



Merging Catholic and Non-Sectarian Hospitals: NYS 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. 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 state hospital oversight system.

Issues in Catholic/Secular 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* (*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 are seeking 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.

NYS Hospital Oversight

New York’s 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 paper 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 review, 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 of itself bring about 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 findings that emerged from this process were 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, that are the subject of our second case study.

First Case Study: Kingston, NY

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 had 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 with representatives of the Berger Commission, according to Kaminski. Women’s reproductive health advocates met separately with commission leadership and community representatives testified at commission-related public hearings.

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 Commission specified that the Kingston-Benedictine partnership should be “contingent upon Kingston Hospital continuing to provide reproductive health services in a location proximate to the hospital.”¹⁶

The hospitals agreed to create a joint parent, Health Alliance, a non-sectarian entity that includes Kingston and Benedictine hospitals. Each hospital remained a separate corporation, and no hospital achieved majority control of the Health Alliance board. Initially, the parent organization was legally “passive” to allow Kingston Hospital to maintain abortion services until a plan could be carried out to move abortions to another location, under the auspices of a separate corporation. “The reason for the passive parent was...the Catholic Church would not allow Benedictine to follow any dictates of this parent corporation until and unless Kingston discontinued abortion services,” Kaminski said.¹⁷ Once that was accomplished, the “passive” parent would become an “active” parent over the hospitals. Each of the hospital’s boards would report to and be responsible to the “active” parent, but each hospital would continue to maintain separate operating certificates and financials under the “active” parent arrangement. The passive phase of the partnership did not require state approval, but the active parent arrangement did.

After much negotiation, and consultation with the Archdiocese of New York, the two parties developed a memorandum of understanding that expressly permits Kingston Hospital to continue to provide post-partum tubal ligations, contraception and contraceptive counseling, treatment of ectopic pregnancies and miscarriage management. Community pressure was exerted through in-person meetings with hospital officials and through intervention in the State Department of Health's Certificate of Need regulatory proceedings. The continued provision of post-partum tubal ligations (either at the time of cesarean delivery or immediately following a normal delivery) was accomplished, and accepted by the Catholic partner, by defining that service as merely a "continuation of procedure" that had already begun with the initiation of childbirth.

However, abortions, "interval" tubal ligations (those not performed immediately after childbirth) and vasectomies could not be continued in Kingston Hospital because of Catholic objections. The hospital historically had performed first-trimester abortions, largely for low-income women without other easily-available alternative providers.¹⁸ Continued provision of those reproductive services was made possible with the establishment of a new 5,500 square-foot outpatient ambulatory surgery center, located in the parking lot of Kingston Hospital, just steps away from a hospital entrance. The Foxhall Ambulatory Surgery Center has its own board of directors and is legally distinct from Kingston Hospital.

This solution was the result of many months of contentious negotiations. The Archdiocese would not accept an early plan that placed abortion services within a "carved-out" separately-incorporated section of Kingston Hospital itself, according to Kaminski.¹⁹ Proposals to place the services within a suite in a medical office building were turned down by doctors with offices in the building, who were worried about protestors creating disruptions, and by community members who were concerned about the safety of women seeking abortion care in an unsecured building. By constructing the surgery center in the parking lot of Kingston Hospital, the hospital better assured that it could maintain security on its own land.

Kingston Hospital officials working to create a business plan for the surgery center decided to offer a range of other non-reproductive ambulatory surgeries for two reasons: 1) to better ensure financial viability of the center, which otherwise would have to survive solely on the revenues from a narrow range of reproductive health services; and 2) to protect the safety and privacy of women seeking care there by making it impossible to tell which service they were seeking. Community members and women's health advocacy groups approved of this mixed-menu of services, but expressed concerns at state hospital review hearings that the center still appeared financially vulnerable over the long term.

To pay for construction of the Foxhall Center, Kingston Hospital officials turned to the state. They were able to secure more than \$4 million for the center as part of a larger \$47 million grant the State Health Department made available to help Kingston and Benedictine carry out a number of changes that were necessary to bring about the partnership.²⁰ When meeting with state officials, Kaminski recalls, Kingston Hospital representatives "tried to make it clear that,

without state funding, the realignment of services and creation of the parent corporation and ambulatory surgery corporation could not occur.”²¹

The next challenge was to address objections from Benedictine and the Archdiocese to plans to staff the Foxhall Center by leasing staff from Kingston Hospital. This hurdle was overcome by transferring some hospital staff to the payroll of an unaffiliated entity, Nistel, Inc., which employs staff and leases them back to the ambulatory surgery center and the two hospitals. These staff work a few days a week in the ambulatory surgery center and the rest of the time in the two hospitals. The transfer of staff is intended to insulate Benedictine from any appearance of involvement in having their staff going to the ambulatory surgery center and providing services forbidden by the Catholic *Directives*.

How is the Kingston solution working? All maternity services from the two hospitals have been consolidated at Kingston Hospital, which continues to perform post-partum tubal ligations. The Foxhall Center remains open, but only two to four days a week, and with a limited range of non-reproductive services. Financial viability remains a concern. Most troubling is the news that the physician who had been providing abortions at the Foxhall Center retired in late 2011 and, while the Center has made a commitment to maintain these services, a replacement had not yet been found as of March 1. This situation raised community concerns that the commitment to reproductive health access in Kingston would be further undermined.

Second Case Study: Troy/Albany, New York

Troy is home to New York State’s first “hospital-within-a-hospital” or “co-located hospital” solution created to preserve access to key reproductive health services at a non-sectarian hospital ahead of a planned merger with two local Catholic hospitals. The Burdett Care Center is an independent, separately-licensed 15-bed maternity hospital located on the second floor of the historically non-sectarian Samaritan Hospital. The facility consolidates all maternity services from Samaritan Hospital and nearby St. Mary’s Hospital and preserves services that can no longer be offered by Samaritan itself, under the terms of the merger: sterilization procedures, birth control and treatment of certain pregnancy emergencies.

In the early 1990s, Troy, NY, supported three hospitals: two non-sectarian facilities, Leonard and Samaritan, and a Catholic hospital, St. Mary’s. In 1994, St. Mary’s merged with Leonard, creating Seton Health System, a Catholic-sponsored entity, and St. Mary’s was the surviving hospital. Women who had depended upon Leonard’s outpatient clinic for contraceptive services were turned away. A lawsuit was filed by reproductive health organizations in 1995 asserting that the State failed to adequately consider public need when approving the merger and contending the merged hospital’s refusal to counsel and refer patients for contraceptive care violated standards of care. The lawsuit was eventually settled, with the hospital agreeing to allow physicians to counsel patients about contraception and provide patients with a list of providers who offered contraceptive care. The settlement also explicitly allowed physicians to

follow up with the patient to ensure needed care was received and to include such information in patient's medical records.²² The most significant benefit to this approach was it set an expected minimum standard for future such affiliations.

A decade later, one of the two remaining hospitals in Troy – Samaritan Hospital, which was part of the non-sectarian Northeast Health system – began to actively consider its options. The CEO of Northeast Health, James K. Reed, M.D., began talking to the CEO of St. Peter's Health Care Services, a Catholic health system in nearby Albany. “The organizations were not in a current financial bind,” Dr. Reed recalled, “but we believed the future was fundamentally going to change for the community hospital.”²³

When officials of St. Mary's Hospital (the other remaining hospital in Troy) – learned that Northeast Health was in talks with St. Peter's, they asked to be involved as well. Women's health advocates became concerned that a merger of Samaritan Hospital with St. Mary's Hospital could eliminate hospital provision of reproductive services completely in Troy, if Catholic health restrictions became applied to Samaritan Hospital. Months of negotiations between the merger partners, and conversations with the women's health advocates, then took place.

The result was the creation of a new independent maternity hospital – the Burdett Care Center – carved out from the second floor of Samaritan Hospital in Troy in order to maintain community access to sterilizations and contraception. This case has a number of characteristics which highlight the complexities of working around religious restrictions.

The new parent corporation of the merged hospitals, St. Peter's Health Partners, is a non-sectarian entity in which corporate “members” St. Peter's and Seton Health retain their identities as Catholic facilities and member Northeast Health (including Samaritan Hospital) retains its identity as a non-sectarian health care system. As a condition of the agreement, however, Northeast Health agreed to abide by Catholic health restrictions, and despite its non-sectarian identity, banned abortions, tubal ligations, contraceptive counseling and other reproductive health services within Samaritan Hospital.

The creation of the Burdett Care Center as a separately-licensed entity ensures the continuation of these reproductive health services at the location of Samaritan Hospital, with the exception of elective abortions which were banned at both Samaritan and Burdett Care Center at the request of Northeast's Catholic merger partners. Local providers outside the hospital setting have agreed to absorb the small number of abortion cases that were routinely performed at Samaritan prior to the merger.²⁴ Those cases that require hospitalization are referred through an existing network to nearby Albany Medical Center. The New York State Department of Health provided \$5 million in grant funding to help create the center.²⁵ Prior to merger, Samaritan also created a \$5 million trust for the Burdett Care Center as a financial buffer.²⁶

The creation of the Burdett Care Center was a complex endeavor that consumed months of the time of Northeast Health executives, one of whom later said that this approach is “not for the faint of heart.”²⁷ Burdett Care Center has its own staff and board. Board members include an obstetrician-gynecologist and an attorney who has been active in support of reproductive rights, as well as a midwife. Midwives, who had played a larger role at St. Mary’s maternity unit than at Samaritan’s, demanded and got changes to the Center’s physical configuration and policies to accommodate their approach.

In the last month before the opening of the center, Burdett Care Center officials faced challenges in overcoming some unexpected regulatory demands by the Regional Office of the Centers for Medicare and Medicaid Services (CMS). Very late in the process, Burdett Care staff were informed that CMS would strictly interpret federal regulations that help to define a “separate and distinct” health care facility. Issues regarding 24-hour specialist care, medical record keeping and EMTALA obligations had to be ironed out before a final stamp of approval could be given. With some adjustments to its plans, the Center passed this final roadblock and was given CMS approval, which is needed in order to receive Medicare and Medicaid reimbursements.

In offering advice to other systems considering a hospital merger, Dr. Reed said, “Know your stakeholders and be as open and transparent as you possibly can be, so that the community can help you through this process.”²⁸

Lessons learned

Preservation of community access to reproductive health services in Troy and Kingston was achieved only with considerable investments of time and money, including nearly \$10 million in public funds. What lessons can be drawn from these two cases?

First, executives and boards of the non-sectarian hospitals shouldered primary responsibility for devising solutions to preserve access to reproductive health services – in one case through creation of an ambulatory surgery center and in the other through establishment of a co-located, separately-licensed maternity hospital. The leaders of the non-sectarian hospitals spent countless hours negotiating every detail of the arrangements with their prospective Catholic hospital partners. They also met repeatedly with community members and representatives of women’s health organizations, responding to questions and critiques. Finally, they navigated regulatory requirements at the state level and, in the case of Troy, surmounted unexpectedly complicated federal requirements.

Second, the development of such case-specific solutions demands extraordinary vigilance and engagement by volunteer members of the concerned community. In Kingston, community members actively monitored and critiqued merger talks between the two hospitals for more than a decade, helping defeat a first merger attempt that would have sacrificed some reproductive services and building public pressure for protection of these services. When the Berger Commission mandated a Kingston merger, community activists worked with hospital

executives to shape the creation of the Foxhall Ambulatory Surgery Center. In both the Kingston and Troy cases, professionals at women's health advocacy organizations and community activists devoted many hours to analyzing the hospitals' proposals and submitting comments to hospital executives and to state regulators. This level of commitment and resources is not available in many communities.

Third, despite all of this effort and money spent, each of the two solutions is imperfect. Abortion services were preserved in Kingston, but not Troy, and abortions recently ceased even in the Kingston ambulatory surgery center after its only provider retired and a replacement was not immediately identified. Kingston Hospital managed to preserve post-partum tubal ligations within the hospital, while sending "interval" tubal ligations and vasectomies to the surgery center in its parking lot. In Troy, all sterilization services were removed from Samaritan Hospital and placed in the Burdett Care Center.

Each of these solutions involved divorcing key women's reproductive health services from the non-sectarian hospitals in which they had long been delivered, and placing those services in separately-incorporated health facilities. The long-term financial viability of such separate centers remains uncertain, because they have a narrow range of poorly reimbursed services generating revenue, and expansion of their service menus would potentially place them in direct competition with the hospitals that created them. Kingston's ambulatory surgery center, in particular, appears financially vulnerable. Creators of the Burdett Care Center in Troy took steps to protect it from losses by establishing a \$5 million trust, and providing revenues from an expected 1,200 births per year.

The hospitals and state officials overseeing these transactions have accomplished financially-desirable hospital consolidation, while satisfying ethical differences between the hospitals and, at least initially, protecting community access to all or most reproductive health services. However, the long-term benefits and costs of these approaches have not been thoroughly examined. We encourage hospital regulators to actively monitor these two cases and intervene when necessary to ensure that access to reproductive health care is preserved. Moreover, we urge public policymakers to examine the shortcomings of these two approaches and develop policies that explicitly address the need for long-term assurances of community access to reproductive health services.

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¹ *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed., United States Conference of Catholic Bishops (Nov. 17 2009), <http://uscgb.org/about/doctrine/ethical-and-religious-directives/>.

² *Id.*

³ *Brackenridge Hospital: Contract to be revised in Face of Vatican Criticism*, Kaiser Daily Reproductive Health Report (August 21, 1998).

⁴ Susan Berke Fogel and Tracy A. Weitz, “Health Care Refusals: Undermining Quality Care for Women,” Los Angeles, CA: National Health Law Program, 2010.

⁵ Employees of Catholic-affiliated hospitals should gain contraceptive coverage after August of 2013, the deadline set by the U.S. Department of Health and Human Services for religiously-affiliated employers to come into compliance with new women’s preventive services coverage requirements promulgated by HHS under the authority of the Affordable Care Act. A final rule issued by HHS states that these religiously-affiliated employers do not have to pay for the coverage themselves, however.

⁶ The Commission consisted of 18 statewide members and six regional members who represented different regions of the state. Six regional advisory committees developed non-binding recommendations to reconfigure its region’s hospitals and nursing homes to meet regional needs. The authorizing legislation directed the Commission to consider factors that included: the need for capacity; the existence of other health care services in each region; and the extent to which the facility in question served the health care needs of the region, including serving Medicaid recipients, the uninsured and underserved communities.

⁷ *2005 Interim Report Statewide Comprehensive Plan for Mental Health Services*, New York State Office of Mental Health (Nov. 2005), <http://omh.ny.gov/omhweb/Statewideplan/2005/interimreport/>.

⁸ In response to the Commission report, the state Senate and Assembly held public hearings to gather input from interested and affected parties. Pursuant to the enacting legislation, the legislature could only vote down the report in its entirety or accept it. Although there was significant opposition to many of the Report’s specific recommendations, the Legislature chose not to reject it down. With the state legislature’s refusal to act, the recommendations of the Berger Commission became legally binding mandates on January 1, 2007.

⁹ In Schenectady, non-sectarian Ellis Hospital took over both non-sectarian Bellevue Women’s Hospital and Catholic-affiliated St. Clare’s Hospital, which had gone bankrupt. St. Clare’s name was changed to Ellis Health Center and it ceased to be a Catholic hospital, allowing the affiliation to take place without the need for complicated accommodations to preserve the provision of reproductive health services.

¹⁰ *Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century*, New York State Department of Health, p.80 (November 2007), http://www.nyhealth.gov/facilities/commission/docs/implementation_of_the_report_of_the_commission.pdf.

¹¹ Arnot Ogden Medical Center and St. Joseph’s Hospital received state approval in June 2011 to operate under a single parent umbrella called Arnot Health that allows both hospitals to largely retain their differing cultures. St. Joseph’s remains a Catholic facility and Arnot Ogden maintains its non-sectarian status with a promise to operate in accordance to a “Catholicity Agreement” which required it to ban elective abortions and euthanasia. Bob Recotta, *Hospital Merger Plan Moves Forward*, The Leader (January 13, 2011), <http://www.the-leader.com/news/x1958454966/Hospital-merger-plan-moves-forward>.

¹² Cynthia Werthamer, *FTC Concern Clouds Merger: Kingston-Benedictine Alliance ‘Problematic,’* The Kingston Daily Freeman (July 29, 1998).

¹³ Meanwhile, Northern Dutchess Hospital became an affiliate of Health Quest, a non-sectarian health system formed in 1999 that includes Vassar Brothers Medical Center, located in the southern Dutchess County city of Poughkeepsie, and Putnam Hospital Center. Kingston Hospital was also approached to join Health Quest, but ultimately did not. Cynthia Werthamer, *Affiliation of Hospitals Clears Boards*, The Kingston Daily Freeman (June 2, 1999).

¹⁴ MergerWatch interview with Michael Kaminski, former CEO of Kingston Hospital, Millbrook, NY (August 24, 2011), p. 5.

¹⁵ *A Plan to Stabilize and Strengthen New York’s Health Care System: Final Report of the Commission on Health Care Facilities in the 21st Century*, Commission on Health Care Facilities in the 21st Century, p.111 (December 2006), <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf>.

¹⁶ *Id.*, p. 12.

¹⁷ Interview with Michael Kaminski, p. 7.

¹⁸ Cynthia Werthamer, *Three Hospitals Unite*, The Kingston Daily Freeman (May 9, 1997).

¹⁹ Interview with Michael Kaminski, p.9.

²⁰ *Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century*, p. 55.

²¹ Interview with Michael Kaminski, p.21.

²² Patricia Donovan, *Hospital Mergers and Reproductive Health Care*, Family Planning Perspectives (Nov/Dec 1996), <http://www.guttmacher.org/pubs/journals/2828196.html>.

²³ MergerWatch interview with Jim Reed, M.D., CEO of Northeast Health, and Susan McDonough of Northeast Health, Troy, NY (July 19, 2011), p. 5.

²⁴ Cathleen F. Crowley, *Birth Services to be Merged*, Times Union (November 20, 2009), <http://www.timesunion.com/local/article/Birth-services-to-be-merged-557636.php>.

²⁵ *Id.*

²⁶ *Id.*

²⁷ Interview with Jim Reed, M.D. and Susan McDonough, p. 18.

²⁸ Interview with Jim Reed, M.D., p. 2.