Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing the Ethical Challenges

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In New York, as elsewhere in the nation, community hospitals are exploring the potential for mergers, affiliations and other forms of business partnerships. The goal is to improve their bottom lines and position themselves to best advantage in a changing health care marketplace. Negotiating such partnerships can be challenging, especially when one of the partners is a Catholic-affiliated hospital or health system that restricts the provision of medical care deemed to violate Catholic teaching.

In recent years, several proposed Catholic/non-sectarian hospital partnerships in New York State have addressed ethical conflicts over the provision of health care services. Each of the outcomes has been unique, shaped by particular community needs and by such factors as the relative financial position of the merging partners and the commitment of the non-sectarian hospital's leadership to find ways of preserving patient access to reproductive health services threatened by the introduction of religiously based restrictions. In some cases, innovative approaches have emerged that could serve as lessons for future Catholic/non-sectarian hospital partnerships in New York and other states.

With grant support from the New York State Health Foundation and the Robert Sterling Clark Foundation, the authors have been studying and documenting these cases for a forthcoming briefing paper. This article describes and compares two of these approaches: the creation of an outpatient surgery center and the establishment of a "hospital-within-a-hospital" or co-located hospital. The article describes the process by which each of these approaches was developed, and compares their strengths and weaknesses. The authors also discuss the role of the New York State hospital oversight system.

Issues in Catholic/Non-sectarian Hospital Mergers

Catholic-affiliated hospitals, like all non-profit hospitals, are accountable to their boards of directors and sometimes to larger health systems of which they are members. Like other hospitals, they must answer to state regulators who grant hospital licenses and federal regulators who certify hospitals as eligible to receive Medicare and Medicaid reimbursements. But what sets Catholic hospitals apart, even from other faith-based health care providers, is their accountability to the religious orders that are their sponsors and to local Catholic Bishops and ultimately, the Vatican.

While all hospitals have ethics policies and committees, Catholic hospitals also are guided by the *Ethical and Religious Directives for Catholic Health Care Services*[1] *(Directives)*, which are promulgated and updated by the U.S. Conference of Catholic Bishops. These *Directives* spell out general principles for Catholic health care delivery, and specifically prohibit or restrict the provision of certain reproductive health care services: contraception, emergency contraception, sterilization, abortion, infertility services and comprehensive "safer sex" counseling to prevent the transmission of sexually transmitted diseases.[2] Each local Bishop has the responsibility for interpreting how the *Directives* are applied at Catholic health facilities in his Diocese. On occasion, these Bishops are overruled by the Vatican.[3]

When Catholic hospitals seek to partner with non-Catholic health facilities, future adherence to the *Directives* by one or both of the merging entities becomes a point of negotiation, and potentially a significant hurdle. If the non-Catholic hospital is asked to follow the *Directives*, there may be opposition from that hospital's medical staff, board of directors and patients, because the merger could then cause a loss of access to services in a community and could require physicians to follow religious guidelines that may conflict with prevailing medical standards of care and the ethical principles of health care professionals.[4] Staff of the non-Catholic hospital also could lose their employee health insurance coverage for contraception, sterilizations, abortions and infertility services through the merger.[5] On the other hand, if the Catholic hospital agrees to allow the non-Catholic facility to continue providing a full range of services, including those prohibited by the *Directives*, there is a strong possibility that the local Bishop will disapprove the transaction.

New York State Hospital Oversight

New York State's hospital oversight system has played a role in ensuring continued community access to reproductive health services as the hospital industry has consolidated, although this article suggests that patient protections should be strengthened. New York's Certificate of Need (CON) process governs the purchase of major medical equipment, renovation and construction of health facilities and the establishment of health facilities, which includes the sale or merger of health facilities. New York has several levels of review, with the intensity of re-

view, ranging from administrative review to full review, dependent on the type of application. Establishment applications undergo full review, which involves the highest level of scrutiny.

The CON process, however, responds to hospital-initiated proposals and does not cause hospital consolidation. In 2005, the New York State Legislature and Governor George Pataki created the Commission on Health Care Facilities in the 21st Century, known as the Berger Commission after its chairman, Stephen Berger.[6] The Commission was charged with "examining the system of general hospitals and nursing homes in New York State and recommending changes to that system."[7] The intent in establishing the Commission was to reconfigure and "rightsize" New York's hospital and nursing homes in order to eliminate excess capacity and to ensure that regional needs would be met as health care delivery changed.

The core finding that emerged from this process was that many regions of New York had an over-supply or mal-distribution of acute care hospital beds and technology that generated wasteful costs and poor quality. The final recommendations, which became law on January 1, 2007, affected 57 hospitals—one quarter of the state's hospitals—calling for 48 reconfigurations, affiliations or realignments and the closure of nine hospitals, eliminating approximately 7% of licensed hospital beds in the state.[8]

Of the affiliations recommended by the state hospital commission, four involved partnerships between Catholic and non-sectarian hospitals. Two of those four, the Kingston case discussed in this article and the merger of three hospitals in Schenectady County, were implemented largely as recommended.[9] Another Commission-recommended merger of Catholic and non-sectarian hospitals in Niagara Falls did not result in a successful partnership.[10] A fourth recommended merger, in Elmira, did not occur immediately, but ultimately did take place.[11]

Several other partnerships between Catholic and non-sectarian hospitals have occurred in New York State in recent years without a specific mandate from the Berger Commission. One of those transactions involved hospitals in Troy, NY, and is the subject of our second case study.

First Case Study: Kingston, New York

Non-sectarian Kingston Hospital and Catholic-affiliated Benedictine Hospital are located less than a mile apart in Kingston, NY, which has a population of 22,000. Kingston Hospital historically provided a full range of women's reproductive health services, including abortions and tubal ligations. The two hospitals had attempted to merge in 1997 in a proposed partnership that also included non-sectarian Northern Dutchess Hospital across the Hudson River. That proposed transaction fell apart in 1998 amid vehement community opposition to plans for Kingston and Northern Dutchess hospitals to discontinue provision of reproductive health services that violate Catholic teaching. Anti-trust concerns raised by the Federal Trade Commission and differences in culture and management style among the three hospital boards of directors and CEOs also played a role.[12]

Following that failed merger attempt, Kingston Hospital officials held focus group discussions with community residents about the future of the hospital, and in 1999 they unveiled a new hospital mission statement that underscored its non-religious mission.[13]

Kingston and Benedictine hospitals began looking at each other again as financial stresses mounted at both facilities. Both hospitals were operating at only 70 percent of capacity, and offering duplicate services. Michael Kaminski, who became CEO of Kingston Hospital in 2004, recalled that "we recognized the reality of the situation. We were really going to have to do something."[14] However, given the acrimony left over from the previous merger attempt, "the boards of both hospitals were reluctant to make another attempt at merging," Kaminski said.

In 2004, the boards and management of both hospitals undertook new negotiations with the understanding that: 1) the missions of both hospitals had to be preserved, 2) a plan had to be developed to realign services to avoid duplication, 3) abortions and sterilization services had to continue to be available to the community, and 4) neither hospital could appear to have taken over the other. Throughout the hospitals' negotiations, discussions were held with the NYS Department of Health and the Berger Commission, according to Kaminski. Women's health advocates met separately with Commission leadership and testified at commission-related public hearings about the need to protect reproductive health services.

The Commission's report recommended that Kingston and Benedictine hospitals come together under one unified governance system and reduce their combined capacity from 385 beds to 300 or fewer. The report summary asserted that this reconfiguration "will improve the financial standing of both facilities, reduce duplication of services, allow for efficient future investments, and improve the organization's ability to meet the community's health care needs."[15] Should the hospitals find themselves unable to merge after one year, the Berger Commission recommended lifting the operating license of one of the hospitals, without saying which one it should be. In recognition of the conflict over reproductive health services that had stymied the previous merger, the Berger Com-