procedures which violate human dignity. While the case was appealed by St. Vincent's to the Ninth Circuit Court, [523 F.2d 75] St. Vincent's was enjoined by the lower court to perform the procedure due to the fact that the hospital had received federal funds through the Hill-Burton Act and tax benefits from the state. By the time of the appeal, federal legislation had passed which forced the court to find in favor of the hospital.[41]

The Montana case, in addition to concerns about other potential conflicts arising after the U.S. Supreme Court ruling in Roe v. Wade, prompted the enactment of conscience clauses in federal and state legislation that provide protection for conscientious objection for health care providers and institutions. In 1973, Senator Frank Church introduced legislation to specifically protect the conscience rights of health care workers and entities that refuse to participate or provide sterilizations or abortions based upon moral or religious convictions. The first of the Church Amendments [42 U.S.C. 300a-7][42] enacted by Congress at various times during the 1970's has three provisions. As listed in the Federal Register, the first provides that any individual or entity receiving grants, contracts, loans, or loan guarantees by the Department of Health and Human Services (HHS) does not authorize any court, public official or other public authority to

[41] Taylor v. St. Vincent's Hospital, Mont. 369 F.Supp. 948 (1973).

[42] The first Church amendment was enacted as part of the Health Programs Extension Act of 1973 [P.L. 93-45]

require "1) an individual to perform or assist in a *sterilization procedure or an abortion*, [emphasis added by the author] if it would be contrary to his/her religious beliefs or moral convictions" [42 U.S.C. 300a-7]. The second requirement further extends to any entities stating that they do not have to make their facilities available for such procedures. The last provision states that entities may not be forced to provide personnel for the performance or assistance in such procedures on the basis of religious beliefs or moral convictions of such personnel.[43]

The second, third, fourth and fifth revisions of the Church Amendments broaden the conscience clause provisions to provide further protection for health care workers and entities. The second prohibits any entity from *discriminating* against any physician or health care personnel because of his religious beliefs or moral convictions respecting sterilization procedures or abortions [42 U.S.C. 300a-7(c)(1)]. The third also addresses discrimination but includes any entities receiving *grants or contracts for biomedical or behavioral research* under any program administered by HHS [42 U.S.C. 300a-7(c)(2)]. The fourth provision extends the protections to health care workers for *any activity* which would be contrary to his religious beliefs or moral convictions [42 U.S.C. 300a-7(d)]. The final provision of the Church Amendments addresses discrimination against applicants (including internships and residencies). The amendment provides protection for individuals applying for medical positions who, "for *training or study* [emphasis added by author] because of the applicant's reluctance, or unwillingness, to counsel, suggest, recommend, assist or in any way participate in the performance of abortions or

[43] A complete summary of the Church Amendments may be found in the Federal Register/Vol. 74, No. 45/Tuesday, March 10, 2009.

sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions." [42 U.S.C. 300a-7(e)]

In the 1996, Congress passed the Public Health Service Act Sec. 245 [42 U.S.C. 238n]. This act gave very specific provisions under which an individual could not be discriminated against. It put teeth in the act by providing that legal status (including a State's determination of whether to issue a license of certificate) could be withheld from any entity, who, while training physicians if they required those physicians "(1) to perform induced abortions; or (2) to require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training" [42 U.S.C. 238n].

Extending the conscious clauses to include federal funding by the Departments of Labor and Education in addition to HHS and the Public Health Service, the Weldon Amendment was attached to the 2005 Consolidated Appropriations Act [Public Law 108-447, 118 Stat. 2809, 3163 (Dec. 8, 2004)]. This act specifically addressed abortions, but it also broadened the definition of a health care entity to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." Since the Weldon Amendment was attached to an appropriations bill, it required renewal every year and was successfully incorporated into Consolidated Appropriations Acts through 2009.

Activists for abortion and reproductive rights, however, have been maneuvering around the federal amendments to find new avenues to fight for these abortive and sterilization services as rights of access. As early as 1976, a group challenged in the New

Jersey state courts the right of non-profit non-sectarian hospitals to refuse abortion services in Doe v. Bridgeton [366 A.2d 641 (N.J. 1976)]. The defendants in the case had contended that the group of hospitals they represented was a private nonprofit group governed by their board of trustees and that they had the absolute right to determine who should use their facilities and whether elective abortions should be permitted. The defendants won the initial case. While the cause was pending on appeal, an act referred to as the "conscience laws" was enacted in New Jersey [N.J.S.A. 2A:65A-1 et seq.] to allow hospitals to refuse to do procedures for sterilizations and abortions. Despite the new Act, on appeal to the New Jersey Supreme Court, the Court found in favor of the plaintiffs and struck down the statue as applied to non-sectarian hospitals. The court held that secular hospitals could not invoke conscientious objection.[44] The defendants did not pursue further appeals in the case.

Continued interest by the ACLU in opposing state conscience clauses is evident in the 1997 Alaska case of Valley Hospital Association, Inc. v. Mat-Su Coalition for Choice. Valley Hospital, a private non-profit, non-sectarian hospital in Alaska created a new abortion policy for the hospital restricting abortions except in certain cases such as a result of rape or incest, or if the pregnancy threatened the mother's life. The Mat-Su Coalition for Choice represented by the Alaska ACLU opposed the policy and filed suit. While the plaintiffs won the initial case, the appeal to the Alaska Supreme Court ruled in favor of the Coalition holding that the hospital was required to allow elective abortions

[44] Doe v. Bridgeton Hospital Ass'n, Inc, 71 N.J. 478 (NJ Supreme Ct. App. 1978).

on its premises.[45] Marueen Kramlich writing in the *Fordham Urban Law Journal* summarizes the action as follows.

> According to the court, several factors transform the hospital into a 'quasi-public' actor, including: the state's granting of a certificate of need to the hospital; the receipt of federal and state funds for construction and operation of the hospital; and the fact that the hospital's board is drawn from the community.[46]

In effect, Kramlich argues, the Court "ultimately struck down the state conscience laws as applied to this hospital, holding there is not compelling state interest in the conscience rights of the hospital."[47]

Kramlich reviews actions regarding Catholic mergers with non-Catholic hospitals illustrating the effectiveness in which actions brought by organizations such as the ACLU have prevented or attempted to prevent the mergers based on the fact of restrictive reproductive services. She notes that strategies of these organizations could be quite effective especially in areas in which hospital services are limited such as in rural locations.[48]

Positions on the Conscience Clauses

The literature regarding conscience clauses reflects two fundamental views on health care that are reflected in positions on the conscience clauses. Pellegrino in *the Philosophy of Medicine Reborn* illustrates the two positions as he examines medicine today and the role of the physician. He distinguishes between the goals and the ends of

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[45] Valley Hospital Association v. Mat-Su Coalition for Choice. [948 P.2d 963 (Alaska 1997)].

[46] Maureen Kramlich, "The Abortion Debate Thirty Years Later: From Choice to Coercion," *Fordham Urban Law Journal* XXXI, no. 31 (2004): 783.

[47] Ibid.

[48] Ibid.

medicine suggesting that when a community focuses on the goals of medicine, they can construct medicine to be anything they desire. A constructionist worldview, held by many in today's society, propounds that a community constructs reality, meaning, and morality. Thus, medicine becomes "primarily a social endeavor since its concepts of disease, illness, healing, and health are all socially defined."[49] Pellegrino emphasizes his point by referring to the Hasting Center Goals of Medicine project report in which, he claims, "the goals of medicine are arrived at by social dialogue, consensus formation, political process or negation." [50] In this socially constructed view of medicine and medical ethics, the goals of medicine could be constantly changing.

Such perspective views any legal medical procedure as an entitlement or human right with the provider's rights as subservient to the rights of the patient. It eventually places the burden on the government, both Federal and state, to define and ensure provision of health care. It could also require that the government determine which patients have access to medical care and stipulate who should provide it. In addition it could specify the responsibilities of the patient in determining how care should be reimbursed—this could include increased taxes or required health insurance on the part of the patient. The provider, seen as an agent of the state or legally bound medical care giver, would be required to provide services regardless of personal objection.

[49] Edmund Pellegrino, D.H. Engelhardt, and Fabrice Jotterand, *The Philosophy of Medicine Reborn : A Pellegrino Reader*. Notre Dame Studies in Medical Ethics. (Notre Dame, Ind: University of Notre Dame Press, 2008) 142. Dr. Pellegrino is one of the founders of bioethics and served as the Chairman of the President's Council on Bioethics from 2005-2009.

[50] The Hastings Center is a research institution dedicated to bioethics. Pellegrino refers to its report *The Goals of Medicine: Setting New Priorities* published in 1996.

Pellegrino describes the alternative view as an essentialist construction which focuses on the ends of medicine rather than society's defined goals. The ends are derived from the nature of medicine itself. It is the need of the sick person for care, cure, help and healing. This is medicine as it was originally conceived from Hippocrates and practiced by physicians throughout time even to the present day. He concludes by explaining that "medicine exists because humans become sick." Its purpose is to "heal, help, care and cure, to prevent illness and cultivate health."[51] The provider is primarily a care giver who will do his best according to his conscience to ensure that the patient is receiving care that alleviates pain and suffering and helps to establish a better quality of life based upon proper medical treatment of underlying ailments and the prevention of disease. While the provider has a right to payment, his primary concern is treating the patient to the best of his ability.

Many providers abiding by Catholic teaching on health care have adopted what Pellegrino calls the essentialist position. These providers do not consider procedures such as routine abortion and tubal ligations as health care to be necessary because no pathology is being treated. If a provider refuses specific treatment for such procedures, the patient has a right to be informed of this and to seek treatment elsewhere. Thus, in general, those who believe the final end of medicine to be relief from pathology would support the conscience clauses and consider that the religious freedom clause of the First Amendment (protecting, in this case, the conscience of the provider) would outweigh the right to privacy interpretations of the Fourteenth Amendment in support of individual reproductive rights.

[51] Pellegrino, 142.

Support for Conscience Clauses

In the view of medicine as an end, scholars such as Richard Myers[52], writing for the National Catholic Bioethics Center, provides a legal perspective in support of the conscience clauses. He discusses the threats to religious liberty in the California law requiring all employers providing health insurance to offer all reproductive services. Myers includes discussion of a similar proposal in Washington, D.C. He expresses concern about the separation between religious and secular views on life issues, and he compares the logic of these arguments to other areas of law. For an example, he draws upon the legal requirement that landlords must rent to unmarried couples regardless of the moral beliefs of the landlords. Because renting is "commercial" activity and is therefore not considered religious, renting is not entitled to protection under religious liberty. Myers claims that the same logic would apply to health care if health care were not considered a "religious activity." If, like the renting of real estate, heath care were considered commercial, institutions would be expected to abandon their religious missions and provide "secular" health care.[53]

Similar to the renting example that Richard Myers illustrates, The American Civil Liberties Union does not view health care as falling under the blanket of protection that religious liberty affords; rather, the ACLU argues as follows:

> When, however, religiously affiliated organizations move into secular pursuits—such as providing medical care or social services to the public or running a

[52] R. S Myers, "On the Need for a Federal Conscience Clause," *The National Catholic Bioethics Quarterly*, Vol. 1 (2001), 24. Richard Myers is a Professor of Law at the Ave Maria School of Law in Ann Arbor, Michigan. Other contributors to the article are John Haas, President of the National Catholic Bioethics Center, Carol Hogan, Associate Director of the California Catholic Conference, and Germain Grizez, Ph.D., Professor of Christian Ethics at Mount St. Mary's College in Emmitsburg, Maryland.

[53] Ibid.

> business—they should no longer be insulated from secular laws. In the public world, they should play by public rules. The vast majority of health care institutions—including those with religious affiliations—serve the general public. They employ a diverse workforce. And they depend on government funds.[54]

According to the ACLU, the public arena is strictly secular; the right to moral or religious convictions, the "specific protections" of minorities that were upheld by the ruling of Sherbert v. Verner [374 U.S. 398 (1963)] are here brushed aside in favor of what the ACLU names "public rules."

Myers, by contrast, promotes a comprehensive solution in the provision of a federal law providing for full protection of conscientious objections for institutions and individuals. In "On the Need for a Federal Conscience Clause," he argues the following:

> Legislation of this sort is absolutely necessary in order to preserve the essential liberty of religious organizations and individuals to define the very nature of their ministries and to preserve the liberty of all of those with conscientious objections from being forced to support morally objectionable activities. [55]

An article by Wesley Smith in *First Things* is cogent as Smith describes the current state of affairs in medicine and predicts what the future holds if our conscience clauses cease to exist, or are not drafted to be more inclusive. Smith explains,

> Over the past fifty years, the purposes and practices of medicine have changed radically. Where medical ethics was once life-affirming, today's treatments and medical procedures increasingly involve the legal taking of human life. The litany is familiar: More than one million pregnancies are extinguished each year in the United States, thousands late-term. Physician-assisted suicide is legal in Oregon, Washington, and, as this is written, Montana via a court ruling (currently on appeal to the state supreme court). One day, doctors may be authorized to kill

[54] Catherine Weiss, "Testimony of ACLU Reproductive Freedom Project Director Catherine Weiss on Refusal Clauses in the Reproductive Health Context before the House Energy and Commerce Committee Health Subcommittee," (ACLU, July 12, 2002) http://www.aclu.org/reproductive-freedom/testimony-aclu-reproductive-freedom-project-director-catherine-weiss-refusal-cl. (accessed March 26, 2011)

[55] Myers, 26.

> patients with active euthanasia, as they do already in the Netherlands, Belgium, and Luxembourg. [56]

Smith concludes that the "rights of medical conscience need to be expanded and made explicit" and suggests general principles that should be used in crafting such protections.[57]

Robin Wilson, Professor of Law at the Washington & Lee University School of Law, maintains that the controversy over the conscience clauses is mainly due to the increasing number of pharmacists refusing to fill prescriptions for Plan B, a morning after contraceptive pill considered by many to also be an abortifacient. Wilson does an exhaustive review of state laws as well as federal ones regarding support and lack of support for conscience clauses. He concludes that we must make a choice between what we prize more highly--access to health services or religious freedom. Wilson states:

> They could choose not to burden the professional's choice at all--prizing religious liberty more highly than access. They could force providers to provide every service legally requested--prizing patient access more highly than moral or religious freedom. Or they could choose to allow individuals of conscience to exempt themselves up to the point that it creates a hardship for the patient or employer. In a pluralistic society, a live-and-let-live regime like this may be the most we can hope for.[58]

Positions against the Conscience Clauses

Currently, patient access focuses mainly on reproductive health care. Most of those opposing the conscience clauses are groups and individuals who consider women to

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[56] Wesley J. Smith, "Pulling the Plug on the Conscience Clause," *First Things* no.198 (December 2009) 41.

[57] Ibid., 43.

[58] Robin Fretwell Wilson, "Essay: The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures," *American Journal of Law and Medicine*, Vol. 34 (March, 2008), 63.

have "reproductive rights" and believe that physicians have a duty to treat a woman according to her wishes regardless of the physician's or hospital's ethical considerations. According to Asha Moodley,

> …reproductive rights refer to a group of legal and ethical principles, central to which is the notion of control. More specifically, reproductive rights are about women's ability to control what happens to their bodies and their persons through legal and ethical principles which protect and enhance their ability to make and implement decisions about their reproduction.[59]

In reviewing the positions of those who wish to limit or eliminate the conscious clauses because of women's reproductive rights, the position that was most interesting because of its origin was that of the American College of Obstetricians and Gynecologists (ACOG). The ACOG Committee on Ethics issued an opinion paper titled "The Limits of Conscientious Refusal in Reproductive Medicine." It held that "conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled."[60] The paper stated further that "lawmakers should advance policies that balance protection of provider' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services."[61]

These recommendations raise concern over whether ACOG could cease to give board certification to obstetricians and gynecologists who refuse to abide by the recommendations. The Christian Medical Association responded strongly to the recommendations and asked Secretary Michael Leavitt of the U.S. Department of Health

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[59] Asha Moodley, "Defining Reproductive Rights," *Agenda: a Journal about Women and Gender*, no. 27 (1995), 8.

[60] American College of Obstetricians and Gynecologists (ACOG), "The Limits of Conscientious Refusal in Reproductive Medicine" *Obstetrics and Gynecology* 110, no. 5 (November 2007), 1203.

[61] Ibid., 1207.

and Human Services to intervene. He did by expressing "strong concern" that the ACOG position might run counter to the conscience clauses stating that "health care organizations that require ABOG [the Board that certifies obstetricians and gynecologists] certification could be in danger of violating the Weldon Amendment."[62]

Hypotheses and Assumptions

The Ethical and Religious Directives (ERD) for Catholic Health Care issued by the USCCB are very explicit in affirming the Catholic position on direct sterilizations and the responsibilities of the hospitals and their employees in following the ERD. The bishop within each diocese is responsible for overseeing the ethical directives for the hospitals in his diocese. The hospitals are to prepare their official hospital policies based upon them under the guidance of the bishops. The hospitals usually are sponsored by religious orders that are also responsible for overseeing the morality of their practice. However, the hospitals establish their own policies and monitor their own compliance without any official mechanisms for external review by ecclesial superiors. The individual hospitals are most often affiliated with large hospitals systems that cross diocesan and state boundaries. These systems are in a state of flux as they merge or purchase other hospitals including non-Catholic ones. In mergers or purchases of non-Catholic hospitals, they must gain the approval of the local bishop or the Vatican ensuring compliance with the ERD. However, compliance with the requirements and the

[62] The full text of the letter issued by Secretary Leavitt may be found in a news release by the U.S. Department of Health and Human Services on their website at http://www.hhs.gov/news/press/2008pres/03/20080314a.html.

ERD has depended solely on the good faith efforts of the religious orders responsible for the hospitals and their interpretation of the ERD.

There have been public reports of divergent practices regarding interpretation and application of the ERD. This diversity seems to arise because hospitals have differing visions for Catholic health care and because there are no mandatory system-wide mechanisms for accountable practice of the ERD. In the absence of uniform interpretation of the ERD, some hospitals have had no Catholic objection to providing procedures that other Catholic hospitals oppose. Consequently, the Catholic hospitals opposing certain procedures could have their claim to object as Catholics seriously undercut. The courts, confronted with divergent Catholic practice could conclude that a given Catholic hospital could not refuse procedures based on Catholic identity. Such a hospital could then be judged in the same manner as a secular non-profit hospital as in the case of Valley Hospital in Alaska. (See p. 21.) Furthermore, since Catholic hospitals have differing practices, their ability to engage in effective political advocacy could be diminished or destroyed. Hospitals permitting what other hospitals oppose cannot be expected to support the conscience clauses in the same way.

The extent of diversity that exists among Catholic hospitals needs to be quantified in order to assess the judicial and political risk of reliance upon the conscience clauses to protect the rights of Catholic hospitals to refuse to offer procedures considered morally objectionable. This dissertation will examine the patient records from three years of data obtained from over 200 Catholic hospitals in seven states to ascertain if there is indeed a diversity of practice in offering direct sterilizations in violation of official Catholic teaching. A major diversity in practice will bring into question the ability of Catholic

identity or the ERD to provide individual hospitals with a legal basis for appealing to the conscience clauses when they face legal challenges regarding their refusal to provide procedures considered inhumane and immoral by the hospital and the Catholic Church.

CHAPTER TWO

Operational Definitions, Data Collection and Methodology for Analysis

This dissertation investigates the practices of Catholic hospitals operating in seven states across the nation to determine if there is a lack of uniformity in interpretation and application of Catholic teaching and what might be the effect of divergence of practice on a legal defense for conscientious objection. To aid the reader of this study, a list of operational definitions precedes the discussion of methodology and data collection.

Operational Definitions

Hospital Inpatient Discharge Data

Hospitals track patient data by coding information from the patient's record upon discharge from the hospital. For hospital stays lasting one night or more, the information is considered to be inpatient data. Outpatient data is maintained separately for procedures such as one-day surgery where the patient is discharged the same day in which the surgical procedure is performed. While some outpatient data was collected for this study, only inpatient discharge data is used in the analysis.[63]

[63] According to Robert Zurawin, MD, Director of Baylor College of Medicine Program for Minimally Invasive Gynecology, outpatient procedures for tubal ligations represent approximately fifty percent of all such procedures. He also states that outpatient procedures are preferred since there is a lower level of patient regret resulting from outpatient procedures. Robert Zurawin and Avi Sklar, "Tubal Ligation," *Medscape Reference*, (January 4, 2011) http://emedicine.medscape.com/article/266799-overview (accessed March 19, 2011).

Public-Use Data Files

The federal government's Nation Center for Health Statistics (NCHS) collects data including inpatient discharge data records from hospitals throughout the nation. Its purpose is to research various medical, quality, and cost issues and to create reports that can be useful in identifying needs and determining trends. It makes their data available to medical researchers based upon certain restrictions; thus, the name "public-use data." Many states have mandates from their state legislatures to collect similar data which usually includes charges, utilization data, diagnoses and procedures for the purposes of promoting cost-effective, quality health care. In most states this process is managed by the department of health of the respective state; however, in some cases, the data collection is controlled by the respective hospital association of the state. These are also usually called public use data files because of their availability to medical researchers. The data collected by NCHS and states ensure patient confidentiality by eliminating patient name and address, and providing encryption on other identifying characteristics.

The public use data collected by NCHS was not useful for this study because it records incomplete data for diagnostic and procedure codes, and it does not provide the individual hospital identification necessary for the study. Public use data files collected independently in many states do provide detailed records including diagnoses and procedure codes for all patients by hospital; therefore, data from individual states was collected for this study. With the exception of California and Indiana, state departments of health charge fees to medical researchers to obtain the data. The fees for data collected and distributed by the state departments of health other than California and Indiana range from a low of $5.00 (New Jersey) to a high of $9,450 (Iowa) per year.

Those states where the data is controlled by the respective hospital association usually have much higher fees and more restrictions on the availability of the data such as in the case of Missouri which is $6,000 per year. Also, there are some states that simply do not collect the data or if they do, the level of specificity is not adequate for the present study. Additionally, to protect patient confidentiality, there are legal requirements that researchers must meet in the form of data use agreements. In all public use data files, identifiers such as name, exact age, and address have been deleted or encrypted; however, there is still concern that confidentiality could be breached. The use of some of the public use data files requires lengthy agreements with stringent restrictions, but with the cooperation of Baylor University, these legal issues have been met.

ICD-9-CM Diagnostic Codes

These refer to the *International Classification of Diseases, Ninth Revision, Clinical Modification*. The International Classification of Diseases is developed by the World Health Organization (WHO) and expanded and published by the National Centers for Disease Control and Prevention (CDC). These codes are the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States and are used for insurance claims and the submission of data to state and national levels. They allow for consistency in evaluating data and generating statistics about illnesses and deaths. There are two major classifications within the codes in the clinical modification published by the CDC. One set is for diagnostic codes to assign diagnoses for the patient and the other for procedure codes to indicate how the patient was treated for accompanying diagnoses. Most of the codes are numeric and include an integer for a major category followed by a decimal and subsequent number to indicate

levels within the major category. In a majority of hospitals, codes are entered into patient databases by well paid coding specialists utilizing physicians' notes. In some cases, the physician themselves may enter the codes into their records which are then transcribed by a specialist into the database. Presumably, errors may sometimes occur in the data entry, but this would be rare given the expertise of the coders and the financial and medical consequences of errors.

Patient Data Sets

The patient data available from the public use data files is usually made available from all hospitals within the state and includes specific data including diagnostic and procedures codes for all patient records for each hospital for each year requested. These data sets are enormous files ranging from 3 gigabytes to 45 gigabytes depending upon the state. The individual patient records contained in the data sets report similar data elements within each state with some variations. The items in the records relevant for this study are the discharge date, the hospital ID and name, the sex of the patient, the ICD-9-CM diagnostic and procedure codes recorded for the patient admission and discharge. The number of codes supplied in a record varied by state. For the diagnostic codes, the range was from nine to twenty five codes. Procedure codes ranged from six to twenty-nine. In the data received from the states, many more fields containing data such as financial information and more specific information regarding the patient and treating physician were supplied, but these were not necessary for this study and were eliminated from the records which were abstracted for the study. An example patient record which includes the fields relevant to the study is given in Figure 1. Note that the example record is truncated and only a few of the many fields for diagnostic and procedure codes

that appear in the actual data are illustrated. It should be noted that all data agreements from the states prohibited the publication of individual patient data, and consequently limits this study to presenting summary tables of the data. Furthermore, the data agreements require that after specified time periods, all patient data must be destroyed.

Discharge Date	Hospital ID	Hospital Name	Patient Sex	ICD-9-CM Diagnostic Codes				ICD-9-CM Procedure Codes	
4/1/2008	1100	Example Hospital	Female	654.21	648.81	V27.0	V25.2	74.1	66.32

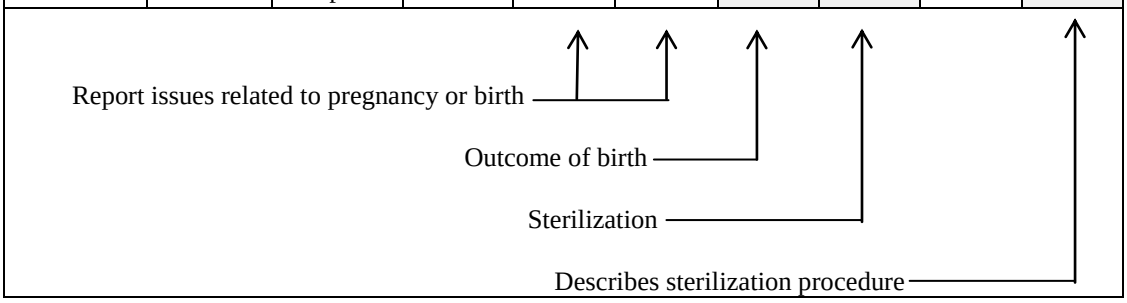

Figure 1. Example Record

V25.2 ICD-9-CM Diagnostic and Related Procedure Codes

The major diagnostic category labeled V25 is a code defined in the classification as "encounter for contraceptive management." As a V code, it is not used to indicate any illness. V25.2 is "sterilization: admission for interruption of fallopian tubes or vas deferens." [64] The patient records containing these codes also have a procedural code which indicates the type of procedure used to cause the direct sterilization such as 66.32 which indicates "other bilateral ligation and division of fallopian tubes: Pomeroy

[64] Centers for Disease Control and Prevention, International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (Atlanta, Georgia, 2010)

operation."[65] Additional procedure codes used explicitly to designate bilateral procedures on the fallopian tubes for sterilization are 66.21, 66.22, 66.29, 66.31, and 66.39.

V27 ICD-9-CM Diagnostic Code

V27 codes indicate outcome of child delivery and provide necessary information to determine if and how many deliveries are performed within a hospital. Analysis of inpatient discharge data demonstrates that procedures for tubal ligations are usually performed after the delivery of a child. Tubal ligations that are not provided after child delivery are routinely done as outpatient procedures and would not be included in inpatient discharge data. Therefore, hospitals without patient records with the V27 codes indicating the availability of obstetric services within the hospital would generally not have V25.2 codes and thus could be easily eliminated from the patient study.

Sterilization/Direct Sterilization

According to 53 in the ERD

> Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.[66]

ERD 53 references a document by the Congregation for the Doctrine of the Faith of the Holy See entitled *Responses to Questions Proposed Concerning "Uterine*

[65] Ibid.

[66] USCCB, *Ethical and Religious Directives for Catholic Health Care Services, 5th ed*. (Washington, DC: United States Conference of Catholic Bishops, 2009) 53.

Isolation" and Related Matters[67] which explains that if a medical procedure has a directly therapeutic character to curtail a serious present danger to the woman then it may be permitted even if it indirectly results in sterilization. The resulting sterilization is often referred to as an indirect sterilization. In the ICD-9-CM coding system, an existing pathology would be signified by a diagnostic code for the underlying illness and the V25.2 code would not therefore be present in the record. For example, if a woman is admitted for an ectopic pregnancy in the fallopian tube, it might require the removal of the fallopian tube. In this case the diagnostic code would be 633.1 and V25.2 would not be present in the record. Therefore, the V25.2 code always indicates a non-pathology based request for a direct sterilization for contraceptive purposes. For this reason, the present study identifies the V25.2 diagnostic code as a direct sterilization. The use of the word sterilization in the paper is to be understood as a direct sterilization.

Data Collection

To collect public use data files of value for this study, the first step was to identify the states with the highest number of Catholic hospitals and investigate the availability of data and the conditions under which the data is made available. The goal was to obtain data from as many Catholic hospitals as possible across the nation and reflect geographic dispersion (Figure 2). The Catholic Health Association of the United States lists all member hospitals on their website (CHAUSA.org). Most Catholic hospitals are members of CHAUSA, so this provided a starting point for determining states with an adequate number of Catholic hospitals to warrant inclusion in the investigation.

[67] Sacred Congregation for the Doctrine of the Faith, *Responses to Questions Concerning Sterilization in Catholic Hospitals,* Vatican City: Libreria Editrice Vaticana, 1975.

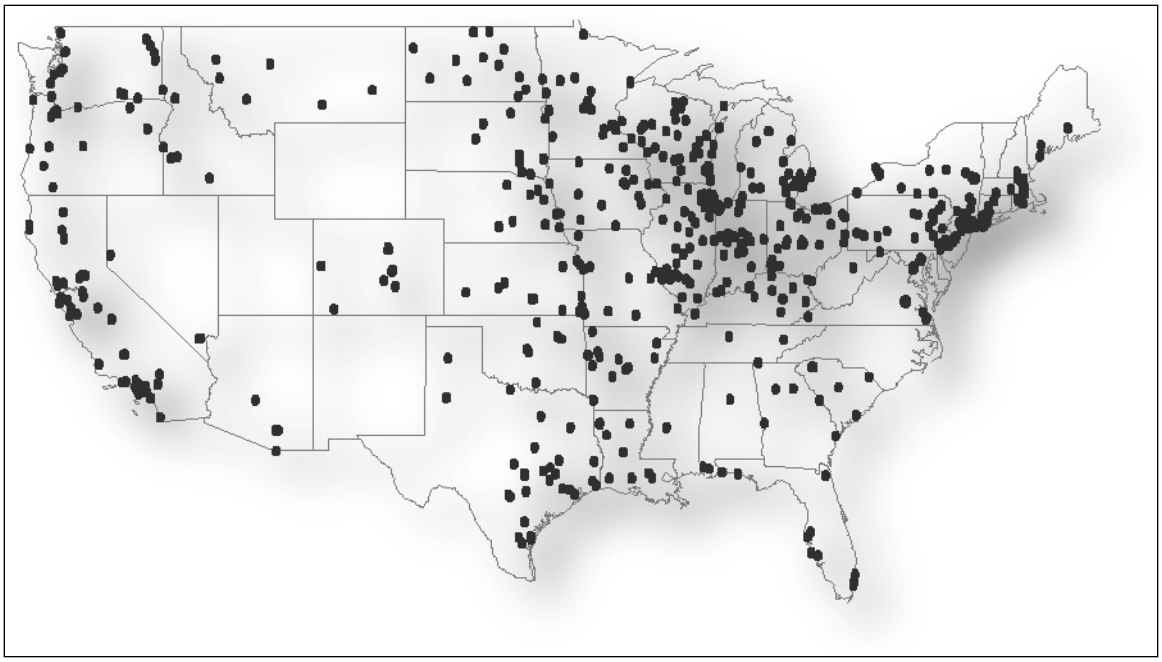

Figure 2. All Catholic Hospitals in the United States (reproduced with permission from the Catholic Health Association ©2010)

The number of CHAUSA hospitals and data availability by state is given in Table 1. States with less than twelve Catholic hospitals are not included in the analysis. To determine data fees and availability, each state department of health was contacted. The states highlighted in gray in Table 1 were chosen for the study due to cost and availability of complete data. Together they provide adequate geographical dispersion and a sufficient number of hospitals and hospital systems to determine if there is a divergence of practice among hospitals and within hospital systems across the U.S.

Table 1: Catholic Hospitals by State as Reported by CHAUSA

State	Number of CHAUSA Hospitals	Data fees and availability
Illinois	48	$1,500 per year
Texas	44	$4,600 per year
California	43	Free
Wisconsin	40	$2,500 per year; managed by hospital association
Indiana	37	Free
Ohio	35	collected data incomplete
Michigan	27	discharge data not available from the Department of Health
New York	26	$1,300 per year
Missouri	22	$6,000 per year; managed by hospital association
Pennsylvania	19	$4,500 per year
Minnesota	17	discharge data not available from the Department of Health
Washington	17	$50 per year
Iowa	16	$9,450 per year
Oregon	15	collected data incomplete
Kentucky	14	$1,500 per year
Louisiana	13	$4,000 per year
Arkansas	12	unable to determine availability
Kansas	12	$6,000 per year
New Jersey	12	$5 per year
Tennessee	12	data not collected

Methodology for Analysis

Three years of data was analyzed for each state with the exception of New Jersey. A total of over 47 million patient records were collected. Multiple years were sought so that trends showing decreasing or increasing incidences of the V25.2 code could be ascertained.

The patient data sets from each state had to be analyzed first to determine all Catholic hospitals within the state. Although the CHAUSA hospitals were already identified, some hospitals do not belong to CHAUSA, and therefore each hospital in the state had to be investigated to determine if it was a Catholic hospital or a merger of a Catholic hospital with another non-profit hospital. *The Official Catholic Directory* editions for 2006, 2009, and 2010[68] were used to aid in locating additional Catholic hospitals and their ownership. Also, websites of Catholic health care systems aided in identifying hospitals. Once the hospitals were identified, all patient records for the respective hospitals had to be abstracted and analyzed for the occurrence of the V27 and V25.2 ICD-9-CM codes and the related procedure codes. This effort required that a special computer program be written and then altered for each state since the formats for the data sets differ from state to state. For each identified hospital, additional information was sought so that trends and variations in practices could be determined within hospital systems, religious orders, and dioceses. Also, changes in hospital names, ownership, and mergers had to be analyzed over the years under investigation. This required contact with the hospitals involved to ensure correct information was being obtained. In many

[68] *The Official Catholic Directory: Anno Domini 2006.* 2006th ed. New Providence, NJ: P.J. Kenedy & Sons. The 2009 and 2010 editions were also used for the study.

cases, the hospitals had websites that contained sufficient information. In other cases, contact was made with the respective hospitals. A table was constructed for each state listing all the Catholic hospitals within the state which contained V27 codes. This indicated that a hospital provided at least some obstetrical services and could be analyzed for the occurrence of the V25.2 codes. For each hospital, the most recent name of the hospital, and the city and diocese in which it is located are included in the table, as well as the health care system to which it belongs, if it is a part of one, and the religious orders responsible for or involved in the hospital or system. Also, for each hospital, the number of women giving birth within the hospital for the combined years is given followed by the total incidences of the V25.2 codes. A percentage for the incidence of the V25.2 codes to women giving birth was calculated, followed by the number of V25.2 codes by year. A narrative summarizing the findings and analyzing any variances among dioceses and hospital systems is given. Chapter Three provides an analysis of the inpatient data for each of the seven states studied.

In a further effort to verify the data under supervision of the author, the data was analyzed by a faculty member of the Computer Science Department and a doctoral student in the Sociology Department of Baylor. The small discrepancies they found in the state of California (an under reporting of 14 V2.5 codes) and in Indiana (an over reporting of five V25.2 codes) were corrected such that Chapter Three reflects the changes.

CHAPTER THREE

Direct Sterilizations in Catholic Hospitals in Seven States across the United States: Analysis and Summary of Findings

Patient data for 2007-2009 was obtained from 239 Catholic hospitals in seven states across the United States to investigate the incidence of sterilizations by hospital, health care systems, religious orders, and dioceses within each state. This allowed for the determination of diversity of practice not only within the state, but also within health care systems, dioceses and the religious orders responsible for the hospitals. The data is presented by states in alphabetical order and followed by a review of interstate hospital systems. A conclusion summarizes all of the findings.

California Catholic Hospitals

The state of California contains more Catholic hospitals than any of the other states investigated. Fifty-eight Catholic hospitals were identified of which 48 reported births. The California Office of Statewide Health Planning and Development provided the inpatient discharge data for the state for the years 2007, 2008 and 2009. The Office made the data available free of charge for research purposes with strict requirements about confidentiality and handling of the data. All patient records were provided for the 448 hospitals in the state. The file size was16.5 gigabytes. The data was recorded by fiscal quarters in comma separated values format, and contained a total of 25 diagnostic codes and 21 procedure codes per patient record.

Table 2 provides a listing of the 48 acute care Catholic hospitals in the state whose records contained diagnostic codes for women giving birth. The name of the

hospital is followed by the city and diocese in which it is located. If the hospital is part of a system of hospitals, the name of the health care system follows. The data reported in the table for each hospital includes the number of women giving birth for the combined years, the total incidences of the V25.2 codes for the years of the reported data, the percent of V25.2 codes of women giving birth, and the number of patients with V25.2 codes by year. The table is sorted by health care system. For the three year period, a total of 9,318 sterilizations were reported in 33 of the 48 hospitals reporting births. The rate of sterilizations to women giving birth for hospitals which had more than a 0% rate was 5.6%. As is illustrated below, 68.8% of the Catholic hospitals in California provided sterilizations.

Table 2: Analysis of Catholic Hospitals in California 2007-2009

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Bakersfield Memorial Hospital-34th St.	Bakersfield	Fresno	CHW	8,384	527	6.3%	161	172	194
California Hospital Medical Center	Los Angeles	Los Angeles	CHW	13,896	882	6.3%	265	327	290
Community Hospital of San Bernardino	San Bernardino	San Bernardino	CHW	8,343	775	9.3%	310	235	230
Dominican Hospital - Santa Cruz/Soquel	Santa Cruz	Fresno	CHW	3,164	252	8.0%	96	78	78
French Hospital Medical Center	San Luis Obispo	Monterey	CHW	2,476	119	4.8%	48	32	39

Table 2: Analysis of Catholic Hospitals in California 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Glendale Memorial Hospital and Health Center	Glendale	Los Angeles	CHW	4,961	516	10.4%	187	189	140
Marian Medical Center	Santa Maria	Los Angeles	CHW	8,835	545	6.2%	187	197	161
Mercy General Hospital	Sacramento	Sacramento	CHW	8,213	65	0.8%	20	19	26
Mercy Hospital - Bakersfield	Bakersfield	Fresno	CHW	9,743	347	3.6%	138	121	88
Mercy Hospital - Folsom	Folsom	Sacramento	CHW	2,908	64	2.2%	28	19	17
Mercy Medical Center	Redding	Sacramento	CHW	6,124	278	4.5%	82	97	99
Mercy Medical Center Merced-Community Campus	Merced	Fresno	CHW	8,093	898	11.1%	310	305	283
Mercy Medical Center Mt. Shasta	Mount Shasta	Sacramento	CHW	487	28	5.7%	11	9	8
Mercy San Juan Hospital	Carmichael	Sacramento	CHW	9,053	161	1.8%	55	53	53
Methodist Hospital of Sacramento	Sacramento	Sacramento	CHW	3,575	218	6.1%	73	72	73
Northridge Hospital Medical Center	Northridge	Los Angeles	CHW	8,304	1,076	13.0%	371	344	361
Oak Valley District Hospital (2-RH)	Oakdale	Stockton	CHW	907	94	10.4%	22	32	40

Table **2**: Analysis of Catholic Hospitals in California 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Sequoia Hospital	Redwood City	San Francisco	CHW	4,320	156	3.6%	44	47	65
Sierra Nevada Memorial Hospital	Grass Valley	Sacramento	CHW	1,469	84	5.7%	30	29	25
St. Bernardine Medical Center	San Bernardino	San Bernardino	CHW	6,940	0	0.0%	0	0	0
St. Elizabeth Community Hospital	Red Bluff	Sacramento	CHW	2,135	104	4.9%	40	30	34
St. John's Pleasant Valley Hospital	Camarillo	Los Angeles	CHW	1,057	0	0.0%	0	0	0
St. John's Regional Medical Center	Oxnard	Los Angeles	CHW	5,443	0	0.0%	0	0	0
St. Joseph's Medical Center of Stockton	Stockton	Stockton	CHW	7,000	0	0.0%	0	0	0
St. Mary Medical Center	Long Beach	Los Angeles	CHW	8,747	0	0.0%	0	0	0
Woodland Memorial Hospital	Woodland	Stockton	CHW	2,119	225	10.6%	83	73	69
O'Connor Hospital - San Jose	San Jose	San Jose	DCHS	11,092	0	0.0%	0	0	0
Seton Medical Center	Daly City	San Francisco	DCHS	2,122	0	0.0%	0	0	0
St. Francis Medical Center	Lynwood	Los Angeles	DCHS	20,303	0	0.0%	0	0	0
St. Louise Regional Hospital	Gilroy	San Jose	DCHS	1,861	28	1.5%	3	11	14

Table **2**: Analysis of Catholic Hospitals in California 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Citrus Valley Medical Center - QV Campus	West Covina	Los Angeles	Indepen-dent	15,786	1,019	6.5%	325	352	342
Scripps Mercy Hospital	San Diego	San Diego	Mercy	8,819	0	0.0%	0	0	0
Scripps Mercy Hospital - Chula Vista	Chula Vista	San Diego	Mercy	4,197	0	0.0%	0	0	0
Little Company of Mary - San Pedro Hospital	San Pedro	Los Angeles	Providence	2,303	0	0.0%	0	0	0
Little Company of Mary Hospital	Torrance	Los Angeles	Providence	8,074	2	0.0%	0	0	2
Providence Holy Cross Medical Center	Mission Viejo	Los Angeles	Providence	8,147	1	0.0%	0	0	1
Providence Saint Joseph Medical Center	Burbank	Los Angeles	Providence	9,058	13	0.1%	5	6	2
St. John's Health Center	Santa Monica	Los Angeles	SCLHS	5,573	0	0.0%	0	0	0
Mission Hospital Regional Medical Center	Mission Viejo	Orange	St. Joseph	12,763	0	0.0%	0	0	0
Petaluma Valley Hospital	Petaluma	Santa Rosa	St. Joseph	1,589	85	5.3%	32	26	27
Queen of the Valley Hospital – Napa	Napa	Santa Rosa	St. Joseph	2,918	121	4.1%	29	56	36

Table **2**: Analysis of Catholic Hospitals in California 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Redwood Memorial Hospital	Fortuna	Santa Rosa	St. Joseph	1,065	82	7.7%	34	25	23
Santa Rosa Memorial Hospital - Montgomery	Santa Rosa	Santa Rosa	St. Joseph	3,504	249	7.1%	92	91	66
St. Joseph Hospital - Eureka	Eureka	Santa Rosa	St. Joseph	2,075	155	7.5%	51	47	57
St. Joseph Hospital - Orange	Orange	Orange	St. Joseph	15,298	1	0.0%	1	0	0
St. Jude Medical Center	Fullerton	Orange	St. Joseph	6,207	0	0.0%	0	0	0
St. Mary Regional Medical Center	Apple Valley	San Bernardino	St. Joseph	8,551	0	0.0%	0	0	0
St. Agnes Medical Center	Fresno	Fresno	Trinity Health	11,893	148	1.2%	60	42	46
Totals				309,894	9,318		3,193	3,136	2,989

Eight health care systems operate 47 of the 48 hospitals. Two of the smaller systems, Scripps Mercy and SCL Health Systems were consistent in not providing sterilizations within their hospitals. The largest health system in the state is Catholic Health West which operates 26 hospitals with obstetric services. Twenty-one of their hospitals recorded a total of 7,402 sterilizations for the three period representing 6.3% of women giving birth. The next largest Catholic health system operating in California is St. Joseph Health System with nine hospitals providing obstetric services. Of these, six reported a total of 691 V25.2 codes representing 6.2% of women giving birth. The Daughters of Charity Health System operating four hospitals reporting births had only one of their hospitals, St. Louise Regional Hospital, recording V25.2 codes for the period. The hospital reported 28 incidences of V25.2 codes. One other system, Trinity Health, a

large health care system operating only one hospital in the state, reported V25.2 codes. There is one independent hospital, Citrus Valley Medical Center – Queen of the Valley Campus, which also reported V25.2 codes during the period. A complete listing of the hospital systems is given in Table 3. It also includes information about the health care system location and responsible religious orders.

Table 3: Health Care Systems Operating in California

Health System	# of Hospitals Reporting Births	# of Hospitals Reporting V25.2 Codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Sponsoring Orders
Catholic Healthcare West (CHW)	26	21	San Francisco, CA	Sisters of Mercy of the Americas	San Francisco
				Adrian Dominican Sisters	Lansing, Michigan
				Dominican Sisters of Kenosha, Wisconsin	Milwaukee
				Dominican Sisters of San Rafael	San Francisco
				Sisters of Charity of the Incarnate Word of Houston	Galveston-Houston
				Sisters of St. Francis of Penance and Christian Charity	San Francisco
				Franciscan Sisters of the Sacred Heart	Joliet, Il
Daughters of Charity Health System (DCHS)	4	1	Los Altos Hills, CA	Daughters of Charity Province of the West	San Jose
Providence Health and Services	4	3	Torrance, CA	Little Company of Mary	Chicago
Scripps Mercy	2	0	Burlingame, CA	Sisters of Mercy of the Americas	San Francisco
SCL Health System (SCLHS)	1	0	Lenexa, KS	Sisters of Charity of Leavenworth	Kansas City-Kansas
St. Joseph Health System	9	6	Orange, CA	Sisters of St. Joseph of Orange	Orange
Trinity Health	1	1	Detroit	Sisters of Mercy Regional Community of Detroit	Detroit
				Congregation of the Sisters of the Holy Cross	Fort Wayne-South Bend
Independent					
Citrus Valley Medical Center - QV Campus	1	1	Los Angeles	Immaculate Heart Community	Los Angeles

Since Catholic hospitals are responsible to ecclesial authorities, it is also of interest to examine whether there is consistency of practice regarding sterilizations on a diocesan basis. To determine if there is diversity across the twelve dioceses in California, the hospitals were also grouped by diocese. One diocese, Oakland, had no Catholic hospitals located within its boundaries. Only one diocese, San Diego, had no sterilizations in the Catholic hospitals reporting births. All other dioceses have hospitals reporting sterilizations. Table 4 presents by diocese the number of hospitals reporting V25.2 codes.

Table 4: Number of Hospitals by California Diocese

Diocese	Hospitals reporting births	Hospitals with V25.2	Hospitals without V25.2
Fresno	5	5	0
Los Angeles	14	8	6
Monterey	1	1	0
Oakland	0	0	0
Orange	3	1	2
Sacramento	8	8	0
San Bernardino	3	1	2
San Diego	2	0	2
San Francisco	2	1	1
San Jose	2	1	1
Santa Rosa	5	5	0
Stockton	3	2	1
Totals	48	33	15

As the data reflects, there is diversity of practice in Catholic hospitals in California. This diversity exists within hospital systems and dioceses.

Illinois Catholic Hospitals

For the state of Illinois, 41 Catholic acute care hospitals were identified. The Illinois Department of Public Health collects the inpatient discharge data from all hospitals in Illinois. For three years of data, 2007, 2008, and 2009, the total fee was $4,843. An IRB[69] and strict documentation regarding the use of the data was required.

One hundred and fifty-five hospitals reported data to the Illinois Department of Public Health and included records for approximately five million patients. The file size was less than three gigabytes and was supplied in comma separated values format. The Department required only nine diagnostic codes and six procedure codes to be reported by the hospitals.

Of the 41 identified Catholic hospitals, 37 reported women giving births. Table 5 presents the information on the hospitals including the location of the hospital and the diocese in which it operates. If the hospital is affiliated with a health system, that system is named and the name is followed by the total number of women giving birth for the three year period. The total number of V25.2 codes recorded by the hospitals for the respective years is presented next, followed by the percentage of sterilizations to women. The number of sterilizations represented by the presence of the V25.2 code for the years 2007, 2008, and 2009 follows. The table is ordered by health system. Hospitals not affiliated with a health system are indicated as independent. Of the 37 hospitals listed, there are only five hospitals reporting incidences of the V25.2 codes for a total of 176

[69] IRB stands for institutional review board which is established by an institution in this case, Baylor University, to be responsible for overseeing research involving human subjects. Several states from which data was obtained required that a statement be issued by the IRB at Baylor to ensure that the data would not violate rights of patients. The letter issued by the IRB is generally referred to as an IRB.

sterilizations. While there is diversity of practice among the hospitals, it is noteworthy that only 13.5% of the hospitals reported sterilizations. This is considerably less than some of the states, for example California in which 68.8% of the hospitals reported sterilization.

Table 5: Analysis of Catholic Hospitals in Illinois 2007-2009

Hospital Name	City	Diocese	System	Total Women Giving Birth	Total V25.2 Codes	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Alexian Brothers Medical Center	Elk Grove Village	Chicago	Alexian Brs Health System	7,432	0	0.0%	0	0	0
St. Alexius Medical Center	Hoffman Estates	Chicago	Alexian Brs Health System	8,745	0	0.0%	0	0	0
Saint Anthony Hospital	Chicago	Chicago	Ascension & Missionary Srs of the Sacred of Jesus	6,061	0	0.0%	0	0	0
St. James Hospital & Health Centers	Chicago Heights	Chicago	Franciscan Alliance	4,304	0	0.0%	0	0	0
St. James Hospital & Health Centers	Olympia Fields	Chicago	Franciscan Alliance	218	0	0.0%	0	0	0
St. Anthony's Memorial Hospital	Effingham	Springfield	HSHS	2,299	0	0.0%	0	0	0
St. Elizabeth's Hospital	Belleville	Belleville	HSHS	3,305	0	0.0%	0	0	0
St. Francis Hospital	Litchfield	Springfield	HSHS	1,001	0	0.0%	0	0	0
St. John's Hospital	Springfield	Springfield	HSHS	5,184	0	0.0%	0	0	0
St. Joseph's Hospital	Breese	Belleville	HSHS	1,347	7	0.5%	4	1	2

Table 5: Analysis of Catholic Hospitals in Illinois 2007-2009--continued

Hospital Name	City	Diocese	System	Total Women Giving Birth	Total V25.2 Codes	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
St. Mary's Hospital	Streator	Peoria	HSHS	1,944	0	0.0%	0	0	0
St. Mary's Hospital	Decatur	Springfield	HSHS	1,121	0	0.0%	0	0	0
Holy Cross Hospital	Chicago	Chicago	Independent	933	0	0.0%	0	0	0
Mercy Hospital & Medical Center	Chicago	Chicago	Independent	7,966	5	0.1%	2	0	3
Saint Anthony's Health Center	Alton	Springfield	Independent	1,625	0	0.0%	0	0	0
St. Bernard Hospital & Health Care Center	Chicago	Chicago	Independent	2,927	0	0.0%	0	0	0
Little Company of Mary Hospital & HC Centers	Evergreen Park	Chicago	Independent	3,308	1	<.1%	1	0	0
Loyola Gottlieb Memorial Hospital	Melrose Park	Chicago	Loyola Univ Health System	2,041	147	7.2%	66	55	26
Loyola University Medical Center	Maywood	Chicago	Loyola Univ Health System	3,396	16	0.5%	6	6	4
OSF Saint Anthony Medical Center	Rockford	Rockford	OSF HealthCare	1,993	0	0.0%	0	0	0
OSF Saint Francis Medical Center	Peoria	Peoria	OSF HealthCare	6,734	0	0.0%	0	0	0
OSF Saint James Medical Center	Pontiac	Peoria	OSF HealthCare	715	0	0.0%	0	0	0

Table 5: Analysis of Catholic Hospitals in Illinois 2007-2009--continued

Hospital Name	City	Diocese	System	Total Women Giving Birth	Total V25.2 Codes	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
OSF St. Joseph Medical Center	Bloomington	Peoria	OSF HealthCare	2,149	0	0.0%	0	0	0
OSF St. Mary Medical Center	Galesburg	Peoria	OSF HealthCare	1,026	0	0.0%	0	0	0
Provena Covenant Medical Center	Urbana	Peoria	Provena Health	3,139	0	0.0%	0	0	0
Provena Mercy Medical Center	Aurora	Chicago	Provena Health	3,428	0	0.0%	0	0	0
Provena Saint Joseph Hospital	Elgin	Chicago	Provena Health	1,053	0	0.0%	0	0	0
Provena Saint Joseph Medical Center	Joliet	Joliet	Provena Health	5,583	0	0.0%	0	0	0
Provena St. Mary's Hospital	Kankakee	Joliet	Provena Health	1,167	0	0.0%	0	0	0
Provena United Samaritans Logan	Danville	Peoria	Provena Health	2,319	0	0.0%	0	0	0
Resurrection Medical Center	Chicago	Chicago	RHS	3,422	0	0.0%	0	0	0
Saint Joseph Hospital	Chicago	Chicago	RHS	5,309	0	0.0%	0	0	0
Saints Mary and Elizabeth Medical Center	Chicago	Chicago	RHS	6,134	0	0.0%	0	0	0
St. Francis Hospital	Evanston	Chicago	RHS	2,487	0	0.0%	0	0	0
St. Margaret's Health	Spring Valley	Peoria	SMP	1,032	0	0.0%	0	0	0

Table 5: Analysis of Catholic Hospitals in Illinois 2007-2009--continued

Hospital Name	City	Diocese	System	Total Women Giving Birth	Total V25.2 Codes	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Good Samaritan Regional Health Center	Mt. Vernon	Belleville	SSM Health Care	2,468	0	0.0%	0	0	0
St. Mary's Hospital	Centralia	Belleville	SSM Health Care	656	0	0.0%	0	0	0
Totals				115,971	176		79	62	35

In the case of Illinois, there is a significant difference in the number patient records where procedures were performed for direct sterilization that did not have the V25.2 code in the diagnostic codes. This is illustrated in Table 6. Three of the hospitals recorded more records with procedures specifically for the purpose of sterilization without reporting V25.2 codes for those records. This brings the total number of sterilizations up to 250. This does not necessarily affect the outcome of this study which is intended to simply illustrate the number of hospitals in the state providing sterilizations. It should be noted that this comparison of the number of V25.2 diagnostic codes to procedures for sterilizations was also performed for other states and only reported where the number of procedure codes for direct sterilizations demonstrates a significant increase (more than 10%) over the number of V25.2 diagnostic codes. For Loyola Gottlieb Memorial Hospital, the new calculation raised the number of sterilizations to 175 for a new percentage of the number of sterilizations of women giving birth from 7.2% to 8.6%. Loyola University Medical Center, sterilizations increased from 16 to 56 raising the percentage from .5% to 1.6% for sterilizations of women giving birth. For Mercy Hospital and Medical Center the number of sterilizations went from 5

to 11 which did not significantly change the percentage of sterilizations. The additional 74 procedures raise the number of sterilizations for Catholic hospitals in Illinois to 250.

Table 6: Comparison of V25.2 Diagnostic Codes to Procedure Codes for Tubal Ligation in Illinois

Hospital Name	Total Women giving Birth	Total V25.2 codes	% V25.2 to Women	Additional Procedure Codes for Tubal Ligation	V25.2 Codes Plus Procedure Codes for Tubal Ligation	% V25.2 plus Procedures Codes to Women
Loyola Gottlieb Memorial Hospital	2,041	147	7.2%	28	175	8.6%
Loyola University Medical Center	3,396	16	0.5%	40	56	1.6%
Mercy Hospital & Medical Center	7,966	5	0.1%	6	11	0.1%
Totals		168		74		

Of the thirty-seven hospitals included in the study for Illinois, 33 belong to one of 11 health systems. Four of the hospitals are independently owned and operated by a respective religious order. Of the hospital systems, Hospital Sisters Health System (HSHS) operates seven hospitals, the largest number of hospitals in the state owned by one system. Only one of their hospitals, St. Joseph's in Breese, recorded V25.2 codes—seven for a rate of .5% of women giving birth. The Loyola University Health System with two hospitals recorded V25.2 codes in both hospitals operated by the system. The total number of sterilizations for the two hospitals (when the number of procedures as mentioned above is taken into consideration) amounts to 231. As indicated in Table 7, no occurrences of the V25.2 codes were reported for the other systems in Illinois. Only one of the independent hospitals, Mercy Hospital and Medical Center reported the V25.2 codes. Combined with procedures codes for sterilization, it reported a total 11 for the

three years. The table provides the details regarding the diocese of the home offices, the religious orders responsible for the systems, and the dioceses of the religious orders involved. It also displays the same information for the independently owned hospitals. It is sorted by health system name. The independent hospitals are listed at the end of the table.

Table 7: Health Care Systems Operating Hospitals in Illinois

Health System	# of Hospitals Reporting Births	# of Hospitals Reporting V25.2 Codes	Home Diocese of System Office	Responsible Religious Orders	Diocese of Sponsoring Orders
Alexian Brothers Health System	2	0	Chicago	Alexian Brothers	Chicago
Ascension	1	0	St. Louis	Daughters of Charity of St. Louis	St. Louis
				Daughters of Charity of Evansville	Evansville
				Daughters of Charity of Albany	Albany
				Daughters of Charity of Emmitsburg	Baltimore
				Sisters of St. Joseph of Nazareth	Kalamazoo
				Sisters of St. Joseph of Carondelet	St. Louis
Franciscan Alliance	2	0	Fort Wayne-South Bend	Sisters of St. Francis of Perpetual Adoration	Fort Wayne-South Bend
Hospital Sisters Health System (HSHS)	7	1	Springfield	American Province of the Hospital Sisters of St. Francis	Springfield
Little Company of Mary	1	1	Chicago	Little Company of Mary	Chicago
Loyola University Health System	2	2	Chicago	Chicago-Detroit Province Society of Jesus	Chicago
OSF HealthCare	5	0	Peoria	Sisters of the Third order of St. Francis	Peoria
Provena Health	6	0	Joliet	Franciscan Sisters of the Sacred Heart, ,	Chicago
				The Servants of the Holy Heart of Mary	Joliet
				The Sisters of Mercy of the Americas	Omaha

Table 7: Health Care Systems Operating Hospitals in Illinois--continue

Health System	# of Hospitals Reporting Births	# of Hospitals Reporting V25.2 Codes	Home Diocese of System Office	Responsible Religious Orders	Diocese of Sponsoring Orders
RHS - Resurrection Health Care	4	0	Chicago	Sisters of the Resurrection	Albany
				Sisters of the Holy Family of Nazareth	Chicago
SMP Health System	1	0	Fargo	Sisters of Mary of the Presentation	Fargo
SSM Health Care	2	0	St. Louis	Franciscan Sisters of Mary	St. Louis
Independents					
St. Anthony's Health Center	1	0	Springfield	Sisters of St. Francis of the Martyr St. George	Springfield
St. Bernard	1	0	Chicago	Religious Hospitallers of Saint Joseph	Green Bay
Holy Cross Hospital	1	0	Chicago	Sisters of St. Casimir*	Chicago
Mercy Hospital & Medical Center	1	1	Chicago	Sisters of Mercy	Washington

There are six dioceses in the state of Illinois. As illustrated in Table 8, there is consistency of practice within four of the dioceses, Joliet, Peoria, Rockford, and Springfield. None of the hospitals in those dioceses reported sterilizations. The diocese of Belleville has one of its four hospitals providing sterilizations. The major diversity is seen in the Archdiocese of Chicago with four of its seventeen hospitals providing sterilizations.

Diversity of practice within the state of Illinois in the provision of sterilization procedures does exist; however, it is less than in some states. In one of the health care systems, and in two of the dioceses in Illinois, diversity of practice occurs.

Table 3: Number of Hospitals by Illinois dioceses

Diocese	Hospitals reporting births	Hospitals with V25.2	Hospitals without V25.2
Belleville	4	1	3
Chicago	17	4	13
Joliet	2	0	2
Peoria	8	0	8
Rockford	1	0	1
Springfield	5	0	5
Totals	37	5	32

Indiana Catholic Hospitals

Thirty-four Catholic hospitals were identified in the state of Indiana with 22 reporting births. The Indiana State Department of Health is responsible for collecting and reporting the data from the hospitals. Their mode of operation in providing the data differed from the other states. While still requiring strict data agreements and an IRB, they abstracted the patient records according to the requirements provided to them. This included a list of Catholic hospitals and the diagnostic and procedure codes being investigated. The department prepared the data in an Excel spreadsheet providing the records for over 21,000 patients for each year. They compiled the data for 2007, 2008 and 2009. As is illustrated in Table 9, only three of the 22 hospitals reported V25.2 codes.[70]

[70] After the dissertation was completed, but prior to its inclusion in the UMI database of dissertations, a version of the data was made available on the Internet (catholichospitals.org). Questions were raised regarding procedure codes reported for the Indiana hospitals. An initial review by the author

Table 4: Analysis of Hospitals in Indiana 2007-2009

Hospital	City	Diocese	System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Saint John's Health System	Anderson	Lafayette	Ascension	1,557	13	0.8%	9	2	2
St. Mary's Medical Center	Evansville	Evansville	Ascension	4,691	0	0.0%	0	0	0
St. Vincent Carmel Hospital Inc	Brazil	Indianapolis	Ascension	3,791	0	0.0%	0	0	0
St. Vincent Dunn Hospital	Bedford	Indianapolis	Ascension	1,234	111	6.3%	40	38	33
St. Vincent Frankfort Hospital	Frankfort	Lafayette	Ascension	1,740	0	0.0%	0	0	0
St. Vincent Health St. Joseph Hospital	Kokmo	Lafayette	Ascension	5,131	0	0.0%	0	0	0
St. Vincent Indianapolis Hospital	Indianapo -lis	Indianapolis	Ascension	12,306	0	0.0%	0	0	0
St. Vincent Randolph Hospital	Winches- ter	Lafayette	Ascension	1,833	0	0.0%	0	0	0
St. Catherine Hospital	East Chicago	Gary	Community Healthcare	3,525	0	0.0%	0	0	0
St. Mary Medical Center Inc	Hobart	Gary	Community Healthcare	6,857	0	0.0%	0	0	0

found that there had been an error in processing the procedure codes for the Indiana hospitals that resulted in the erroneous reporting of sterilization procedures for five hospitals. The author also found that the diagnostic V25.2 codes were also inflated by five out of the 171 reported in Indiana. They were corrected and a later independent review by the Baylor Graduate School supervised by the author confirmed these corrections. The processing error arose because the Indiana data was provided in a different format than the other states (as noted on page 60). These errors though regrettable do not affect the thesis or the conclusion of the present dissertation. The procedure codes were reported, but not used in developing the rationale of the thesis (as noted on page 56). The V25.2 codes were mistakenly inflated by a total of five out of 171 reported in Indiana and in no case were V25.2 codes attributed to a hospital that actually had none. Consequently, these errors do not create a false reporting of the degree of diversity among Catholic hospitals.

Table 5: Analysis of Hospitals in Indiana 2007-2009--continued

Hospital	City	Diocese	System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Saint Joseph Regional Medical Center	Indianapo-lis	Indianapolis	Franciscan Alliance	4,493	0	0.0%	0	0	0
St. Anthony Health	Crown Point	Gary	Franciscan Alliance	5,853	0	0.0%	0	0	0
St. Anthony Health	Michigan City	Gary	Franciscan Alliance	2,726	0	0.0%	0	0	0
St. Clare Medical Center Franciscan	Crawfords-ville	Lafayette	Franciscan Alliance	1,643	0	0.0%	0	0	0
St. Elizabeth Health - Lafayette East	Lafayette	Lafayette	Franciscan Alliance	10,541	1*	0.0%	1	0	0
St. Francis Hospital -- Indianapolis	Indianapo-lis	Indianapolis	Franciscan Alliance	9,197	0	0.0%	0	0	0
St. Francis Hospital Mooresville	Moores-ville	Indianapolis	Franciscan Alliance	1,732	0	0.0%	0	0	0
St. Margaret Mercy Healthcare Centers	Hammond	Gary	Franciscan Alliance	3,572	0	0.0%	0	0	0
Memorial Hospital & Health Care Center	Jasper	Evansville	Indepen-dent	3,889	0	0.0%	0	0	0
Saint Joseph Regional Medical Center	Misha-waka	Ft. Wayne-South Bend	Trinity	1,349	0	0.0%	0	0	0
Saint Joseph's Regional Medical Cent	Plymouth	Ft. Wayne-South Bend	Trinity	1,392	0	0.0%	0	0	0
Totals				89,248	166		70	55	40

*After completion of the dissertation, St. Elizabeth Health submitted corrected records for 2007 to the Indiana Department of Health. The Department indicated they received a corrected record and the President of the hospital verified that the record was the one which included the V25.2 diagnostic code.

As is presented in Table 10, 21 of the Catholic hospitals reporting births belong to health care systems. Nine belong to Ascension Health, the largest Catholic health care system in the U.S. Three of the nine hospitals reported V25.2 codes. Eight of the Indiana Catholic hospitals belong to Franciscan Alliance which has hospitals in Illinois and Indiana. None of their hospitals reported V25.2 codes as noted in the corrected information from the Department of Health. Trinity Health with two hospitals in Indiana reported no V25.2 codes. The other system is Community Healthcare with two hospitals reporting no V25.2 codes. Community Healthcare is not sponsored by a religious community. The sisters left the hospital in 2001; however, Community Healthcare is still listed in the *Catholic Directory* under the diocese of Gary, Indiana. The hospital maintains that it upholds the Catholic tradition in adherence to the ERD. There is one independent hospital which provided no sterilizations.

The state of Indiana is divided into five dioceses. Taking into consideration the V25.2 codes and procedures for tubal ligation, two of the dioceses report no V25.2 codes.

Table 6: Health Care Systems Operating Hospitals in Indiana

Health System	# of hospitals reporting births	# of hospitals reporting V25.2 codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Religious Order
Ascension	9	3	St. Louis	Daughters of Charity of St. Louis	St. Louis
				Daughters of Charity of Evansville	Evansville
				Daughters of Charity of Albany	Albany
				Daughters of Charity of Emmitsburg	Baltimore
				Sisters of St. Joseph of Nazareth	Kalamazoo
				Sisters of St. Joseph of Carondelet	St. Louis

Table 10: Health Care Systems Operating Hospitals in Indiana--continued

Health System	# of hospitals reporting births	# of hospitals reporting V25.2 codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Religious Order
Community Healthcare	2	0	Gary		
Franciscan Alliance	8	0	Fort Wayne-South Bend	Sisters of St. Francis of Perpetual Adoration	Fort Wayne-South Bend
Trinity Health	2	0	Fort Wayne-South Bend	Sisters of Mercy Regional Community of Detroit Congregation of the Sisters of the Holy Cross	Detroit Fort Wayne-South Bend
Independent Memorial Hospital & Health Care Center	1	0	Evansville	Sisters of the Little Company of Mary, Inc.	Evansville

The Dioceses of Indianapolis, Gary, and Lafayette contain hospitals reporting the V25.2 codes and sterilization procedures. Table 11 provides the information by diocese.

Table 117: Number of Hospitals by Indiana Dioceses

Diocese	Total Hospitals	Hospitals with V25.2 codes	Hospitals without V25.2 codes
Evansville	2	0	2
Ft. Wayne-South Bend	2	0	2
Gary	5	0	5
Indianapolis	7	2	5
Lafayette	6	1	5
Totals	22	3	19

While the percentage of hospitals reporting V25.2 codes is lower than some states at 18.2%, diversity still exists. It exists within health care systems and some dioceses.

New Jersey Catholic Hospitals

Fifteen Catholic hospitals were identified in the state of New Jersey. Of these, eight reported births. The State of New Jersey Department of Health and Senior Services is responsible for collecting the inpatient discharge data from the 105 acute care hospitals in the state. The Department made the data available for research for all hospitals for a fee of $5.00 per year with stringent data use requirements. There were problems with the 2007 data. The Department changed the format for 2008 and subsequent years. The 2008 and 2009 data was presented in a fixed length text file, and the required data was able to be abstracted. As a result for the state of New Jersey, only two years of data are presented, 2008 and 2009. The file size was 14 gigabytes and contained a total of 13 diagnostic and 13 procedure codes per patient record.

Table 12 provides a listing of the eight Catholic hospitals providing obstetric services. The hospitals are sorted by health system and then by hospital name. The city, diocese and health care system to which the hospital belongs follows. The total number of V25.2 codes, V25.2 codes as a percent of women giving birth, and the codes for 2008 and 2009 follow. As illustrated, seven of the hospitals, 87.5% of the total, have diagnostic codes of V25.2 indicating that 867 women received a diagnosis for sterilization.

As with other states, the number of procedures for tubal ligation was compared with the incidence of the V25.2 codes in the patient records. Table 13 identifies two of the hospitals reporting a significantly greater number of procedures. St. Joseph's Regional Medical Center recorded 230 procedures compared to 131 diagnoses, and Trinitas Regional Medical Center recorded 173 procedures compared to 109 diagnoses.

Table 128: Analysis of Catholic Hospitals in New Jersey 2008-2009

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as a % of Women	V25.2 2008	V25.2 2009
Our Lady of Lourdes Medical Center	Camden	Camden	CHE	2,763	160	5.8%	77	83
Lourdes Medical Center of Burlington County	Willingboro	Trenton	CHE	1,833	122	6.7%	66	56
Saint Clare's Hospital/Denville	Denville	Patterson	CHI	3,197	75	2.3%	36	39
St. Mary's Hospital	Passaic	Patterson	Independent	2,233	85	3.8%	47	38
Holy Name Medical Center	Teaneck	Newark	Independent	2,821	185	6.6%	97	88
St. Joseph's Regional Medical Center	Paterson	Patterson	Independent	7,572	131	1.7%	49	82
Trinitas Regional Medical Center Williamson Street	Elizabeth	Newark	Independent	4,713	109	2.3%	33	76
Saint Peter's University Hospital	New Brunswick	Metuchen	Independent	12,229	0	0.0%	0	0
				37,361	867		405	462

This brought the total number of sterilizations for Catholic hospitals in New Jersey up to 1,030 representing 4.1% of women giving birth in the hospitals providing sterilizations.

Table 93: Comparison of V25.2 Diagnostic Codes to Procedure Codes for Tubal Ligation in New Jersey

Hospital Name	Total Women giving Birth	Total V25.2 codes	% V25.2 of Women	Additional Procedure Codes for Tubal Ligation	V25.2 Codes Plus Procedure Codes for Tubal Ligation	% V25.2 plus Procedures Codes to Women
St. Joseph's Regional Medical Center	7,572	131	1.7%	98	229	3.0%
Trinitas Regional Medical Center Williamson Street	4,713	109	2.3%	64	173	3.7%
Totals	12,285			162	402	

Only three of the Catholic hospitals in New Jersey are affiliated with a major health care system. They are Catholic Health East with two hospitals which both provide sterilizations and Catholic Health Initiatives with one hospital also providing sterilizations. The remaining five hospitals are independent of a major health care system. Four of the five hospitals provide sterilizations. Saint Peter's University Hospital, owned by the Diocese of Metuchen, was the only hospital that did not have any codes for sterilizations. Table 14 gives the details on systems and independent hospitals listing the diocese of the home office and religious orders involved with them. The shading differentiates the two major systems and their respective religious affiliations from one another.

The state of New Jersey is divided into five dioceses. Four of the dioceses had hospitals performing sterilizations. The only diocese which did not have hospitals performing sterilizations was Metuchen. Table 15 presents the number of hospitals by diocese and indicates those with V25.2 codes and those without the codes.

Table 15: Health Care Systems in New Jersey

Health System	# of hospitals reporting births	# of hospitals reporting V25.2 codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Religious Order
Catholic Health East (CHE)	2	2	Newtown Square, PA	Franciscan Sisters of Allegany, NY	Allegany
				The Sisters of Providence	Springfield
				Sisters of Mercy of the Americas	Washington
				The Sisters of St. Joseph	St. Augustine
				Sisters of Charity of Seton Hill	Greensburg
				Sisters, Servants of the Immaculate Heart of Mary	Scranton

Table 10: Health Care Systems in New Jersey--continued

Health System	# of hospitals reporting births	# of hospitals reporting V25.2 codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Religious Order
Catholic Health Initiatives (CHI)	1	1	Denver	Benedictine Sisters of Mother of God	Sioux Falls
				Franciscan Sisters of Little Falls, MI	St. Cloud
				Congregation of the Dominican Sisters of St. Catherine of Siena of Kenosha, WI	Milwaukee
				Nuns of the Third Order of St. Dominic	Dodge City
				Sisters of Charity of Cincinnati	Cincinnati
				Sisters of the Holy Family of Nazareth	Philadelphia
				Sisters of Charity of Nazareth	Louisville
				Sisters of Mercy of the Americas, Regional Community of Omaha	Omaha
				Sisters of the Presentation of the Blessed Virgin Mary	Fargo
				Sisters of St. Francis of Colorado Springs	Colorado Springs
				Sisters of St. Francis of Immaculate Heart of Mary	Fargo
				Sisters of St. Francis of Philadelphia	Philadelphia
Independent					
St. Mary's Hospital	1		Newark	Sisters of Charity of Saint Elizabeth	Patterson
St. Joseph's Regional Medical	1		Patterson	Sisters of Charity of Saint Elizabeth	Patterson
Holy Name Medical Center	1		Patterson	Sisters of St. Joseph of Peace	Washington
Trinitas Regional Medical Center Williamson Street	1		Newark	Sisters of Charity of Saint Elizabeth	Newark
Saint Peter's University Hospital		0	Metuchen	Diocese of Metuchen	Metuchen

In New Jersey, there is little diversity in the practice of sterilizations since all but one of the hospitals offers sterilizations. There is no diversity within systems or within

dioceses. The fact that the one diocese which has a hospital owned by the diocese does not have any sterilization procedures is noteworthy.

Table16: Number of Hospitals by New Jersey Diocese

Diocese	Total Hospitals	Hospitals with V25.2 codes	Hospitals without V25.2 codes
Camden	1	1	0
Newark	2	2	0
Patterson	3	3	0
Metuchen	1	0	1
Trenton	1	1	0
Totals	8	7	1

New York Catholic Hospitals

Patient data for the state of New York was obtained for 2006, 2007 and 2008. Twenty-seven Catholic hospitals were identified of which 21 provided obstetric services. The New York State Department of Health Statewide Planning and Research Cooperative System referred to as SPARCS collects the data from the hospitals and provided the inpatient discharge data. The cost of the data was $3,900 and included ambulatory surgery center data as well. The requirements for patient confidentiality and handling of the data required stringent data agreements for handling the data and an IRB. The patient dataset included over 8.4 million records reported for 229 hospitals. Fifteen diagnostic and fifteen procedure codes were recorded in each patient record. The file size was 30.6 gigabytes and was provided in fixed length format.

Of the 21 hospitals, five reported V25.2 codes for a total of 318 sterilizations. Table 16 includes a listing of the 21 acute care Catholic hospitals containing diagnostic codes for women giving birth. As with the other states, it also includes the total number of V25.2 codes for the three years, V25.2 codes as a percent of women giving birth followed by the V25.2 codes by year. It is ordered by health system followed by hospital name. For the three year period V25.2 codes were reported in 23.8% of the Catholic hospitals in the state.

Table 16: Analysis of Hospitals in New York 2006-2008

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2006	V25.2 2007	V25.2 2008
Mt. St. Mary's Hospital and Health Center	Lewiston	Buffalo	Ascension	2,334	0	0.0%	0	0	0
Our Lady of Lourdes Memorial Hospital, Inc.	Binghamton	Syracuse	Ascension	3,453	1	0.0%	0	0	1
Seton Health System St. Mary's Campus	Troy	Albany	Ascension	1,570	0	0.0%	0	0	0
St. Mary's Hospital at Amsterdam	Amsterdam	Albany	Ascension	1,586	0	0.0%	0	0	0
Bon Secours Community Hospital	Port Jervis	New York	Bon Secours	1,094	0	0.0%	0	0	0
Good Samaritan Hospital of Suffern	Suffern	New York	Bon Secours	5,514	0	0.0%	0	0	0
St. Anthony Community Hospital	Warwick	New York	Bon Secours	1,145	0	0.0%	0	0	0
Mercy Hospital	Buffalo	Buffalo	CH	7,582	0	0.0%	0	0	0

Table 16: Analysis of Hospitals in New York 2006-2008--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2 Codes	V25.2 as % of Women	V25.2 2006	V25.2 2007	V25.2 2008
Sisters of Charity Hospital	Cheekto-waga	Buffalo	CH	8,380	0	0.0%	0	0	0
St. James Mercy Hospital	Hornell	Rochester	CHE	1,341	68	3.9%	30	16	22
St. Peters Hospital	Albany	Albany	CHE	7,916	0	0.0%	0	0	0
Good Samaritan Hospital Medical Center	West Islip	Rock-ville Centre	CHSLI	8,118	0	0.0%	0	0	0
Mercy Medical Center	Buffalo	Buffalo	CHSLI	4,266	0	0.0%	0	0	0
St. Catherine of Siena Hospital	Smithtown	Rock-ville Centre	CHSLI	5,815	0	0.0%	0	0	0
St. Charles Hospital and Rehabilitation Center, Inc.	Port Jefferson	Rock-ville Centre	CHSLI	4,713	0	0.3%	0	0	0
St. Joseph's Hospital Health Center	Syracuse	Syracuse	Indepen-dent	6,259	247	3.9%	74	93	80
Benedictine Hospital	Kingston	New York	Indepen-dent	1,074	0	0.0%	0	0	0
St. Clare's Hospital	Schenecta-dy	Albany	SVCMC	1,746	2	<.01%	2	0	0
St. John's Queens	Elmhurst	Brooklyn	SVCMC	3,203	0	0.0%	0	0	0
St. Vincents Manhattan	Manhattan	Brooklyn	SVCMC	4,452	0	0.0%	0	0	0
St. Vincents Staten Island*	Staten Island	New York	SVCMC	4,768	0	0.0%	0	0	na
Total				90,369	318		106	109	103

*In 2007, St. Vincents Staten Island became University of Rochester Medical Center and no longer affiliated with the Catholic Church. The “na” in the 2008 column reflects this situation.

Two hospitals in the state recorded a significantly higher number of procedures for tubal ligation than V25.2 codes as is illustrated in Table 17. These were St. Joseph's Hospital Health Center in Syracuse reporting 301 procedures compared to 247 V25.2 codes, and St. Clare's Hospital in Schenectady reporting 37 procedure codes compared to two V25.2 codes. This would bring the total sterilizations for the state up to 481. The percentage of sterilizations to women giving birth for all hospitals reporting V25.2 codes in New York Catholic hospitals is 2.1%. For the entire state of New York the percentage is 5.2% for all hospitals recording V25.2 codes.

Table 17: Comparison of V25.2 Diagnostic Codes to Procedure Codes for Tubal Ligation in New York

Hospital Name	Total Women giving Birth	Total V25.2 codes	% V25.2 of Women	Additional Procedure Codes for Tubal Ligation	V25.2 Codes Plus Procedure Codes for Tubal Ligation	% V25.2 plus Procedures Codes to Women
St. Joseph's Hospital Health Center	6,259	247	3.9%	51	298	4.8%
St. Clare's Hospital	3,458	2	0.1%	39	41	1.1%
Totals	12,285	249		90	339	

As presented in Table 18 which provides an analysis of the hospital systems in New York, six hospital systems operate 20 of the 21 hospitals. Catholic Health Services of Long Island is the system with the most hospitals. It is owned by the Diocese of Rockville Centre. It has four hospitals none of which reported V25.2 codes. Ascension Health is responsible for four of the hospitals and reported one hospital with V25.2 codes. Saint Vincent Catholic Medical Centers owned four hospitals with one reporting V25.2 codes. The Bon Secours Health System owns three hospitals with none reporting any

V25.2 codes. Catholic Health East is responsible for two systems, one of which reported V25.2 codes. The final system is Catholic Health which owns two hospitals and reported no V25.2 codes. The only independent hospital was Benedictine Hospital which also reported no V25.2 codes.

Table 18: Health Care Systems Operating in New York

Health System	# of hospitals reporting births	# of hospitals reporting V25.2 codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Sponsoring Orders
Ascension Health	4	1	St. Louis	Daughters of Charity of St. Louis	St. Louis
				Daughters of Charity of Evansville	Evansville
				Daughters of Charity of Albany	Albany
				Daughters of Charity of Emmitsburg	Baltimore
				Sisters of St. Joseph of Nazareth	Kalamazoo
				Sisters of St. Joseph of Carondelet	St. Louis
Bon Secours Health System	3	0	Baltimore	Sisters of Bon Secours USA	Baltimore
Catholic Health (CH)	2	0	Buffalo	Daughters of Charity of St. Vincent de Paul - Northeast Province	Albany
				Diocese of Buffalo	Buffalo
				Sisters of Mercy of the Americans, NY, PA, Pacific West Community	Washington
				Lists as members Ascension Health and Catholic Health East	
Catholic Health East (CHE)	2	1	Philadelphia	Franciscan Sisters of Allegany, NY	Allegany
				The Sisters of Providence	Springfield
				Sisters of Mercy of the Americas	Washington
				The Sisters of St. Joseph	St. Augustine
				Sisters of Charity of Seton Hill	Greensburg
				Sisters, Servants of the Immaculate Heart of Mary	Scranton
Catholic Health Services of Long Island (CHSLI)	4	0	Rockville Centre	Owned by Diocese of Rockville Centre	Rockville Centre

Table 18: Health Care Systems Operating in New York--continued

Health System	# of hospitals reporting births	# of hospitals reporting V25.2 codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Sponsoring Orders
Saint Vincent Catholic Medical Centers (SVCMC)	4	1	Brooklyn	Owned by Diocese of Brooklyn Sisters of Charity of New York	Brooklyn Brooklyn
Independent					
Benedictine Hospital	1	0	New York	Benedictine Sisters of Elizabeth	Newark

There are eight Catholic dioceses in the state of New York. One of the dioceses contained no hospitals. Three of the dioceses, Albany, Rochester, and Syracuse contained hospitals reporting V25.2 codes. Table 19 presents the dioceses in alphabetical order.

Table 19: Number of Hospitals by New York Dioceses

Diocese	Total Hospitals	Hospitals with V25.2 codes	Hospitals without V25.2 codes
Albany	4	1	3
New York	5	0	5
Brooklyn	2	0	2
Buffalo	4	0	4
Ogdensburg	0	0	0
Rochester	1	1	0
Rockville Centre	3	0	3
Syracuse	2	2	0
Totals	21	5	16

Diversity of practice in the provision of sterilizations exists within the state of New York. Of the Catholic hospitals in the state of New York, 23.8% perform sterilizations. They are dispersed within some dioceses and systems.

Texas Catholic Hospitals

The Texas Health Care Information Collection Center for Health Statistics manages the public use data files for Texas. The data are available by quarter one year after the collection date. The data sets for individual hospitals are provided for all hospitals in the state with the exception of those with fifty beds or less or those located in rural areas. Three Catholic hospitals fell into this category. A total of 494 hospitals in Texas were required to report their inpatient discharge data for 2009. Forty-seven reporting hospitals were identified as Catholic.[71]

The data files were obtained for 2007 through 2009. The files contained all patient discharge records for the reporting hospitals for each year and were delivered in comma separated values format. The file was approximately six gigabytes in size.

Of the 47 reporting hospitals, 25 included one or more births, and therefore met the criteria for providing obstetric services during the time period. During the three years studied from 2007 through 2009, there were a total of 5,560 diagnostic V25.2 codes indicating that procedures for tubal ligation were performed. Of the 25 hospitals, eight hospitals did not provide any tubal ligations. The percentage of sterilizations of women giving birth for non-Catholic hospitals in the state of Texas for the three year period was calculated from the patient records at 10.5%. For all Catholic hospitals providing

[71] As mentioned, three were not required to report data because of their size or location. Two of these hospitals do provide obstetric services, but due to lack of reported data are not included in this study.

sterilizations, the percentage is 11.0%, not significantly different from the non-Catholic hospitals. Table 20 contains a summary of the data from the 25 hospitals. It is sorted by health system and then by hospital name. Three new hospitals reported data for only 2009. These three have "na" in the columns for 2007 and 2008 indicating no available data. Another unusual situation should be noted. UTMB Austin Women's Hospital is a secular non-Catholic hospital that is included in the study because the resident physicians who staff the hospital are under contract with Austin Medical Education Programs (AMEP). AMEP is operated by the Catholic Seton Healthcare Network which is a member of Ascension Health.[72] Over the three year period, UTMB performed 1,514 sterilizations.

Table 2011: Analysis of Catholic Hospitals in Texas 2007-2009

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
Providence Health Center	Waco	Austin	Ascension	3,048	278	9.1%	91	103	84
Seton Medical Center	Austin	Austin	Ascension	10,446	1	<.1%	1	0	0
Seton Medical Center Williamson	Williamson	Austin	Ascension	561	0	0.0%	na	na	0
Seton Northwest Hospital	Austin	Austin	Ascension	3,455	0	0.0%	0	0	0
Seton Southwest Hospital	Austin	Austin	Ascension	1,792	0	0.0%	0	0	0

[72] The resident physicians are employees of Seton Healthcare. The residency agreement of AMEP may be found online at http://www.seton.net/medical_services_and_programs/graduate_medical_education/internal_medicine/Resident_Work_Agreement%20.pdf. (accessed 23 May 2011)

Table 20: Analysis of Catholic Hospitals in Texas 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
UMBC Austin Womens Hospital	Austin	Austin	Ascension	4,816	1,514	31.4%	513	505	496
University Medical Center-Brackenridge	Austin	Austin	Ascension	5,971	3	0.1%	0	0	3
Baptist St Anthonys Health System	Amarillo	Amarillo	Christus	5,484	1,068	19.5%	381	363	324
CHRISTUS Hospital	Beaumont	Beaumont	Christus	3,970	0	0.0%	0	0	0
CHRISTUS Hospital-St Mary	Port Arthur	Beaumont	Christus	502	0	0.0%	0	0	0
CHRISTUS Jasper Memorial Hospital	Jasper	Beaumont	Christus	832	64	7.7%	26	17	21
CHRISTUS Santa Rosa Hospital	San Antonio	San Antonio	Christus	5,742	0	0.0%	0	0	0
CHRISTUS Santa Rosa Hospital New Braunfels	New Braunfels	San Antonio	Christus	798	3	0.4%	na	na	3
CHRISTUS Spohn Hospital Alice	Alice	Corpus Christi	Christus	471	14	3.0%	na	na	14
CHRISTUS Spohn Hospital Corpus Christi	Corpus Christi	Corpus Christi	Christus	1,555	386	24.8%	169	120	97
CHRISTUS Spohn Hospital Corpus Christi-South	Corpus Christi	Corpus Christi	Christus	6,699	381	5.7%	132	123	126

Table 20: Analysis of Catholic Hospitals in Texas 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	V25.2 as % of Women	V25.2 2007	V25.2 2008	V25.2 2009
CHRISTUS Spohn Hospital-Beeville	Beeville	Corpus Christi	Christus	932	217	23.3%	73	79	65
CHRISTUS Spohn Hospital-Kleberg	Kingsville	Corpus Christi	Christus	801	68	8.5%	20	27	21
CHRISTUS St Catherine Hospital	Katy	Galveston-Houston	Christus	1,932	0	0.0%	0	0	0
CHRISTUS St John Hospital	Nassau Bay	Galveston-Houston	Christus	1,435	0	0.0%	0	0	0
CHRISTUS St Michael Health System	Texarkana	Tyler	Christus	3,294	150	4.6%	88	62	0
St Joseph Regional Health Center	Bryan	Austin	Franciscan	4,749	469	9.9%	192	177	100
Covenant Hospital-Levelland	Levelland	Lubbock	St. Joseph	705	157	22.3%	70	38	49
Covenant Hospital-Plainview	Plainview	Lubbock	St. Joseph	1,279	305	23.8%	101	94	110
Mother Frances Hospital	Tyler	Tyler	Trinity	5,851	482	8.2%	328	154	0
Totals				77,120	5,560		2,185	1,862	1,513

All of the hospitals belong to health systems. Two health care systems own the majority of the hospitals, CHRISTUS Health with 14 hospitals and Ascension Health with seven hospitals. Table 21 presents each health system and includes the home diocese of the system office, the responsible religious orders, and the home diocese of the religious orders. Of the 14 CHRISTUS hospitals, five had no occurrences of the V25.2

code. The other nine CHRISTUS hospitals reported 2,351 V25.2 codes for a sterilization of 15.3% of women giving birth for the nine hospitals. Ascension Health, operating six hospitals had three hospitals with no V25.2 codes, one hospital with only one occurrence of the V25.2, one hospital with three V25.2 codes, and one hospital with 278 V25.2 codes for 9.1% of V25.2 codes to women giving birth for the hospital. However, St. Joseph Health System, a smaller system operating two hospitals, demonstrated consistency in reporting a total of 462 sterilization procedures over the three year period with occurrences in both hospitals for 23.3% of V25.2 codes to women giving birth. The Franciscan Services Corporation which operates one hospital reported 469 incidences of the V25.2 code representing 9.9% of V25.2 codes to women giving birth. Mother Frances Hospital, the only hospital in the Trinity Mother Frances hospitals and clinics reporting data, had an incidence of 482 V25.2 codes resulting in a percentage for the three years of 8.2%. The shading in Table 21 is provided to group the responsible religious orders associated with the respective system.

The state of Texas is divided into 15 Catholic dioceses. Of these, eight dioceses contain hospitals reporting births. As illustrated in Table 22, only the Galveston-Houston Archdiocese hospitals reported no occurrence of sterilizations. In four dioceses, Amarillo, Corpus Christi, Lubbock and Tyler, all hospitals in their dioceses reported sterilizations. The other three dioceses, Austin, Beaumont, and San Antonio contain a mixture with some hospitals performing sterilizations and some not. However, it must be acknowledged that the Tyler diocese while reporting sterilizations in 2007 and 2008, reported none for 2009. This is probably directly correlated with action taken by Bishop Corrada of the Tyler diocese. When the Wikileaks data was released in June of

Table 21: Catholic Health Care Systems Operating in Texas

Health System	Hospitals Reporting Births	Hospitals Reporting V25.2 Codes	Home Diocese of System Office	Responsible Religious Orders	Home Diocese of Religious Order
Ascension Health	6	3	St. Louis	Daughters of Charity of St. Louis	St. Louis
				Daughters of Charity of Evansville	Evansville
				Daughters of Charity of Albany	Albany
				Daughters of Charity of Emmitsburg	Baltimore
				Sisters of St. Joseph of Nazareth	Kalamazoo
				Sisters of St. Joseph of Carondelet	St. Louis
CHRISTUS Health	14	9	Dallas	Sisters of Charity of the Incarnate Word of San Antonio	San Antonio
				Sisters of Charity of the Incarnate Word of Houston	Galveston - Houston
Franciscan Services Corporation	1	1	Toledo	Sisters of St. Francis of Sylvania Ohio	Toledo
St. Joseph Health System	2	2	Orange	Sisters of St. Joseph of Orange	Orange
Trinity Mother Frances Hospitals and Clinics	1	1	Tyler	Sisters of the Holy Family of Nazareth	Chicago

2008 (see p. 14), it demonstrated two hospitals in the Tyler diocese performed over 1,800 tubal ligations. The Bishop investigated the situation and established that the hospitals were indeed providing sterilizations. He publicly acknowledged the problem and entered into discussions with the hospitals to correct their understanding and application of the ERD. As a result of these actions, the hospitals in question ceased to provide sterilizations, thus accounting for zero V25.2 codes for 2009.[73]

[73] Bishop Corrada publically issued three statements over a nine month period. The official text may be located on the Diocese of Tyler website (http://www.dioceseoftyler.org/documents). They are labeled cathhospJulystatement.pdf, CathhospNovStatement.pdf and April3statementsCET.pdf.

Clearly, in the state of Texas, there is diversity of practice in the provision of sterilizations among Catholic hospitals. Presently, diversity exists within hospital systems and within most dioceses in which Catholic hospitals are located.

Table 22: Number of Hospitals by Texas Diocese

Diocese	Hospitals Reporting Births	Hospitals with V25.2 Codes	Hospitals without V25.2 Codes
Amarillo	1	1	0
Austin	7	5	3
Beaumont	3	1	2
Brownsville	0	0	0
Corpus Christi	5	5	0
Dallas	0	0	0
El Paso	0	0	0
Ft. Worth	0	0	0
Galveston-Houston	2	0	2
Laredo	0	0	0
Lubbock	2	2	0
San Angelo	0	0	0
San Antonio	2	1	1
Tyler	2	2	0
Victoria	0	0	0
Totals	24	17	8

Washington Catholic Hospitals

The Washington State Department of Health Center for Health Statistics is responsible for collecting and reporting the inpatient discharge data for the state. The data was obtained for 2007, 2008, and 2009. The cost of the data was $50 per year for a total of $150. The patient dataset contained 18 diagnostic codes and six procedure codes per patient. It was provided in comma separated values format and was approximately

one gigabyte of data. Of the 671 hospitals reporting data, 17 were identified as Catholic and 15 of these reported births.

As is illustrated in Table 23 which provides an analysis of the Catholic hospitals in Washington State, all 15 hospitals reported V25.2 codes for a total of 3,668 sterilizations. There was no significant difference in the number of V25.2 codes and procedures codes for sterilizations in the data. The percent of V25.2 codes to women giving birth for the combined hospitals was 5.2%.

Table 2312: Analysis of Catholic Hospitals in Washington 2007-2009

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	% V25.2 of Women	V25.2 2007	V25.2 2008	V25.2 2009
Lourdes Medical Center	Pasco	Seattle	Ascension	1,126	4	0.4%	0	0	4
Enumclaw Community Hospital	Enumclaw	Seattle	CHI	697	33	4.7%	10	12	11
Saint Francis Hospital	Federal Way	Seattle	CHI	4,335	181	4.2%	59	66	56
Saint Joseph Medical Center	Takoma	Seattle	CHI	11,050	535	4.8%	200	165	170
PeaceHealth Saint John Medical Center	Longview	Seattle	PeaceHealth	3,492	416	11.9%	150	131	135
Saint Joseph Hospital	Bellingham	Seattle	PeaceHealth	5,759	274	4.8%	95	83	96
Holy Family Hospital	Spokane	Spokane	Providence	3,695	134	3.6%	40	41	53

Table 2313: Analysis of Catholic Hospitals in Washington 2007-2009--continued

Hospital Name	City	Diocese	Health System	Total Women Giving Birth	Total V25.2	% V25.2 of Women	V25.2 2007	V25.2 2008	V25.2 2009
Mount Carmel Hospital	Colville	Spokane	Providence	610	57	9.3%	18	19	20
Providence Centralia Hospital	Centralia	Seattle	Providence	1,860	64	3.4%	25	25	14
Providence Everett Medical Center	Everett	Seattle	Providence	10,681	517	4.8%	172	180	165
Providence Saint Peter Hospital	Olympia	Seattle	Providence	6,246	294	4.7%	99	107	88
Sacred Heart Medical Center	Spokane	Spokane	Providence	8,070	302	3.7%	65	107	130
Saint Joseph's Hospital	Chewelah	Spokane	Providence	182	9	4.9%	5	3	1
Saint Mary Medical Center	Walla Walla	Spokane	Providence	1,744	68	3.9%	22	21	25
Totals				70,061	3,668		1,277	1,219	1,172

The 15 Catholic hospitals all belong to Catholic health care systems. The system with the most hospitals operating in the state is Providence Health and Services. It has eight hospitals. Catholic Health Initiatives and PeaceHealth have three hospitals each within the state and Ascension Health operates one hospital. All hospitals in the systems perform sterilizations as is indicated by the presence of the V25.2 codes in their patient files. Table 24 lists the systems, the diocese in which their system office is located, the religious sponsors of the systems and the respective dioceses of their home offices.

Table 24: Health Care Systems Operating in Washington

Health System	# of Hospitals Reporting Births	# of Hospitals Reporting V25.2 Codes	Home Diocese of System Office	Responsible Religious Orders	Diocese
Ascension	1	1	St. Louis	Daughters of Charity of St. Louis	St. Louis
				Daughters of Charity of Evansville	Evansville
				Daughters of Charity of Albany	Albany
				Daughters of Charity of Emmitsburg	Baltimore
				Sisters of St. Joseph of Nazareth	Kalamazoo
				Sisters of St. Joseph of Carondelet	St. Louis
Catholic Health Initiatives (CHI)	3	3	Denver	Benedictine Sisters of Mother of God	Sioux Falls
				Franciscan Sisters of Little Falls, MI	St. Cloud
				Congregation of the Dominican Sisters of St. Catherine of Siena of Kenosha, WI	Milwaukee
				Nuns of the Third Order of St. Dominic	Dodge City
				Sisters of Charity of Cincinnati	Cincinnati
				Sisters of the Holy Family of Nazareth	Philadelphia
				Sisters of Charity of Nazareth	Louisville
				Sisters of Mercy of the Americas, Regional Community of Omaha	Omaha
				Sisters of the Presentation of the Blessed Virgin Mary	Fargo
				Sisters of St. Francis of Colorado Springs	Colorado Springs
				Sisters of St. Francis of Immaculate Heart of Mary	Fargo
				Sisters of St. Francis of Philadelphia	Philadelphia
PeaceHealth	3	3	Portland	Sisters of St. Joseph of Peace	Washington
Providence Health & Services	8	8	Los Angeles	Sisters of Providence	Montreal
				Little Company of Mary	Chicago

The state of Washington is divided into three dioceses. One of the dioceses has no Catholic hospitals located within it. Most of the hospitals are located in the Diocese of Seattle with a total of ten hospitals. The Spokane diocese has five hospitals. As is indicated in Table 25, all hospitals reported V25.2 codes.

Table 25: Number of Hospitals by Washington Dioceses

Diocese	Total Hospitals	Hospitals with V25.2 codes	Hospitals without V25.2 codes
Seattle	10	10	0
Spokane	5	5	0
Yakima	0	0	0
Totals	15	15	0

Washington was unique among the states in that every hospital within the state performed sterilizations. There exists no diversity of practice within systems or dioceses.

Analysis of Catholic Hospital Systems with Additional Hospitals outside the Study Area

It is worth evaluating the practices of those health care systems included in the study which also operate in states outside the study area. The practices of such systems may be reflected in the other states in which they operate. For example, if a health care system operating nine hospitals in two states in the study area has demonstrated that it performs sterilizations in all its hospitals, then one might draw the inference that the other hospitals it operates in states outside the study area may also be providing sterilizations. At least, it would propose that further research be done to determine what the actual situation is.

Ten systems included in the study provide multi-state services in states outside the study area. Ascension Health, the first system listed, is the largest Catholic and also, the largest non-profit hospital system in the U.S. It is based in St. Louis, Missouri in the Diocese of St. Louis and is sponsored by five religious orders. The system has 75 acute

care hospitals across 22 states. The study included 21 of its hospitals located in the states of Illinois, New Jersey, New York, Texas and Washington. Of the 21, eight reported V25.2 codes representing 38.1% of their hospitals included in the study.

Catholic Health East, the next system listed, has 34 hospitals. Its headquarters are in Newtown Square, Pennsylvania in the Diocese of Philadelphia. It is sponsored by six religious orders. Catholic Health East operates in eleven states of which New Jersey and New York were included in the study. Four of its hospitals were studied and of them three reported V25.2 codes. This represents 75% of the hospitals reviewed.

Catholic Health Care West headquartered in San Francisco in the Diocese of San Francisco has 41 hospitals and is sponsored by four religious orders. The system operates in only three states, California, Arkansas, and Nebraska. Of the 26 California hospitals studied, 21 reported V25.2 codes representing 81% of the Catholic Health Care West hospitals investigated.

The second largest system in terms of the number of acute care hospitals it operates is Catholic Health Initiatives with 72 hospitals. Its system headquarters are in Denver, Colorado in the Diocese of Denver. It is sponsored by 12 religious orders across the U.S. The system operates in 18 states of which Indiana, New Jersey, and Washington were included in the study. A total of four hospitals from those states were investigated and all four reported V25.2 codes.

CHRISTUS Health with system headquarters located in Dallas in the Diocese of Dallas operates 40 acute care hospitals of which three appear to be located in Mexico. It is sponsored by two religious orders both located in Texas. CHRISTUS operates in four states Arkansas, Louisiana, New Mexico and Texas as well as in Mexico. Fourteen of the

hospitals included in the study are in the state of Texas. Of these, nine reported V25.2 codes, representing 64% of the system's hospitals included in the study.

Hospital Sisters Health System located in Springfield, Illinois in the Diocese of Springfield operates in only two states, Illinois and Wisconsin. The system is sponsored by one religious order, the Hospital Sisters of St. Francis, also located in Springfield. The system owns thirteen hospitals of which the seven in Illinois were included in the study. Only one of its hospitals reported V25.2 codes.

PeaceHealth is a system headquartered in Bellevue, Washington in the Diocese of Seattle and operates nine hospitals in three states, Alaska, Oregon and Washington. Three of its hospitals located in Washington were included in the study. All three reported V25.2 codes.

Providence Health and Services operates 27 hospitals in five states. Its headquarters are in Torrance, California in the Diocese of Los Angeles. The system is sponsored by two religious orders. Of the 27 hospitals, 12 are located in California and Washington, and therefore were included in the study. Eleven of the 12 hospitals reported V25.2 codes, representing 91.7% of the system's hospitals included in the study. One of the smaller health systems, SCL Health System owning 13 hospitals in four states had only one hospital within the study area. It did not report any V25.2 codes.

Trinity Health, the third largest system in terms of assets, has a total of 46 acute care hospitals. Its main office is in Novi, Michigan in the Diocese of Detroit. The system operates in nine states of which only two, California and Indiana, were included in the study, and contained only four of its hospitals. Only one reported V25.2 codes, representing 33.3% of the Trinity hospitals studied.

There are other Catholic hospital systems not included in the study because none of their hospitals are located in the study area. As is demonstrated, a study of large hospital systems would be appropriate to determine if there is diversity of practices in their various hospitals.

Table 26 lists health care systems which also have hospitals in states which were not included in the study. It includes the name of system, the location of the system office and diocese in which it is located, the total number of hospitals in the system, the number of hospitals included in the study and of those, the number reporting V25.2 diagnostic codes for sterilization, the number of states in which the system operates and a listing of the states, their 2009 financial assets where available, the sponsoring religious orders, and the respective dioceses of the religious orders. The systems are listed in alphabetical order. Of the systems, 95 of the 370 hospitals owned by the systems were included in the study. Sixty-four percent of them reported sterilizations.

Table26: Health Care Systems with Hospitals outside the Study Area

System (states)	Location of System Office (Diocese)	Hospitals			2009 Assets in Billions	Sponsoring Religious Orders	Diocese of Sponsoring Orders
		Total #	# in Study	w/ V25.2			
Ascension Health 22 states (AL; AR; AZ; CT; D.C.; DE; FL; IL; KS; MA; MD; MO; MS; LA; NJ; NM; NY; PA; RI; TX; WA; WI)	St. Louis, MO (St. Louis)	75	21	8	$16.5	Daughters of Charity of St. Louis	St. Louis
						Daughters of Charity of Evansville	Evansville
						Daughters of Charity of Albany	Albany
						Daughters of Charity of Emmitsburg	Baltimore
						Sisters of St. Joseph of Nazareth	Kalamazoo
						Sisters of St. Joseph of Carondelet	St. Louis
Catholic Health East (CHE) 11 states (AL, CT, DE, FL, GA, MA, ME, NJ, NY, NC, PA)	Newtown Square, PA (Philadelphia)	34	4	3	$6.0	Franciscan Sisters of Allegany, NY	Allegany
						The Sisters of Providence	Springfield
						Sisters of Mercy of the Americas	Washington
						The Sisters of St. Joseph	St. Augustine
						The Sisters of Charity of Seton Hill	Greensburg
						Sisters, Servants of the Immaculate Heart of Mary	Scranton
Catholic Health Care West (CHCW) 3 states (CA; AR; NE)	San Francisco, CA (San Francisco)	41	26	21	$10.8	Sisters of Mercy of the Americas	San Francisco
						Adrian Dominican Sisters	Lansing
						Dominican Sisters of Kenosha, Wisconsin	Milwaukee
						Dominican Sisters of San Rafael	San Francisco
						Sisters of Charity of the Incarnate Word of Houston	Galveston-Houston
						Sisters of St. Francis of Penance and Christian Charity	San Francisco
						Franciscan Sisters of the Sacred Heart	Joliet

Table 26: Health Care Systems with Hospitals outside the Study Area--continued

System (states)	Location of System Office (Diocese)	Hospitals			2009 Assets in billions	Sponsoring Religious Orders	Diocese of Sponsoring Orders
		Total #	# in Study	w/ V25.2			
Catholic Health Initiatives (CHI) 18 States (AR; CO; IA; IN; KY; KS; MD; MN; ND; NJ; NM; OH; OR; PA; SD; WA; WI)	Denver, CO (Denver)	72	4	4	$11.3	Benedictine Sisters of Mother of God	Sioux Falls
						Franciscan Sisters of Little Falls, MI	St. Cloud
						Congregation of the Dominican Sisters of St. Catherine of Siena of Kenosha, WI	Milwaukee
						Nuns of the Third Order of St. Dominic	Dodge City
						Sisters of Charity of Cincinnati	Cincinnati
						Sisters of the Holy Family of Nazareth	Philadelphia
						Sisters of Charity of Nazareth	Louisville
						Sisters of Mercy of the Americas, Regional Community of Omaha	Omaha
						Sisters of the Presentation of the Blessed Virgin Mary	Fargo
						Sisters of St. Francis of Colorado Springs	Colorado Springs
						Sisters of St. Francis of Immaculate Heart of Mary	Fargo
						Sisters of St. Francis of Philadelphia	Philadelphia
CHRISTUS Health 4 states (AR; LA; NM; TX)	Dallas, TX (Dallas)	40	14	9	$4.3	Sisters of Charity of the Incarnate Word of San Antonio	San Antonio
						Sisters of Charity of the Incarnate Word of Houston	Galveston - Houston
Hospital Sisters Health System 2 states (IL, WI)	Springfield, IL (Springfield in Illinois)	13	7	1	na	Hospital Sisters of St. Francis	Springfield in Illinois
PeaceHealth 3 states (AK, OR, WA)	Bellevue, WA (Seattle)	9	3	3	na	Sisters of St. Joseph of Peace	Washington

Table 26: Health Care Systems with Hospitals outside the Study Area--continued

System (states)	Location of System Office (Diocese)	Hospitals			2009 Assets in billions	Sponsoring Religious Orders	Diocese of Sponsoring Orders
		Total #	# in Study	w/ V25.2			
Providence Health and Services 5 states (AK; CA; MT; OR; WA)	Torrance, CA (Los Angeles)	27	12	11	$8.6	Sisters of Providence	Montreal
						Little Company of Mary	Chicago
SCL Health System 4 states (CA, CO, KS, MT)	Lenexa, KS (Kansas City-Kansas)	13	1	0	na	Sisters of Charity of Leavenworth	Kansas City-Kansas
Trinity Health 9 states (CA; IA; ID; IN; MD; MI; NE; OH; OR)	Novi, MI (Detroit)	46	3	1	$9.3	Sisters of Mercy Regional Community of Detroit	Detroit
						Congregation of the Sisters of the Holy Cross	Fort Wayne-South Bend
Totals		370	95	61			

*The Annual Reports of the respective systems are available through their websites. The reports are the sources for the annual assets numbers. In cases in which the annual report was not available, "na" is placed in the column.

Summary of Findings from the Analysis of Catholic Hospitals, Systems, and Dioceses

This study required obtaining patient datasets from seven states. Approximately 27 million patient records from 1,734 hospitals were acquired. Over 71 gigabytes of data were analyzed to identify and filter out the Catholic hospitals and the patients associated with them. A total of 176 Catholic hospitals with obstetric services were studied. Of those hospitals, the study revealed that 86 reported diagnoses and procedures for sterilization.

For the seven states for the periods covered, 20,059 sterilizations were performed in 48.3% of Catholic hospitals providing obstetric services. The number of hospitals performing sterilizations was more pronounced in the states of California, New Jersey,

Texas and Washington where the percentage of hospitals involved in sterilizations was 68% or higher. When examined regionally, the West Coast states of California (68.8%) and Washington (100%) had a combined percentage of 72.6%, the Midwest states of Illinois (13.5%) and Indiana (36.4%) percentage was 15.3%; the East Coast states of New York (23.8%) and New Jersey (87.5%) combined for 41.4%; and, Texas representing the South was 68.0%.

The majority (69.0%) of the hospitals investigated belonged to hospital systems which are sponsored or owned by religious orders, many with multiple orders involved in the systems. The trend is for hospitals to merge into larger systems to share in resources, increase negotiating ability with managed care providers and insurers, and gain a more advantageous position for the purchasing of products and services. Ten hospital systems operating in the seven states also have hospitals outside the study area. Together, they own 370 hospitals. A total of 95 of their hospitals were within the study area. Sixty-four percent of the 95 performed sterilizations. Diversity of practice existed within most of the systems. However, there was uniformity of practice in three systems with two systems reporting V25.2 codes in all hospitals studied and one system reporting none.

The states in which the hospitals were located contained 54 Catholic dioceses. Of those dioceses, 43 had Catholic hospitals located within them. Of the 43 dioceses with hospitals, 30 had Catholic hospitals providing sterilizations. Of these 30 dioceses with sterilizations, 14 of the dioceses had all hospitals within the dioceses reporting sterilizations. The other dioceses had diversity within their dioceses. Two dioceses actually owned hospitals, one of which had no sterilizations reported. Clearly, there is diversity of practice among the dioceses and within some dioceses.

CHAPTER FOUR

The Possible Consequences of Divergent Practices among Catholic Hospitals

This analysis of 176 Catholic hospitals providing obstetric services located in seven states across the U.S. established and quantified diversity of practice in the performance of inpatient direct sterilizations among the hospitals included in the study. Of the 176 hospitals, the study revealed that 48.3% of the hospitals provided sterilizations within the time periods studied. It also demonstrated that diversity of practice exists within hospitals belonging to common health care systems or located within a common diocese. This limited study did not evaluate other medical procedures that violate Catholic ethics, nor did it address outpatient procedures for sterilizations. Both of these areas could be investigated further, and would contribute to a more in depth analysis of diversity of practice in Catholic hospitals.

The extent of divergence of the practices of Catholic hospitals from the ERD calls into question the effectiveness of the ERD as a means to establish common interpretation and application of Catholic morality. This diversity of interpretation and practice may pose a judicial risk for Catholic hospitals to successfully invoke the conscience clauses when they refuse to offer procedures considered to be morally objectionable, and calls into question their ability to present a united political strategy to promote Catholic medical rights and values in future health care legislation.

From its original publication by the US Bishops in 1971, the ERD was updated four times with the latest edition in 2009. As previously indicated, ERD 53 states

> Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.[74]

The diversity in the practice of providing direct sterilizations in some Catholic hospitals seems to be due to divergent interpretations of ERD 53 since all hospitals assert that they are abiding by the ERD. Repeated attempts on the part of the U.S. bishops and the Vatican over a period of 40 years to bring an end to alternate interpretations points to a broader problem. The ERD do not establish transparent and accountable mechanisms for oversight. For example, there are no independent review boards to examine hospital policies or to ensure that ethics committees of hospitals are in accord with a uniform interpretation of the ERD.[75]

Currently, ethics committees are not required to report violations to anyone. A review of its judgments by ecclesial authority is not mandated, and there are no individual review boards to oversee their findings. If a violation is observed by a physician or staff member of a hospital, he or she is not now mandated to report the incident to anyone. In the current state of affairs, if the practitioner makes a formal complaint regarding a specific case to a local bishop, he or she risks violating HIPAA

[74] USCCB, *Ethical and Religious Directives for Catholic Health Care Services, 5th edition*. ed. Vol. 2009 (Washington, DC: United States Conference of Catholic Bishops, 2009) 53.

[75] Ann Carey reported on the fact that many hospital ethics committees are not current on the teachings of the Catholic Church and that there are no uniform standards for membership on such committees. She summarized a survey done by the CHAUSA and also quoted an interview with John Haas, president of the National Catholic Bioethics Center and Bishop Kevin Rhoades, Chairman of the U.S. Bishops' Task Force of Health Care. Ann Carey, "Many Hospital Ethics Boards out of Touch with Church," *Our Sunday Visitor*, February 6, 2011.

rules.[76] Given these conditions, in the absence of any independent oversight mechanisms, the ERD cannot be enforced in a uniform way. [77]

Uniformity in interpretation and implementation remain elusive because the ERD lack best practice methods for establishing transparency and accountability. A point of comparison would be, for example, the mechanism implemented to protect minors from abuse.[78] A best practices model would provide for the mandatory reporting of violations of the ERD to an independent review board with failure to report incidents leading to penalties or dismissal. Also, it would require the ethics committee of a hospital to be required to report all violations that come to their attention to an independent review board. The decisions of the ethics committee would also be mandatorily reviewed by an independent board. Another requirement would be that the hospital be required to report their patient diagnostic and procedure codes to an independent review board and ecclesial authorities on a periodic basis.

Without oversight mechanisms in place, the lack of uniformity of practice among Catholic hospitals may pose a judicial risk to the hospitals if a legal challenge is made against a hospital to force the provision of sterilization procedures. The federal conscience clauses as they currently exist provide health care providers with the right to refuse to perform sterilizations or abortions. Many existing state conscience clauses also

[76] HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 which protects the privacy of individually identifiable health information.

[77] A specific case in San Antonio, Texas highlights this issue. A nurse reported an alleged abortion to the Archdiocese and a suit was brought against her for violating HIPAA rules. Molly Gamble, "Nurse Claims San Antonio Hospital Fired Her for Reporting 'Abortion' to Archdiocese," *Becker's Hospital Review,* March 10, 2011. http://www.beckershospitalreview.com/hospital-financial-and-business-news/nurse-claims-san-antonio-hospital-fired-her-for-reporting-qabortionq-to-archdiocese.html (accessed June 9, 2011).

[78] USCCB, *Charter for the Protection of Children and Young People.* (Washington, DC: United States Conference of Catholic Bishops, 2002)

provide protection for most health care providers, and some specifically protect sectarian hospitals against providing any procedures considered to be morally objectionable. The appeal of Catholic hospitals to the conscience clauses could depend on their distinct religious identity which currently is connected to their stated commitment to the ERD. If however, that commitment is manifest in divergent practice, the ERD might no longer serve as basis for claiming conscientious objection. A court could rather easily find that refusal to provide direct sterilization was based not on the uniform interpretation of the ERD, but on the judgment of a particular Catholic hospital. Construing the objection to direct sterilization not as a violation of religious identity based on the ERD would lead to the conclusion that the Catholic hospital was basing its actions on other philosophical or economic criteria, much as a non-profit non-sectarian hospital might do. This would pose the greatest risk for those hospitals whose practices conform to the ERD. Their refusal to provide certain procedures based on their religious identity could be called into question when other Catholic hospitals are providing these very procedures. Also at risk would be those individual health professionals who conscientiously object to involvement with procedures prohibited by the ERD when the Catholic hospital in which they practice allows those procedures.

It is difficult to anticipate the arguments and outcomes of future court cases, but there seems to be little doubt that successful appeal to conscience clauses by Catholic hospitals and Catholic health professionals is linked to uniform interpretation and implementation of the ERD by Catholic hospitals. Lack of uniformity of interpretation and implementation of the ERD also has the potential of adversely affecting the ability of the bishops and the Catholic hospitals in bolstering the effectiveness of conscience clause

protections through legislative actions. Evidently, if some hospitals have a view of health care or a business model that values the provision of direct sterilization, they might not oppose legislation undermining the conscience clauses. They might in fact lobby for the obligatory provision of such services. With 48% of Catholic hospitals currently providing direct sterilization (ranging from 15.3% in the Midwest to 72.6% on the West Coast), it is hard to imagine the context in which the hospitals would join the bishops in uniform national political action to promote the conscience clauses. Regional cooperation would be more difficult except in the case of the Midwest. The lack of consensus and coordination between the bishops and the hospitals could prove disastrous for Catholic medical personnel and Catholic hospitals refusing participation in immoral medical procedures.

The lack of consensus between the USCCB and many hospitals represented by CHAUSA is already evident in recent cases in which they have publically promoted opposing views. For example, in the passage of the health care reform acts of 2010, the USCCB supported the basic intent of the Acts, but appealed to Congress to continue the federal ban on funding for abortions and reject any mandate for abortion coverage or access to abortion and to preserve freedom of conscience for providers, health care workers and patients.[79] While the USCCB vigorously opposed the passage of the Acts in their final form, CHAUSA publicly announced support for passage at a critical juncture in the political process. A representative of CHAUSA stood behind President Obama as

[79] USCCB, *Action Alert! Reform Health Care and Protect Human Life and Dignity*, (Washington, D.C.: 17 July 2009). (http://www.usccb.org/sdwp/national/2009-07-17-alert-healthcare.pdf; accessed 31 May 2011)

he signed the Acts into law and received one of the signature pens as an expression of gratitude from the administration.[80]

Another case in point is the one in Phoenix, where a hospital was involved in direct abortion, and the Bishop excommunicated a religious sister and removed the Catholic identity of the hospital.[81] In a statement issued by Sr. Carol Keehan, DC, President and CEO of CHAUSA, she publically defended the provision of the abortion as being in accord with the ERD.[82] After discussions between CHAUSA and the USCCB, a statement was issued in which CHAUSA acknowledged that interpretation of the ERD is the responsibility of the local bishop.[83] An appeal to the authority of interpretation by the bishop only points out the weaknesses described in the present study which demonstrates that there is no uniform interpretation of the ERD. Notably, CHAUSA did not state that the abortion in question was in fact a direct abortion prohibited under the ERD, nor did it call upon the hospital to alter its protocols.

This study has demonstrated that a significant diversity in the provision of direct sterilization among Catholic hospitals does exist with nearly one-half of facilities providing them. The lack of best practices for transparency and accountability in the

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[80] Jeff Tieman, "Ministry Plays Vital Role in Final Push for Reform," *Catholic Health World* 20:7, April 15, 2010. http://www.chausa.org/Ministry_plays_major_role_in_final_push_for_reform.aspx (accessed May, 31 2011).

[81] Bishop Thomas Olmstead, "St. Joseph's Hospital No Longer Catholic." (http://www.washingtonpost.com/wp-srv/health/documents/abortion/Bishop-Statement.pdf ; accessed 21 January, 2011).

[82] CHAUSA, *Catholic Health Association Statement Regarding St. Joseph's Hospital and Medical Center in Phoenix,* (Washington, D.C.: 22 December, 2010). (http://www.chausa.org/Contenttwocolumn.aspx?pageid=4294968339; access 31 May 2011)

[83] USCCB News Release, *Catholic Health Association Affirms the Role of the Local Bishop in Catholic Health Care* (Washington D.C.: 31 January 2011) (http://www.usccb.org/comm/archives/2011/11-024.shtml accessed 31 May 2011)

interpretation and implementation of the ERD makes it unlikely that the ERD alone would be able to bring an end to this diversity. While current conscience clauses on the federal level would support those Catholic hospitals wishing to prohibit sterilization and abortion, those conscience clauses are dependent upon annual legislative renewal. Any attempt to continue or strengthen them requires unified political action on the part of the USCCB and the Catholic hospitals—a uniformity which currently does not always exist and given the current practice of Catholic hospitals is unlikely to emerge. Appeal to state conscience clauses may already be weakened by the diversity of practice, thus leading the courts to judge Catholic hospital as non-sectarian regarding the provision of sterilization procedures. Future judicial action on the state and federal level may likely hinge upon competing arguments on the rights of conscience or the free exercise of religion versus rights to all legal medical procedures. Whatever the shape of future judicial and legislative efforts, the current diversity of practice at Catholic hospitals will severely weaken efforts by Catholics to legally and politically defend their conscientious objection to direct sterilization and abortion.

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