

**Author's Statement:** "The purpose of this essay was to write a research paper (in Chicago Manual Style) investigating any topic related to our course material, which discussed the relationship between moral frameworks and various approaches to wellness. I chose to examine Catholic hospitals, where enforcement of church social teachings taper the boundary between religion and healthcare accessibility. As an active Catholic who loves my religion, I am constantly invited to objectively assess the Church as an institution managed by humans, thus making it fundamentally imperfect. This mindset served as a key inspiration for my work."

### **Every Knee Shall Bend and Every Hospital Shall Abide**

Starting in the mid-1990s and extending through the late 2010s, a perfect storm of increasingly sophisticated medical technology, rising wages for healthcare professionals, and legislative healthcare reform began to decimate profit margins at hospitals across the United States.<sup>1</sup> In 1997, the American Hospital Association reported that the inflation-adjusted growth rate in average annual hospital operating expenses surpassed two percent for the first time in years.<sup>2</sup> The industry soon discovered that this was not a fluke spike. This rate increased each year from 1997 to 2002, reaching a maximum of six percent and averaging approximately four percent throughout the following two decades.<sup>3</sup> Each year, it became more difficult for independent hospitals to survive without alliances, and over the next twenty years, over one-fifth of America's hospitals would conduct a merger.<sup>4</sup> Organizations in the industry sought to unite with large groups that possessed the resources to negotiate favorable rates with insurance

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<sup>1</sup> Nina Martin, "Catholic Hospitals Grow, and With Them Questions of Care," ProPublica, last modified October 17, 2013, accessed December 3, 2024,

<https://www.propublica.org/article/catholic-hospitals-grow-and-with-them-questions-of-care>.

<sup>2</sup> American Hospital Association, Trends in Hospital Financing, last modified 2018, 5, accessed December 3, 2024, [https://www.aha.org/system/files/2018-05/20180302-Chartbook-2018\\_Chapter-4-Horizontal-Charts.pdf](https://www.aha.org/system/files/2018-05/20180302-Chartbook-2018_Chapter-4-Horizontal-Charts.pdf).

<sup>3</sup> Catholic Health Association of the United States, A Brief History, last modified December 2001, accessed December 5, 2024,

<https://www.chausa.org/publications/health-progress/archive/article/november-december-2001/a-brief-history>.

<sup>4</sup> Andrew Santos, III, "Acquisition and Partnerships Between Secular and Catholic Health Organizations: Navigating the Canonical, Ecclesial, and Theological Considerations," Catholic Health Association of the United States, last modified November 7, 2023, accessed December 4, 2024,

<https://www.chausa.org/publications/health-care-ethics-usa/archive/article/fall-2023/acquisition-and-partnerships-between-secular-and-catholic-health-organizations-navigating-the-canonical-ecclesial-and-theological-considerations>.

companies and ensure financial security.<sup>5</sup> At the same time, Catholic hospitals supplied ten percent of America's hospital beds, and their tax-exempt status as non-profit organizations captivated secular and independent healthcare executives. After IRS rulings favorably loosened the requirements for a religious tax-exempt status, proposals for partnerships, mergers, or acquisitions between Catholic and secular hospitals multiplied. Acting through the United States Conference of Catholic Bishops (USCCB), the Catholic church endorsed each one as an opportunity to extend the reach of Catholic values.<sup>6</sup> In 1998, these mergers transformed from rare occurrences to thirty-two occurring in just one year, followed by forty-three in 1999.<sup>7</sup> The trend continued through 2018, as the number of Catholic-secular hospital affiliations more than quadrupled. In the same period that the overall number of acute-care hospitals declined by 6%, the number of Catholic-owned or affiliated hospitals in America increased by 22%. The redefined industry resulted with one in six Americans receiving care in a Catholic-affiliated hospital.<sup>8</sup> With this outcome came a growing realization of what it meant for patients, workers, executives, and communities to participate in Catholic-affiliated healthcare. The Catholic values that the USCCB strove to circulate with these mergers, defined by a strict list of directives, carried implications that restricted deals intended to save critical community hospitals and provided pervasive limitations of certain healthcare services from entire communities.

From the start, Catholic hospitals in the United States wrestled with how to apply millennia-old dogma into the process of governing access to contemporary medical services. By

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<sup>5</sup> Chaya Tong, "How Catholic Healthcare Mergers Affect What Care is Offered," Exploring Health, last modified February 22, 2024, accessed December 4, 2024, <https://exploringhealth.org/2024/02/22/access-denied/>.

<sup>6</sup> Santos, "Acquisition and Partnerships," Catholic Health Association of the United States.

<sup>7</sup> Barbra Mann Wall, "Conflict and Compromise: Catholic and Public Hospital Partnerships," PubMed Central, National Library of Medicine, last modified June 16, 2010, accessed December 4, 2024, <https://pmc.ncbi.nlm.nih.gov/articles/PMC2886734/>.

<sup>8</sup> Lois Uttley, Christine Khaikin, and Patricia HasBrouck, "Growth of Catholic Hospitals and Health Systems," MergerWatch, 5, [https://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW\\_Update-2016-MiscarrOfMedicine-report.pdf](https://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf).

the 1900s, the Catholic church established a scattered hospital presence whose mission sought to “foster healing for all persons with special attention to our neighbors who are poor, underserved, and most vulnerable.”<sup>9</sup> At this time, the bishop’s hospital responsibilities ended with blessing the building, leaving the management of these Catholic hospitals to the nuns working within their walls.<sup>10</sup> In the early 1900s, a surge in immigration and densely populated cities enabled the devastation of the 1918 Influenza Pandemic and offered Catholic hospitals a critical opportunity to deliver their mission on an unprecedented scale.<sup>11</sup> The number of Catholic hospitals more than doubled nationwide, and inconsistent policies regarding surgery and death introduced a need to institutionalize. The Catholic Hospital Association, later to become the Catholic Health Association, soon materialized and published its first institution-wide rules with a written set of medical ethical norms in 1921. This standardized document and the following versions allowed church authority in the form of American bishops in the USCCB and the Vatican to declare total control over editing and revising the agreement in the 1960s. This critical change transferred the power to decide what could or could not be done in a Catholic hospital from the professionals responsible for each patient to the USCCB. The USCCB made its first change in 1971, renaming the agreement *The Ethical and Religious Directives For Catholic Health Care Services* and birthing the most influential document in Catholic healthcare.<sup>12</sup>

The USCCB took full advantage of the document’s amenable nature, and by the 1990s, *The Ethical and Religious Directives For Catholic Health Care Services*, typically referred to as the ERDs, contained over seventy strict directives that acted as mandatory implementations of church teaching. The most significant adjustment made in the 1971 document regarded the

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<sup>9</sup> Catholic Health Association of the United States, A Brief History.

<sup>10</sup> Wall, Barbra Mann. *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace*. Columbus, OH: Ohio State University Press, 2005. Digital file, 186-188.

<sup>11</sup> Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace*, 15.

<sup>12</sup> Catholic Health Association of the United States, A Brief History.

resolution of doubt clause. The clause asserted that “in absence of a determination by the magisterium, guidance of approved authors...offer appropriate guidance for ethical decision making.”<sup>13</sup> This addition meant that no patient or worker faced with any unique technicality could justify deviating from church policy. This sentence enabled the USCCB to declare the ERDs as extensions of dogma that determine the official healthcare-related interpretations of scripture, Catholic social teaching, canon law, and the Catholic Church Catechism.<sup>14</sup> All services related to “intrinsically immoral” actions such as “abortion, euthanasia, assisted suicide, and direct sterilization” became prohibited by Catholic teaching and banned from occurring in Catholic hospitals.<sup>15</sup> As a living document, the ERDs responded to the rise in Catholic healthcare partnerships in 2001 by adding a sixth section titled “Collaborative Arrangements with Other Health Care Organizations and Providers.”<sup>16</sup> Section six asserted that all affiliations involving Catholic hospitals “must be operated in full accord with the moral teaching of the Catholic Church, including these Directives,” and thus, the ERDs claimed jurisdiction over Catholic hospital partnerships.<sup>17</sup>

While varying degrees of affiliations offered scarce flexibility, the ERDs required all deals ranging from shared technology investments to total institution acquisitions to comply with its Principles of Cooperation.<sup>18</sup> These principles distinguish formal cooperation and material

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<sup>13</sup> "Ethical and Religious Directives for Catholic Health Care Services: Fourth Edition," Internet Archive, last modified July 2001, 7, accessed December 3, 2024, [https://ia601903.us.archive.org/32/items/ethical-and-religious/Ethical%20and%20religious%20\\_text.pdf](https://ia601903.us.archive.org/32/items/ethical-and-religious/Ethical%20and%20religious%20_text.pdf).

<sup>14</sup> Ron Hamel, "100th Anniversary - The Ethical and Religious Directives: Looking Back to Move Forward," The Catholic Health Association of the United States, last modified December 2019, accessed December 6, 2024, <https://www.chausa.org/publications/health-progress/archive/article/november-december-2019/100th-anniversary---the-ethical-and-religious-directives-looking-back-to-move-forward>.

<sup>15</sup> "Ethical and Religious Directives for Catholic Health Care Services: Sixth Edition," United States Conference of Catholic Bishops, last modified June 2018, 25, accessed December 2, 2024, <https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf>.

<sup>16</sup> Hamel, "100th Anniversary," The Catholic Health Association of the United States.

<sup>17</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 26.

<sup>18</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 23-25.

cooperation as two different forms of engagement with “immoral” acts in which a non-Catholic partner may be involved.<sup>19</sup> The principles define formal cooperation as “direct participation in an immoral act or sharing in the immoral intention of the person committing it.”<sup>20</sup> According to the ERD’s, formal cooperation is “always morally wrong.”<sup>21</sup> The USCCB defends this assertion by citing specific dogma in the Catholic Church Catechism, which declares that “anyone who leads others to do wrong becomes responsible for the evil that he has directly or indirectly encouraged.”<sup>22</sup> The USCCB’s policy thereby makes any formal cooperation guilty of scandal, a term Catholic teaching uses to refer to a serious sin that “leads another to do an evil.”<sup>23</sup> In practice, this meant that consent to “immoral” actions defined in the ERDs “within the [Catholic healthcare] system or a facility under its authority” was a scandalous sin.<sup>24</sup>

Material cooperation can be moral or immoral and is more complex to assess and subjective in ruling. It is defined as cooperation that does not share the “wrongdoer’s intention” in the immoral act or directly participates in it, but rather contributes in a way “related but not essential.”<sup>25</sup> While the ERDs admit that assessing the morality of material cooperation cases may raise “legitimate disagreements,” it places responsibility for the final ruling with the Catholic bishop in charge of the hospital’s diocese.<sup>26</sup> Informing this ruling are two distinctions made within the category of material cooperation. The first is immediate material cooperation, which

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<sup>19</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 24.

<sup>20</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 24.

<sup>21</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 23-26.

<sup>22</sup> *Catechism of the Catholic Church*, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 2022), §2287, accessed December 4, 2024, <https://www.usccb.org/sites/default/files/flipbooks/catechism/V/#zoom=z>.

<sup>23</sup> *Catechism of the Catholic Church*, §2284.

<sup>24</sup> National Catholic Bioethics Center, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services," *The National Catholic Bioethics Quarterly*, last modified August 2014, 338-339, accessed December 8, 2024,

[https://www.pdcnet.org/C1257D43006C9AB1/file/9D2F3706BF459AAFC1257D6B006AE8AE/\\$FILE/ncbq\\_2014\\_0014\\_0002\\_0149\\_0152.pdf](https://www.pdcnet.org/C1257D43006C9AB1/file/9D2F3706BF459AAFC1257D6B006AE8AE/$FILE/ncbq_2014_0014_0002_0149_0152.pdf).

<sup>25</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 24.

<sup>26</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 24.

occurs when the intent of the cooperator is the same as the intent of the wrongdoer.<sup>27</sup> According to the Catholic Health Association, immediate material cooperation is “always morally wrong.”<sup>28</sup> The second is mediate material cooperation, where the intent of the cooperator is separate and the immoral act is performed at “a safe moral distance.”<sup>29</sup> The vague language defining mediate material cooperation, the only acceptable form of cooperation, preserved room for bishops to restrict whatever they pleased.

Once the USCCB transferred all deal power to bishops and mounted their policies in essential Catholic dogma, communities relying on new Catholic-secular hospital affiliations in Sierra Vista and across the county began to feel the ERDs constricting their options. Barbra Mann Wall, who authored two books on the history of Catholic hospitals, published in the National Library of Medicine that half of Catholic-secular partnerships resulted in the discontinuation of services that were available prior to the arrangement.<sup>30</sup> One of these partnerships occurred with Sierra Vista Regional Medical Center in Arizona. The deal at Sierra Vista exemplified the archetype of hospitals hit hardest by rough industry conditions beginning in the late 1990s. It was a rural hospital located over ninety minutes away from the next closest biomedical facility, serving a shrinking regional population of about twenty thousand.<sup>31</sup> Years of financial pressure and fighting to stay alive for the community that relied on it forced Sierra Vista’s hand in merging with the Catholic Carondelet Health Network in 2010. Once the bishop confirmed the deal, protesters hoisted signs pointing out that Catholic directives now dictated a “community of all faiths.”<sup>32</sup> Sierra Vista removed access to several services it had offered for

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<sup>27</sup> Santos, "Acquisition and Partnerships," Catholic Health Association of the United States.

<sup>28</sup> Santos, "Acquisition and Partnerships," Catholic Health Association of the United States.

<sup>29</sup> Santos, "Acquisition and Partnerships," Catholic Health Association of the United States.

<sup>30</sup> Wall, "Conflict and Compromise," PubMed Central.

<sup>31</sup> Tong, "How Catholic," Exploring Health.

<sup>32</sup> Lucky Severson, "Catholic-Secular Hospital Mergers," Religion and Ethics Newsweekly, PBS, last modified March 25, 2011, accessed December 4, 2024, <https://www.pbs.org/wnet/religionandethics/2011/03/25/march-25-2011-catholic-secular-hospital-mergers/8431/>.

years, such as first-trimester abortions, sterilizations, and contraceptives.<sup>33</sup> Within just a few months of negotiations going public, Catholic policy had removed an entire county diverse in religious beliefs from proximity to services included in their insurance.<sup>34</sup>

In cases where the non-Catholic partner had more resources to negotiate compromises with the overseeing bishop on how to obey the ERDs, other Catholic leadership banned the agreements and restricted services. The war on compromises can be followed by tracking the additions made to the ERDs to patch what the USCCB saw as loopholes. Under the jurisdiction of Bishop McCarthy, who judged on a liberal interpretation of the ERDs, the partnership of the Seton Medical Center and Brackenridge Hospital in 1996 provided a masterclass for preserving services in Catholic affiliation deals. In the process, the Vatican and the USCCB added directives that banned each of their compromise arrangements. Seton was Catholic, and Brackenridge was a low-income-focused public hospital operated by the city of Austin. Overwhelmed with over sixty million dollars in debt and looking to avoid a collapse that would create a healthcare shortage in Austin, Brackenridge leased its buildings to Seton's management. Framing the deal as a lease agreement rather than a merger or acquisition, Bishop McCarthy reached the first compromise, ruling that the ERDs did not apply to Brackenridge.<sup>35</sup> Brackenridge management promised the community that it would preserve services like emergency contraception. Bishop McCarthy signed the agreement determined to rescue the city from losing its only large low-income hospital and perform the Catholic mission of charity. The Vatican responded weeks after the deal, threatening McCarthy with stripping both institutions of Catholic affiliation and

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<sup>33</sup> Severson, "Catholic-Secular Hospital," Religion and Ethics Newsweekly.

<sup>34</sup> Stephanie Mencimer, "Do Bishops Run Your Hospital?," Mother Jones, last modified December 2013, accessed December 5, 2024, <https://www.motherjones.com/politics/2013/10/catholic-hospitals-bishops-contraception-abortion-health-care/>.

<sup>35</sup> Peter Cataldo, "Institutional Cooperation: The ERDs," *The Catholic Health Association of the United States*, last modified December 2002, accessed December 3, 2024, <https://www.chausa.org/publications/health-progress/archive/article/november-december-2002/institutional-cooperation-the-erds>.

tax-exempt status. McCarthy defended his reasoning to the Vatican, expressing that Seton projected to provide fifty million dollars of charity care in 1999. The Vatican ultimately overruled McCarthy's decision and ordered the 2001 revision of the ERDs.<sup>36</sup> The new ERDs removed the "appendix of cooperation contained in the 1995 edition," the section McCarthy used to declare his arrangement as mediate material cooperation.<sup>37</sup> The USCCB proclaimed in the new preamble of the ERDs that the 1995 appendix "did not sufficiently forestall certain possible misinterpretations and in practice gave rise to problems in concrete applications of the principles."<sup>38</sup>

While these new rules led to the closure of at least two hospitals that lost their leases, McCarthy turned to the hospital within a hospital system, a method appearing in other deals disrupted by the new directives. This compromise allowed secular hospitals acquired by Catholic providers to continue providing ERD-banned services by establishing a separately licensed hospital located within the building.<sup>39</sup> Bishop McCarthy argued that offering sterilization and emergency contraception on Brackenridge's fifth floor and operating it as a separate entity qualified as permissible mediate material cooperation by the 2001 ERDs.<sup>40</sup> The Vatican initially approved McCarthy's reasoning, but as dozens of deals followed in his footsteps and Catholic groups protested the arrangement's inadequate "moral distance," feelings reversed.<sup>41</sup> When McCarthy retired, the Vatican rushed to replace him with Bishop Aymond, who later led the next revision to the ERDs in 2018.<sup>42</sup> When the updated version was released, McCarthy's hospital

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<sup>36</sup> Wall, "Conflict and Compromise," PubMed Central.

<sup>37</sup> "Ethical and Religious," Internet Archive, 2001, 36.

<sup>38</sup> "Ethical and Religious," Internet Archive, 2001, 36.

<sup>39</sup> Wall, "Conflict and Compromise," PubMed Central.

<sup>40</sup> Cataldo, "Institutional Cooperation," *The Catholic Health Association of the United States*.

<sup>41</sup> Kenneth White, "When Institutions Collide: The Competing Forces of Hospitals Sponsored by the Roman Catholic Church," Multidisciplinary Digital Publishing Institute (MDPI), last modified December 21, 2012, accessed December 7, 2024, <https://www.mdpi.com/2077-1444/4/1/14>.

<sup>42</sup> Wall, "Conflict and Compromise," PubMed Central.

within a hospital compromise violated three of the five new directives. Another popular strategy to preserve services, which involved the secular hospital establishing a new Planned Parenthood center in their community just before a partnership commenced, was also banned in the 2018 ERDs.<sup>43</sup> The ERDs forced the Brackenridge facility to close that same year and move under the roof of Seton's peer hospital, Dell Seton.<sup>44</sup> This facility cooperated strictly with the 2018 ERDs, barring all sterilization and emergency contraception services in the immediate area before Texas imposed its state ban.<sup>45</sup>

The most influential impositions of Catholic health policy took place through partnerships with critical access hospitals like Sierra Vista. Critical access hospitals are facilities at least a forty-five-minute drive away from the next closest biomedical hospital. These hospitals' rural nature and disproportionately low-income patient base often made them the most endangered by rising costs and the weakest negotiators with Catholic deal hunters. A Catholic healthcare merger is often the only way for these communities to keep a local hospital. By 2015, 132 of America's critical access hospitals were Catholic-affiliated. One of these institutions in Maryland reported that their partnership with a Catholic hospital placed patients ninety minutes from sterilization services and over three hours from any form of abortion procedure. These 132 hospitals adhered to the ERDs and logged over a million patients in 2019, wedging bishops and Catholic legislation between entire communities and their doctors.

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<sup>43</sup> Martin, "Catholic Hospitals," ProPublica; "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 26.

<sup>44</sup> Michael Barnes, "Austin Bids Farewell to Brackenridge Hospital after 133 Years," Austin American-Statesman, last modified May 19, 2017, accessed December 9, 2024, <https://www.statesman.com/story/news/2017/05/19/austin-bids-farewell-to-brackenridge-hospital-after-133-years/10054882007/>.

<sup>45</sup> Olivia Aldridge, "What's Going on with Central Health and Ascension Texas' Legal Saga?," KUT News, last modified May 5, 2023, accessed December 4, 2024, <https://www.kut.org/health/2023-05-05/whats-going-on-with-central-health-and-ascension-texas-legal-saga>.

The magnitude and pace of the merger boom with Catholic providers between the late 1990s and the end of the 2010s rendered dangerous confusion regarding what patients believed they could do at their hospital. During the boom, it became more likely for a given Catholic hospital to be affiliated with a secular institution than for it to exist as a standalone facility. This change ushered in a decentralized Catholic hospital system, which created difficulty for patients in distinguishing Catholic facilities from secular ones.<sup>46</sup> Many hospitals working under ERD restrictions were not built as Catholic and thus did not feature religious decor or symbols to signal denomination. It became less common for partnerships to result in name changes, and the Franciscan Alliance, one of the largest Catholic health systems in America, dropped all saint names from its facilities in 2016. The resulting confusion yielded cases where patients were unaware that the ERDs bound their decisions until they were denied a desired service. Examples have been life-threatening, such as a miscarriage patient at Sierra Vista who required emergency transportation to another hospital to save her life.<sup>47</sup> Similar instances became frequent enough that prominent organizations like the National Women's Law Center have threatened legal action and accused Catholic hospitals of disregarding their legal requirement to disclose treatment options.<sup>48</sup>

Just as dangerous to the American healthcare market as restrictions on patients, the limited residency training offered in Catholic hospitals stifled talent development for the entire healthcare industry. Directive seventy-three of the ERDs bans all hospital employees from "performing, assisting, making referrals for, or prescribing" procedures prohibited in the document.<sup>49</sup> Like patients, some healthcare professionals had no knowledge of an institution's

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<sup>46</sup> Mary Homan and Kenneth White, "The Changing Landscape of Catholic Hospitals and Health Systems, 2008–2017," *Journal of Healthcare Management*, last modified 2021, accessed December 7, 2024, [https://journals.lww.com/jhmonline/abstract/2021/0200/the\\_changing\\_landscape\\_of\\_catholic\\_hospitals\\_and.7.aspx](https://journals.lww.com/jhmonline/abstract/2021/0200/the_changing_landscape_of_catholic_hospitals_and.7.aspx).

<sup>47</sup> Tong, "How Catholic," *Exploring Health*.

<sup>48</sup> Mencimer, "Do Bishops," *Mother Jones*.

<sup>49</sup> "Ethical and Religious," *United States Conference of Catholic Bishops*, 2018, 26.

Catholic affiliation. One doctor told *Forbes* in 2016 that she was unaware of her employer's Catholic affiliation until her "application asked [her] to agree to abide by the ERDs."<sup>50</sup> The *Journal of Graduate Medical Education* published research in 2017 finding that residency in a Catholic hospital, especially for prospective OBGYNs, left many feeling "unprepared" to enter a primarily secular job market.<sup>51</sup> 7.2% of residency programs occurred in Catholic-affiliated hospitals during 2017, sending an alarming amount of healthcare professionals into the industry without any hospital experience performing or suggesting several routine operations.<sup>52</sup> Another doctor testified, "I expected to be an expert in women's healthcare and I didn't know how to perform tubal ligation or IUD insertion when I graduated."<sup>53</sup> Restricted training and experience released an infection of incapability onto the industry and emphasized the struggle for doctors who made the increasingly common switch to working at a secular institution.

Catholic-secular mergers often blended institutional identities and values, stripping them of a stable labor force and imposing a circular process of worsened patient experiences. After residency, Catholic hospitals employ roughly ten percent of America's physicians and nurses.<sup>54</sup> The stated Catholic hospital mission and value system centered on charity and extending care to the most vulnerable had historically proved to be a reliable tool for attracting employees.<sup>55</sup> However, as Catholic institutions invited more influence from mergers, the same patterns that

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<sup>50</sup> Judy Stone, "Healthcare Denied at 550 Hospitals Because of Catholic Doctrine," *Forbes*, May 7, 2016, accessed December 6, 2024, <https://www.forbes.com/sites/judystone/2016/05/07/health-care-denied-at-550-hospitals-because-of-catholic-doctrine/#60d7a9725ad9>.

<sup>51</sup> Tong, "How Catholic," *Exploring Health*.

<sup>52</sup> Maryam Guiahi et al., "Impact of Catholic Hospital Affiliation During Obstetrics and Gynecology Residency on the Provision of Family Planning," *Journal of Graduate Medical Education*, National Library of Medicine, <https://pmc.ncbi.nlm.nih.gov/articles/PMC5559237/>.

<sup>53</sup> Tong, "How Catholic," *Exploring Health*.

<sup>54</sup> American Medical Association, "Mergers of Secular & Religiously Affiliated Health Care Institutions," *Code of Medical Ethics*, 1, accessed December 5, 2024, <https://code-medical-ethics.ama-assn.org/sites/default/files/2022-09/11.2.6%20Mergers%20between%20secular%20%26%20religiously%20affiliated%20health%20care%20institutions--background%20reports.pdf>.

<sup>55</sup> Guiahi et al., "Impact of Catholic," *Journal of Graduate Medical Education*.

made Catholic hospitals less distinguishable to community members began occurring at the management level. Ascension Health, one of the most prominent Catholic health providers in the United States, stood at the forefront of many of these actions. Ascension aggravated workers with decisions they claimed contradicted Catholic values, and whistle-blowers accused the company of acting as a private equity fund.<sup>56</sup> In a pure effort to cut costs, Ascension closed 26% of its labor and delivery units between 2012 and 2016 and left its 140 hospitals with just fifty birthing units.<sup>57</sup> These changes put certain communities up to three hours away from a maternity ward and directly contradicted the ERD's "commitment to life."<sup>58</sup> Additional cost-cutting methods like stripping pensions with a court ruling and reporting a rate of charity care 27% below the national average sent employees exiting for other opportunities.<sup>59</sup> These work culture shifts convinced thousands of Catholic healthcare workers to leave for jobs in non-Catholic institutions outside ERD jurisdiction, an environment one Catholic nurse declared many were "inadequately prepared" for.<sup>60</sup> In these settings, patients faced the burden of uncertain counseling and under-rehearsed procedures from nurses who admitted that the deficiency "put patients at risk."<sup>61</sup> In addition to spreading unpreparedness to non-Catholic hospitals, the exodus resulted in staffing shortages that further restricted care in Catholic-affiliated institutions.<sup>62</sup>

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<sup>56</sup> Aleja Hertzler-McCain, "Ascension Catholic Hospitals Outsource Staffing to Private-Equity-Owned Partners," National Catholic Reporter, last modified June 19, 2024,

<https://www.ncronline.org/news/ascension-catholic-hospitals-outsource-staffing-private-equity-owned-partners>.

<sup>57</sup> Aleja Hertzler\_McCain, "Catholic Bishops Silent as Ascension Hospital System Shrinks Maternity Care,"

Religion News, last modified April 8, 2024, accessed December 8, 2024,

<https://religionnews.com/2024/04/08/catholic-bishops-silent-as-ascension-hospital-system-shrinks-maternity-care/>.

<sup>58</sup> "Ethical and Religious," United States Conference of Catholic Bishops, 2018, 16.

<sup>59</sup> Andrew Chung, "Top Court Exempts Church-Affiliated Hospitals from Pension Law," Reuters, last modified June 5, 2017, accessed December 9, 2024,

[https://www.reuters.com/article/us-usa-court-pensions-idUSKBN18W26R/?fbclid=IwZXh0bgNhZW0CMTAAR1qGGrJaIdWScXFA2899Nfr9770hAA9nrsadSMuxYZZoFa1y3fF9TFHvia\\_aem\\_gB-u-qPwYrEE17dpkxmc7g](https://www.reuters.com/article/us-usa-court-pensions-idUSKBN18W26R/?fbclid=IwZXh0bgNhZW0CMTAAR1qGGrJaIdWScXFA2899Nfr9770hAA9nrsadSMuxYZZoFa1y3fF9TFHvia_aem_gB-u-qPwYrEE17dpkxmc7g);

Hertzler\_McCain, "Catholic Bishops," Religion News.

<sup>60</sup> Hertzler\_McCain, "Catholic Bishops," Religion News.

<sup>61</sup> Guiahi et al., "Impact of Catholic," Journal of Graduate Medical Education.

<sup>62</sup> Elaine Bauer and George Longshore, "Improving Recruitment and Retention," The Catholic Health Association of the United States, last modified April 2003, accessed December 9, 2024,

<https://www.chausa.org/publications/health-progress/archive/article/march-april-2003/improving-recruitment-and-retention>.

The Catholic church's staunch teachings and directives, elevated by a boom in hospital mergers to reach American patients nationwide, caused direct healthcare limitations and severe talent lags in the biomedical labor force. The rapid expansion concentrated in a twenty-year period left millions of Americans, 80% of whom were not Catholic, living in a healthcare ecosystem dictated by fewer than three hundred bishops and their ERDs.<sup>63</sup> The ERDs also created ripple effects that established themselves through a high-turnover healthcare labor market, which delivered ERD-trained and developed workers to institutions without Catholic affiliation. The detriments of these factors ultimately landed on American hospital patients, leaving their options and safety at the discretion of USCCB policies.

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<sup>63</sup> Patricia Gabow, "Catholic Healthcare Delivery in America — Noble Origins to the Modern Era," American Association for Physician Leadership, last modified December 17, 2023, accessed December 9, 2024, <https://www.physicianleaders.org/articles/catholic-healthcare-delivery-in-america-noble-origins-modern-era>.

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