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# THE CATHOLIC HEALTH CARE FACILITY: ITS IDENTITY, OWNERSHIP AND CONTROL

EUGENE J. SCHULTE\*

I have been asked to discuss the question of the existence of Catholic hospitals in light of their civil law dimensions in the areas of identity, ownership, and control. Initially, I would offer the following statements to reduce these concepts to the simplest of terms:

## IDENTITY

A Catholic hospital is a community-dedicated, general hospital which has been listed in the Official U.S. Catholic Directory. Each individual ordinary is empowered and entrusted with the final determination of whether or not to endorse a health facility as "Catholic." The criteria he is to use in making this determination are non-existent. Mere listing is the only basis for membership by a hospital in The Catholic Hospital Association. By whatever standard, the hospitals listed in the Directory offer more than 150,000 acute care hospital beds in all 50 states, nearly one of every three nonprofit, nongovernmental beds in the country.

## OWNERSHIP

There are 703 Catholic hospitals listed in the Official U.S. Catholic Directory. Of these, 24 are owned and operated under the auspices of an individual diocese. These are primarily located in the New England and Middle Atlantic states. Two are university-owned or affiliated. Twenty-four are owned by a lay corporation. Sixteen are municipally or county owned and operated under a management agreement by a religious congregation. The balance are owned and administered by individual religious congregations of both men and women.

Approximately 75% of these hospitals have been separately incorporated under their individual state laws as nonprofit, charitable institutions. Using a limited "service area" definition, 168 of these hospitals are the only general hospital facility in the community they serve.

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There is no standard or approved organizational structure for Catholic hospitals. Initially they were closed corporate structures directed entirely by their managing religious personnel. Partly as a result of encouragement by The Catholic Hospital Association and because of the growing influence of lay people in the Church, generally, today almost 50% of these hospitals have "mixed" boards of trustees, with 15% of these being lay-dominated. The remaining 50% still have closed religious boards, but about 85% of these have established and effectively use lay-advisory boards.

Better than 80% of these hospitals have received Hill-Burton loans and grants from the federal government to aid in their construction and expansion. Many have also participated in other governmental grant and loan programs both federal and state, including tax-exempt bond mechanisms offered by many states.

The growth and expansion of the Catholic health system in the United States really began in the post Civil War period. Many of these hospitals are now celebrating more than a century of service to their communities. During all these years, they provided high quality Christian service to all members of the general public. While initially providing service in the classic charitable sense, Catholic hospitals were not immune to the subtle changes occurring in the health-care delivery system in the United States.

With the advent of third-party payors (*i.e.*, Blue Cross and commercial health insurance) in the mid-1930's, health care delivery began the gradual shift from charitable funding to general self-sufficiency in financing. Community service rather than old-line charity became the standard. The movement toward separate incorporation under the civil law became accelerated.

Because they were basically self-sufficient and because the sponsoring religious congregations were sufficiently numerous and well-staffed, very little direct contact was made with the local bishops and church superiors. Unlike Catholic schools and other Church facilities, Catholic hospitals developed a very self-reliant attitude, a near autonomy within the Church structure.

The bishops were not anxious to disrupt this balance. Nominally they exercised their authority. They demanded and received periodic reports, both operational and financial. But as long as the balance figures were in the black and public scandals avoided, the "average" local ordinary was more than willing to allow these hospitals this freedom while they concentrated on establishing new parishes and parochial schools. This "benign neglect" on the part of the bishops was a product of the times, to use an old cliché, but, to use an even earlier cliché, the times are changing.

The most obvious change and the one demanding the most dramatic response by the Catholic health system is the "legalization" and growing public acceptance of medical procedures which heretofore have been considered morally and ethically unacceptable in our society. The abortion

decisions of January 22, 1973 are merely a part of this process, albeit the most shocking to Catholic sensibilities, at least.

It is not the purpose of this paper to discuss the attempts to mandate the performance of abortions and contraceptive sterilizations in Catholic hospitals. While that is the most direct threat to the continued existence of these facilities, it has been the subject of extensive discussion in other forums. Let it suffice to say that this challenge is ominous and the final outcome as yet unclear, although the Catholic system has withstood the initial attacks very well.

But the medical ethics problem is more pervasive than merely abortion and sterilization. When I discussed the identity of Catholic hospitals earlier, I limited myself to the legal niceties only. We must now ask ourselves not only what makes a hospital Catholic but why we feel the need for Catholic hospitals in the first place? If we can't find an answer to that question in the mission of the Church generally or in the need to fulfill the corporal works of mercy, then a whole new rationale has arisen in the area of medical ethics.

Beyond abortion there are the very real prospects of euthanasia, both active and passive, human experimentation, genetic engineering, psychotherapy, and many more. The brave new world demands a Christian influence. Catholic hospitals are that visible presence. They play a substantial role in the health-care delivery system of the United States and they have the potential of being the catalyst for preserving a Christian viewpoint in this scientific community.

The survival of the Catholic health apostolate is being challenged by the comprehensive health planning systems being implemented as part of the nationalization of health care delivery in this country. Without legislative mandate, certain "planners" have taken it upon themselves to determine the future of Catholic hospitals. Because all major capital expenditures, including new construction, expansion, and even replacement must be approved by these planning agencies, all hospitals, and most particularly Catholic hospitals, are at their whim and mercy. In at least three states, Catholic hospitals have been shut out by planners who, as an unwritten precondition of approval, have demanded that these Catholic hospitals provide abortion and sterilization services. With the lifeline cut, unable to grow or even renew, the Catholic health system can only wither and die.

As a lawyer, I am frustrated by these events. I can readily defend an attack on our hospitals by a "Jane Doe" seeking an abortion in an existing facility. I am frustrated by the insidious, subtle and frequently blind-sided attack on the bureaucratic front. The issue is never clear, the battle lines almost nonexistent. The "planners" never make the mistake of overtly evidencing their bias. The denials are always based on otherwise legitimate criteria.

Our response must be firm and, because the bureaucratic operation

is more subject to political pressure, politic as well. Conscience protection legislation in the comprehensive health planning process can be enacted. A judicial determination may resolve this conflict, assuming the factual burden of proving this discrimination can be carried. Because the individual hospital is virtually impotent in this process, a new cooperation between bishop and hospital is demanded. Neither the hospital nor the bishop can continue to act unilaterally, but rather they must work together in promoting a Catholic health care delivery system identity.

But the attacks on the Catholic hospitals system are not limited to the field of medical morality. In January of 1974, a federal district court in the District of Columbia invalidated the 1969 Internal Revenue Service rulings as to nonprofit community hospitals. The newer doctrine of community service 501(c)(3) exemption<sup>1</sup> (as against classic charitable free care) was thrown out. The entire voluntary hospital care delivery system in the country has been jeopardized by this decision. Catholic hospitals form the largest single component of this system. Classic charity cannot support a hospital system demanding multi-billions of dollars. The predictable result of the sustaining of this type of judicial opinion will be the further deterioration of the voluntary system and the acceleration of governmental intrusion.

Federal income taxes, however, for these hospitals would be minimal as compared to the enforcement of local real and personal property taxes. Like the efforts to impose such taxes on all supportive Church property, these taxes potentially mark the difference between the ability to serve and economic disaster. A recent Missouri state court case has extended the federal court decision mentioned above to the property tax area. Similar cases are pending in several other states.

The degree and imposition of these taxes are very subject to local political conditions—conditions which are more likely to be affected by the local bishop than by the individual hospital. Attacks on a hospital may have a “splash” effect on other Church institutions. Once again stronger ties must be maintained to assure a unity of effort in these areas.

But taxation is not the only problem affecting the Church's ability to exercise full ownership prerogatives over hospitals and other related properties. Ever since Father James McGrath proposed his “theory” of civil law effect on Church properties there has been an uneasy feeling that certain of these properties may have passed out of the legal control of official Church agencies.

An ominous decision was rendered by a California state court in January of this year. In *Queen of Angels Hospital v. Younger*, the court set aside a settlement agreement entered into between the hospital and the religious congregation which had founded and administered the hospital for nearly

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<sup>1</sup> INT. REV. CODE OF 1954 § 501(c)(3).

fifty years. The court held that the property in question did not belong to the sisters (and by inference, the Church) but rather was held in trust for the people in the City of Los Angeles, California. He further argued that the distribution of the assets of this "charitable trust" was to be governed entirely by state law without reference to the Canon Law of the Roman Catholic Church.

This case is further aggravated by the fact that only a minimal amount of the capital financing for the institution had come from public sources. There were no Hill-Burton grants or loans, nor were there ever any extensive community fund-raising projects. The sponsoring congregation had used its own funds and credit to finance it in its formative years and had contributed untold hours of labor for free.

The implications of this case for not only hospitals but also schools and other church facilities are as yet unclear. The trial judge used very sweeping language which if upheld on appeal could have dire consequences across a wide spectrum of Church activity in the United States. The effect of civil law on such properties at a time when change is demanded in many subsidiary church organizations could have disastrous financial effect, all the more so if the decision is applied retroactively.

The Catholic Hospital Association has seen nearly two hundred of its member hospitals cease to exist over the past ten years. Many of these were mergers of two or more small facilities into a single, larger, more efficient facility. Others were forced out by economic necessity, declining population, and facility obsolescence. These were nonviable institutions whose cessation was demanded by conditions outside of the control of the Catholic health-care system. But all too many of these hospitals were economically viable and were capable of contributing immensely both in the way of health services to their civic communities and in fulfilling the spiritual mission of the Church. They closed because the Church, either through its religious communities or dioceses, did not have the incentive to continue. The declining numbers of nuns have forced many of these sponsors to attempt to consolidate their activities, to retrench to more limited service activities. Effective leadership has not been coming forward to preserve these facilities as an integral part of the Catholic health system. In most cases little or no effort was made to find an alternative sponsor, religious, diocesan, or lay, which would continue the hospital under Catholic auspices. In some cases the Catholic hospital was sold outright to a for-profit organization which among other things would permit the facility to be used for abortions.

Through all of this, the Catholic hospital system has continued to grow. The actual number of beds (a more important statistic than the number of hospitals) has increased over the past five years at a nominal pace. This growth, however, is threatened not only by the health planners as mentioned earlier, but by a myriad of additional problems.

Catholic hospitals are not unique in being challenged by outside pres-

tures. A growing public demand for improvement in the quantity and quality of services is leading to a confrontation between the medical profession as represented in the hospital by the medical staff and the management. This confrontation has taken many faces and has arisen over several issues. The sterilization question has prompted a boycott of a hospital in Michigan by that hospital's Ob-Gyn staff. These doctors have adopted this tactic as a device to pressure the hospital into liberalizing its stand on contraceptive procedures. They argue that the hospital's prohibition is an interference in their practice of medicine. At another hospital in Arizona the entire county medical society voted to boycott a Catholic hospital over the question of the administration interfering in medical staff policies and practices. This problem is being accentuated by the recent growth in malpractice litigation and judgments being rendered against the corporate hospital entities in the multi-millions of dollars. Recent federal legislation (the PSRO Act of 1973) is moving in the direction of defining national standards on the quality of care. "Good medicine" may be subjected to a legal definition and there are those who argue that the term must include abortions and sterilizations.

The relationship of Catholic hospitals to third-party payors (Blue Cross, commercial insurance, and government) has always been somewhat delicate because of the inclusion of cost factors relating to pastoral care and chaplaincy services. While auspicious agencies such as the American Medical Association, the American Psychological Association and others have affirmed pastoral care as being "true" patient care, auditors for these third-party payors have wielded a broad pencil in striking out reimbursement for such so-called "frills." With the advent of even more governmental payment, this problem has become accentuated. The backlash on this item has recently been extended to allowance and reimbursement for services in Catholic hospitals unrelated to spiritual care. Thus, religious nursing personnel are not reimbursed for overtime hours under Medicare even though they may be working side-by-side with lay personnel who are. One auditor has recently rejected the otherwise legitimate debt interest because the monies were lent by a religious community and not a bank or insurance company.

The use of cost controls by governmental agencies has a particularly deleterious effect on hospitals. Catholic hospitals, because of their ethical commitment in terms of free care, labor recognition, and pastoral services have been subjected to even greater pressures. The opportunity for abuse of discretion to discriminate against the denominational hospital in this area is greatly increased.

I have covered a broad area of problems facing the Catholic health apostolate. I have only inferentially referred to such areas as labor law, where the pending removal of the Taft-Hartley exemption for nonprofit community hospitals will exert even greater inflationary pressure on such

institutions.<sup>2</sup> Catholic hospitals, because of the teachings of the Church relative to the rights of workers, are faced with cross-concerns emanating out of their moral obligation to render continuous patient care conflicting with the threat of strikes disrupting hospital operation.

Changes in the pattern of health care delivery raise questions concerning the ability of Catholic hospitals to enter into shared-service agreements with other facilities, health maintenance organizations (HMO) and governmental agencies, many of which provide and promote medical procedures which are considered immoral by the Church. The question is asked whether such economic and political cooperation amounts to cooperation in the commission of an immoral act. Many of our hospitals are faced with the practical necessity of developing and operating ancillary facilities, including professional office buildings, in order to attract and maintain a competent medical staff. Again the question is asked whether the Catholic hospital can control (yet alone monitor) the private practice of medicine by physicians in these facilities.

My main fear in this presentation of some of the problems facing the Catholic health apostolate is that I will have driven many to opt away from the field as a viable apostolate within the Catholic Church. On the contrary, the health apostolate is crying out for a renewed vigor and revitalized spiritual and administrative leadership. "Now, more than ever" may be a slogan gone awry in other forums but in the health field, a strong and effective Catholic voice is essential.

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<sup>2</sup> As of August 1974, private nonprofit hospitals are no longer exempt from NLRB coverage. Pub. L. No. 93-360 (Aug. 25, 1974).—Ed.