

## THE CATHOLIC MERGER CRUSADE

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Hospital merger mania is prevalent in our country.<sup>1</sup> Changes in the health care industry, including increased competition, the creation of health maintenance organizations, and rising costs of health care delivery, have induced hospitals to merge simply to stay alive.<sup>2</sup> In particular, Catholic hospitals have begun to merge with non-sectarian hospitals at an alarming rate.<sup>3</sup> Since Catholic hospitals tend to be financially stable,<sup>4</sup> they are able to offer struggling non-sectarian hospitals the much-needed financial resources to stay afloat. However, the financial resources the Catholic hospitals provide come at a tremendous cost.<sup>5</sup> Most significantly, the Church<sup>6</sup> guidelines that Catholic

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1. See Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1093 (1996) (citing a hospital merger "boom" beginning in the 1980s).

2. See Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1430, 1432-34 (1995). See also MERGERWATCH, RELIGIOUS HOSPITAL MERGERS & HMOs: THE HIDDEN CRISIS FOR REPRODUCTIVE HEALTH CARE 10-11 (1997-98) (citing the impact of managed care, government budget cuts, changes to hospital financing systems, overcapacity, the desire to reach suburban patients, and competition from for-profit hospitals as the "key economic factors forcing previously-competitive hospitals to work together") (on file with JOURNAL OF HEALTH CARE LAW & POLICY) [hereinafter MERGERWATCH]. MergerWatch, funded by the Education Fund of the Family Planning Advocates of New York State, monitors sectarian/non-sectarian mergers and trains and provides resources to communities opposing sectarian/non-sectarian mergers. See *id.* at 3.

3. See Ikemoto, *supra* note 1, at 1094 (citing fifty-seven Catholic mergers with non-sectarian hospitals between 1990 and 1995). Furthermore, most Catholic hospitals are considering a merger of some type. See *id.* at n.38 (citing *Catholic Hospitals Struggle to Keep Identity*, 5 HEALTH CARE PR & MARKETING NEWS, Mar. 7, 1996). In particular, Catholic Health Initiatives, a national Catholic health care organization, has targeted various cities for mergers between Catholic and non-sectarian hospitals. See CATHOLIC HEALTH INITIATIVES, CATHOLIC HEALTH CARE INITIATIVES: A SPIRIT OF INNOVATION, A LEGACY OF CARE (planning "growth strategy" in Baltimore, MD, Denver, CO, Nebraska, Iowa, Philadelphia, PA, and the Delaware Valley) (pamphlet on file with author). Another large Catholic health care organization, Catholic Healthcare West (CHW), "leads the recent 'merger mania,' with at least thirty-five hospitals in California, Arizona and Nevada." Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159, 177 (1997).

4. See Ikemoto, *supra* note 1, at 1092 (citing CATHOLICS FOR FREE CHOICE, HEALTH CARE LIMITED: CATHOLIC INSTITUTIONS AND HEALTH CARE IN THE UNITED STATES 7 (rev. ed. 1995)). Although Catholic hospitals are non-profit, they generate substantial gross revenue and gross income. See *id.*

5. See *infra* notes 15-25 and accompanying text.

6. I simply use "Church" to refer to the Catholic Church as an institution. I do not intend it to signify the Catholic Church as the only or best type of church or religion.

hospitals force non-sectarian hospitals to comply with upon merger often result in the loss of patients' rights to obtain and refuse numerous services.<sup>7</sup>

This paper explores the cost hospitals, communities, and patients will pay when Catholic hospitals merge with non-sectarian hospitals. In particular, this paper focuses on the post-merger elimination of patients' rights to create end-of-life directives and refuse unwanted medical treatment. Due to a heavy focus on the loss of reproductive services which often result from Catholic mergers, end-of-life issues have not been adequately addressed. This paper, although narrow in scope, attempts to bring end-of-life issues to the forefront of the Catholic/non-sectarian merger discussion.

Part I of this paper describes the Catholic health care system and explains the details of Catholic mergers. In particular, Part I explains the Catholic guidelines that non-sectarian hospitals are frequently forced to follow post-merger. Compliance with these guidelines could eliminate patients' rights to create advance directives and refuse unwanted treatments.<sup>8</sup> Catholic doctrine and Church activity regarding artificial nutrition and hydration are explored in Part II. Part II illustrates that Catholic hospitals, despite protestations and promises to the contrary, will most likely refuse to honor patients' advance directives and decisions to refuse unwanted medical treatment. Part III examines patients' rights to refuse medical treatment, specifically artificial nutrition and hydration, and to create advance directives. Moreover, Part III examines providers' conscience clause rights to object to patients' requests to withdraw or withhold artificial nutrition and hydration on religious grounds. Most importantly, Part III illustrates the danger of allowing merged-facilities to maintain policies that conflict with patients' rights to create advance directives and refuse unwanted medical treatment.

#### PART I. CATHOLIC HEALTH CARE AND THE MERGER MANIA SCENE

Catholic health care institutions deliver the largest portion of private sector care in the United States.<sup>9</sup> Moreover, Catholic health care institutions have expressed a strong commitment to providing health

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7. See *infra* notes 15-25 and accompanying text.

8. See *infra* notes 9-47 and accompanying text.

9. See Ikemoto, *supra* note 1, at 1090. Additionally, Catholic health care facilities, taken as a whole, "comprise the single largest provider of institutional health care in the country." Singer, *supra* note 3, at 167.

care to the poor,<sup>10</sup> including both Medicaid recipients and those patients who cannot pay.<sup>11</sup> Most importantly, Catholic health care<sup>12</sup> is strongly committed to protecting and promoting Catholic values in the health care it provides.<sup>13</sup> The commitment to Church doctrine primarily shapes the delivery of Catholic health care.<sup>14</sup>

All Catholic hospitals and "affiliated physicians" are bound to adhere to the "Ethical and Religious Directives for Catholic Health Care Services" (ERDs) set forth by the National Conference of Catholic Bishops.<sup>15</sup> The ERDs fulfill a "two-fold [purpose]: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today."<sup>16</sup> To effectuate this purpose, the ERDs mandate certain rules Catholic health care institutions must abide by in order to avoid scandal<sup>17</sup> and to maintain the "distinctive Catholic identity of the Church's institutional health care services."<sup>18</sup>

10. See Liz Bucar, *When Catholic and Non-Catholic Hospitals Merge*, 19 CONSCIENCE 3, 3 (1998). But see Charles J. Milligan, Jr., *Provisions of Uncompensated Care in American Hospitals: The Role of the Tax Code, the Federal Courts, Catholic Health Care Facilities, and Local Governments in Defining the Problem of Access for the Poor*, 31 CATH. LAW. 7, 28 (1987) ("Catholic hospitals . . . have in recent years vastly neglected indigent care."). In reality, only 3.1% of Catholic health care's net patient revenue is dedicated to charity care. See Deanna Bellandi & Bruce Jaspen, *While You Weren't Sleeping: Not-For-Profit Growth Keeps Investor-Owned Systems up at Night According to 1998 Multi-Unit Providers Survey*, MODERN HEALTHCARE, May 25, 1998, at 35.

11. See Ikemoto, *supra* note 1, at 1091.

12. The provision of Catholic health care is centered around the Catholic faith: The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care: to see healing and compassion as a continuation of Christ's mission: to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection: and to see death, transformed by the resurrections, as an opportunity for a final act of communion with Christ.

NATIONAL CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 3 (1995) [hereinafter ERDs].

Neither the author nor this paper advocates Catholicism as the only or best religion or the Catholic conception of its god as the only or best conception.

13. See Boozang, *supra* note 2, at 1439 (citing a "desire to preserve Catholic identity of the Church's health care facilities").

14. See Bucar, *supra* note 10, at 6. "As opposed to most other health care sectors, Catholic health care is specifically linked to a ministry." Singer, *supra* note 3, at 209.

15. Boozang, *supra* note 2, at 1439; Bucar, *supra* note 10, at 6.

16. ERDs, *supra* note 12, at 1.

17. See *id.* at 26-27. The ERDs describe an example of scandal as "generating a confusion about Catholic moral teaching." *Id.* at 27.

18. *Id.* at 1. See also *infra* notes 35-44 and accompanying text (describing the permissive nature of the ERDs and the consequences of non-compliance). However, many scholars believe that the Catholic health care mission should not override patient's health care rights. See, e.g., Bucar, *supra* note 10, at 4 (The Catholic health care mission "should not be

In particular, the ERDs prohibit Catholic health care institutions from performing or providing certain services and procedures.<sup>19</sup> Most obviously, the ERDs prohibit the provision of abortions at Catholic hospitals.<sup>20</sup> Closely related and equally as problematic, the ERDs

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overstated or used to justify Catholic hospitals' denial of basic reproductive health services.”).

19. See *infra* notes 20-25 and accompanying text.

20. See ERDs, *supra* note 12, at 19. ERD 45 provides that “abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is *never permitted*.” *Id.* (emphasis added). “Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.” *Id.* The ERDs' prohibition on the provision of abortion and other reproductive health services has heretofore been the primary focus of the Catholic/non-sectarian merger debate. See for example: Bucar, *supra* note 10; Ikemoto, *supra* note 1; Janet Gallagher, *Religious Freedom, Reproductive Health Care, and Hospital Mergers*, 52 J. AM. MED. WOMEN'S ASS'N 65 (1997); Jane Hochberg, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 OR. L. REV. 945 (1996).

Federal and state law does allow providers, including Catholic ones, the right not to provide or perform abortions. See *infra* notes 124-31 and accompanying text. On the other hand, women have a fundamental, although not absolute right, to abortion. See *Roe v. Wade*, 410 U.S. 113 (1973). When the state has a compelling interest, it may regulate against a women's right to abortion after viability *except* when the life or health of the mother is at risk. See *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). However, federal and state conscience clause rights allow Catholic hospitals to ignore women's rights to abortion under *Casey* and *Roe* even when the life or health of the mother is at risk. See *infra* notes 124-31 and accompanying text.

However, when a Catholic hospital has merged with a non-sectarian one, the merged facility should not have the same conscience clause rights. Although a full religious freedom analysis is outside the scope of this paper, it appears that conscience clause rights in the sectarian/non-sectarian merger context should be limited because the merger reduces the treatment options for patients. See Ikemoto, *supra* note 1, at 1104. “[W]hen all or most of a health care market becomes dominated by a provider with restrictive religious rules, patients are in danger of losing their access to a full range of health services.” MERGERWATCH, *supra* note 2, at 15. See also *infra* notes 137-42 and accompanying text.

Dr. Wayne Goldner, a physician in Manchester, New Hampshire, has experienced the limitation of options sectarian/non-sectarian merger creates. See *Democracy Now: A Threat to Women's Choice in This Country* (Pacifica Radio radio broadcast, May 26, 1998) (transcript on file with JOURNAL OF HEALTH CARE LAW & POLICY) [hereinafter *A Threat to Women's Choice*]. “Kathleen,” one of Dr. Goldner's patients, “want[s] to have a healthy baby” but has lost two pregnancies. *Id.* at 1-2, 7. During the second pregnancy, “Kathleen's” water broke at fourteen weeks; as a result, the fetus had a two percent chance of survival, and there was a high possibility that “Kathleen” would become infected. See *id.* at 2. Dr. Goldner's hospital had recently merged with a Catholic one; therefore, when he determined that “Kathleen” needed an abortion, he consulted the merged administration about “the new guidelines” his hospital had been required to follow upon merger. *Id.* at 2. The administration told him he could not perform the abortion. See *id.* Dr. Goldner was adamant that “Kathleen's” request for an abortion be honored. See *id.* He called the vice president of the hospital and requested permission to perform the procedure; he “basically threatened [Dr. Goldner] and said, ‘I'll pull your privileges if you do this.’” *Id.* The administration asked Dr. Goldner “to change [his] diagnosis, [to consult] an emergency ethics committee, [and to have “Kathleen”] reexamined” to see if they could get a different diagnosis.” *Id.* at 5. Finally,

prohibit all forms of contraceptive services including both male and female sterilizations.<sup>21</sup> Furthermore, Catholic institutions may not provide fertility treatments or procedures.<sup>22</sup> Finally, and most impor-

Kathleen alone, got into a cab with a person she didn't know, [traveled] 80 miles, where she then had to wait five hours to be seen by a physician, . . . who she did not know who did a termination on her of a pregnancy she desperately would have loved to have, who then traveled back alone in a cab, on a Friday night, and got home at 10:30 at night.

*Id.* Lois Uttley, director of MergerWatch, described "Kathleen's" case as "probably the most shocking example [she has] seen nationally of how church dogma is being allowed to interfere with a physician's ability to care for his patients." *Id.* at 3.

Although the ERDs prohibit Catholic health care institutions from providing abortions, Catholic institutions are permitted, under ERD 46, to provide "compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion." ERDs, *supra* note 12, at 19.

21. "Catholic health institutions may not promote or condone contraceptive practices but should provide, *for married couples* . . . , instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning." ERDs, *supra* note 12, at 20 (ERD 52). "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution when its sole immediate effect is to prevent conception." *Id.* (ERD 53). In other words, natural family planning, more commonly known as the rhythm method, is the only contraception method Catholic institutions can discuss, and they may only discuss it with married couples.

Emergency contraception can not be provided to victims of rape and sexual assault under the ERDs unless it is clear that conception has not occurred. *See id.* (ERD 36). "If . . . there is no evidence that conception has occurred already, [a rape or sexual assault victim] may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization." *Id.* "It is not permissible, however, to initiate or recommend treatments [(like the morning after pill)] that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum." *Id.* (citing Pennsylvania Catholic Conference, *Guidelines for Catholic Hospitals Treating Victims of Sexual Assault*, 22 ORIGINS 810 (1993)).

22. Generally, fertility treatments that interfere with the marital act are prohibited, but those that do not are permitted. For example,

heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses [e.g., an egg donor or a sperm donor]) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.

ERDs, *supra* note 12, at 18-19 (ERD 40). Furthermore, surrogate motherhood is expressly prohibited by ERD 42 because it interferes with the "uniqueness of the mother-child relationship." *Id.* at 19. Similarly, "homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act." *Id.* at 19 (ERD 41). In other words, all types of fertility treatment that separate conception from the marital act of sexual intercourse are prohibited by the ERDs.

The ERDs do provide that a fertility treatment which "does not substitute for the marital act itself may be used to help married couples conceive." *Id.* at 18 (ERD 38). These techniques are only permitted, however, when they "do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting." *Id.* at 18 (ERD 39). The ERDs do not describe or list fertility treatments that do not interfere with the marital act.

tantly for this paper, the ERDs prohibit Catholic health care institutions from honoring patient end-of-life directives, including requests to withhold or withdraw artificial nutrition and hydration for example, which are in conflict with Catholic teaching.<sup>23</sup> Despite this elimination of patients' rights to create advance directives,<sup>24</sup> "Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church."<sup>25</sup>

Catholic hospitals sometimes contemplate merging with non-sectarian hospitals.<sup>26</sup> The impetus behind Catholic mergers with non-sectarian hospitals is unclear. One explanation is financial; Catholic hospitals, like most other hospitals, are struggling to maintain resources and deliver services in a changing health care market.<sup>27</sup>

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23. See *id.* at 14. "[A Catholic health care] institution . . . will not honor an advance directive that is contrary to Catholic teaching." *Id.* (ERD 24). See also *infra* notes 92-187 and accompanying text (describing Catholic treatment of artificial nutrition and hydration and speculating that merged facilities will not honor patients' advance directives to withdraw or withhold artificial nutrition and hydration). End-of-life directives are more commonly known as advance directives;

[a]n advance directive is a written statement that is intended to govern health care decision-making for its author, should he or she lose decisional capacity in the future. Though by this definition advance directives can apply to any health care decision, they are almost always addressed to end-of-life issues, and it is in this context that they are best known. As 'living wills' (directives giving lists of instructions), 'health care proxies' (durable powers of attorney naming proxy decision-makers, or agents, for health-related decision-making), or both, advance directives are becoming commonplace.

NANCY M.P. KING, MAKING SENSE OF ADVANCE DIRECTIVES 2 (1996) (citation omitted).

24. Patients have a "constitutionally protected liberty interest in refusing unwanted medical treatment." *Cruzan v. Mo. Dept. Health*, 497 U.S. 261, 278-79 (1990). See also *infra* notes 96-98 and accompanying text. In almost every state, patients have rights to create advance directives and appoint agents or proxies to make health care decisions for them in the event that they later become incompetent. See *infra* notes 99-101 and accompanying text.

25. ERDs, *supra* note 12, at 7. But see *infra* notes 181-86 and accompanying text.

26. See *A Threat to Women's Choice*, *supra* note 20, at 4 ("There is . . . an increasing trend toward Catholic systems acquiring or attempting to merge or affiliate with secular, non-profit, community hospitals . . .") (quoting Lois Uttley, director of MergerWatch).

27. See *Boozang*, *supra* note 2, at 1434 ("[Catholic with non-sectarian] mergers are frequently pursued because neither facility can continue to maintain the financial or technological resources necessary to exist independently . . ."). See also *supra* note 2 and accompanying text (describing changes in the health care market). Even though Catholic hospitals, like other hospitals, may choose to merge because of business opportunity or business necessity, "[w]hat distinguishes many of the transactions occurring in Catholic health care from these types of traditional business decisions . . . is that much of the activity is driven by the Church's need to coalesce control of its ministry." Singer, *supra* note 3, at 161. In reality, Catholic hospitals most likely choose to merge for both financial and religious reasons. Cf. *id.* at 175 (identifying "concerted efforts [by Catholic health care institutions] to protect both the market viability and the Catholic identity of their institutions").

Whatever the reason, when a Catholic hospital seeks to merge with a non-sectarian one, the merger agreement and its terms are almost always kept secret until after the merger is announced to the public.<sup>28</sup>

Although the terms of a Catholic/non-sectarian merger are generally kept secret from the community in which the merger is proposed,<sup>29</sup> the Church does have a decision-making structure for approving such mergers.<sup>30</sup> First, for "the 'alienation' of any church property valued at more than \$3 million," the local bishop must be consulted and permission must be obtained from the Vatican.<sup>31</sup> Although approval by the local bishop is required for every merger,<sup>32</sup> the bishops vary in their method and manner of approval.<sup>33</sup>

In approving a merger, the local bishop must interpret the ERDs that prohibit all Catholic health care institutions from providing serv-

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In addition to financial necessity, Prof. Boozang suggests that Catholic hospitals may be motivated to seek mergers with non-sectarian hospitals "by the perception that refusal by Catholic hospitals to provide religiously prohibited services adversely affects their marketability. Thus, religious providers seek to combine with secular entities whose services will supplement those prohibited by Catholic doctrine." Boozang, *supra* note 2, at 1434 (citing Howard J. Anderson, *Catholic Hospitals Join Forces with Non-Catholic Competitors*, HOSPITALS, Oct. 20, 1990, at 44).

Despite Prof. Boozang's argument, MergerWatch and communities that have fought the restrictive terms of Catholic with non-sectarian mergers have found that Catholic institutions do not seek these mergers to augment their provided services. On the contrary, Catholic institutions almost always require the sectarian hospital to comply with the ERDs that prohibit these services. See *A Threat to Women's Choice*, *supra* note 20, at 4 (quoting Lois Uttley, director of MergerWatch) ("When these affiliations take place, typically the religious authorities, those representing the religiously affiliated hospital, will come to the negotiating table with a set of non-negotiable demands and insist that the secular hospitals ban all or some . . . reproductive health services and start following religious rules.').

28. See MERGERWATCH, *supra* note 2, at 6 ("Secretly, in meetings behind closed doors, hospital and HMO executives across the United States are negotiating away their patients' access to reproductive health care."); Bucar, *supra* note 10, at 4 ("[T]he preliminaries to a merger go on behind closed doors . . ."). See also Milligan, Jr., *supra* note 10, at 28 ("[T]he internal workings of Catholic hospitals, like other Catholic institutions are deliberately hidden from public view.').

29. See *supra* note 28 and accompanying text. See also, e.g., Craig Timberg, *Allegany Hospital Merger May End: Cumberland Divided on Union of Catholic, Secular Facilities*, BALT. SUN, Apr. 5, 1998, at A1.

30. See Ikemoto, *supra* note 1, at 1097-1102 (describing the Church's decision-making structure for approving mergers).

31. See Bucar, *supra* note 10, at 6 (citing Bishop John Meyers, *The Ins and Outs of Hospital Mergers: How Canon Law Watches over Vital Interests*, NAT'L CATH. REG., Jan. 1997, at 5).

32. See ERDs, *supra* note 12, at 26 (ERD 68) ("The diocesan bishop's approval is required for partnerships sponsored by institutions subject to his governing authority."). ERD 68 "give[s] the local bishop veto power over any Catholic hospital merger by requiring his approval to close the deal." Bucar, *supra* note 10, at 6.

33. See Boozang, *supra* note 2, at 1435.

ices in conflict with the Church's teachings.<sup>34</sup> Apparently, however, a particular bishop *may* decide not to follow certain ERDs.<sup>35</sup> As a result, some bishops may allow the merged facility to provide services banned by the ERDs, and some bishops may follow the ERDs' "ban on certain services to the secular facility."<sup>36</sup> While a given bishop may decide not to follow a particular ERD, a certain amount of pressure from the Vatican may force him to do so.<sup>37</sup>

Although the ERDs arguably purport to give bishops discretion in following the ERDs, the Pope has warned that if certain ERDs are not followed, specifically those prohibiting reproductive health services, Catholic hospitals may lose their Catholic sponsorship.<sup>38</sup> Moreover, under Church law local bishops are not only "empowered to strengthen and promote institutional catholicity and greater Catholic health care, they are commanded to do so."<sup>39</sup> In addition to Church pressure, the National Conference of Catholic Bishops (NCCB) is "urging bishops to assert themselves more aggressively in the health care ministry."<sup>40</sup>

Arguably, bishops are also receiving indirect pressure from NCCB to adopt the ERDs. Recently, NCCB published "Living the Gospel of Life," proclaiming that Catholic politicians who oppose abortion but vote pro-choice "cannot be considered faithful members of the church."<sup>41</sup> NCCB's "Living Gospel of Life" urged these Catholic officials "to consider the consequences for their own spiritual well-being, as well as the scandal they risk by leading others into serious sin."<sup>42</sup>

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34. See ERDs, *supra* note 12, at 26-27 (explaining that ERDs 67 through 70 provide guidelines for bishops to interpret the ERDs so as to avoid scandal in mergers). See also *supra* note 17 (providing the ERDs' definition of scandal).

35. See Ikemoto, *supra* note 1, at 1100 ("[E]ach bishop has a great deal of influence over how a hospital will follow the [ERDs]."). Apparently, the ERDs are permissive rather than mandatory; this is evidenced by the use of "should" and "may" in ERDs 67 through 70. See also *supra* note 34 (providing ERDs' description of its provisions as "guidelines").

36. Boozang, *supra* note 2, at 1435.

37. See Bucar, *supra* note 10, at 8.

38. See *id.* (discussing the Vatican's *Evangelium Vitae* of 1995).

39. Singer, *supra* note 3, at 226.

40. *Id.* at 212.

41. John Rivera, *Bishops Warn Elected Catholics*, BALT. SUN, NOV. 19, 1998, at A1 (citing NAT'L CONFERENCE CATHOLIC BISHOPS, *LIVING THE GOSPEL OF LIFE: A CHALLENGE TO AMERICAN CATHOLICS* (1998) [hereinafter *LIVING THE GOSPEL OF LIFE*]).

42. *Id.* (quoting *LIVING THE GOSPEL OF LIFE*). Local bishops have already begun acting upon "Living the Gospel of Life." In fact, Bishop Donald Trautman of Erie, Pennsylvania has "declared that politicians such as [Pennsylvania's Governor Ridge]—a Catholic from Erie—[would be] unwelcome to speak at Catholic-sponsored events." Ron Goldwyn, *Pro-choice Views Barred at Catholic Events*, PHILADELPHIA DAILY NEWS, NOV. 21, 1998, at 3. Governor Ridge "has begun turning down Catholic invitations" so as not to violate his bishop's instructions. *Id.*



Given that NCCB has taken to threatening public officials who are not faithful to Church teaching, it is most likely that the majority of American bishops (represented by NCCB) would feel uncomfortable allowing services, reproductive or otherwise,<sup>43</sup> at a merged facility in their jurisdiction that violated the ERDs and Church teaching. If bishops are banning politicians from *speaking* at Catholic events, it is *highly* likely that they will ban the *provision of services* at hospitals.

Whether the Church or NCCB pressures bishops to follow the ERDs or not, pro-merger advocates argue that a bishop may interpret the ERDs as he sees fit.<sup>44</sup> As a result of this discretion, the compliance a non-sectarian hospital will be forced to make upon merger with a Catholic hospital will depend on the interpretation of the bishop in that jurisdiction.<sup>45</sup> However, in reality, non-sectarian hospitals are usually requested to comply with the at least some of the ERDs upon merger with a Catholic hospital<sup>46</sup> unless an alternative arrangement can be created.<sup>47</sup> If an alternative arrangement cannot be made and

43. NCCB most likely will not stop with attacking reproductive health care. The history of NCCB and Catholic statements and activities regarding the withholding or withdrawal of artificial nutrition and hydration suggest that end-of-life directives are next. *See infra* notes 71-90 and accompanying text.

44. *See supra* notes 34-39 and accompanying text (providing suggestions of ERDs as discretionary).

45. *See supra* note 35 and accompanying text.

46. *See* MERGERWATCH, *supra* note 2, at 7.

47. *See id.* at 21 ("Through these creative solutions, religious beliefs are respected at religious-sponsored hospitals, but are not imposed on the health care delivered at non-sectarian hospitals."). Sometimes merging hospitals can create an alternative solution to merger that allows the non-Catholic hospital to continue the provision of services that are prohibited by the ERDs. *See id.* at 19-21 (providing examples of creative solutions). For example,

two religiously-based hospital networks in Texas, one of which includes a Catholic medical center, are preparing a joint operating agreement that would respect the ethical views of each denomination represented. One religious view will not be forced on all partners as a condition of the agreement, and all partners will be able to continue to provide medical care in line with their own beliefs. . . . Under the arrangement, the partners would maintain control over their own assets, while combining some operations, including purchasing.

MergerWatch, *Creative Solutions: Joint Operating Agreement Between Two Texas Hospital Networks Will Maintain Reproductive Services* (last modified Sep. 11, 1998) <<http://www.fpaofnys.org/MergerWatch/cresolu.html>>. However, "whether the Church hierarchy will consider these alternatives sufficiently faithful to its directives depends largely upon the bishops' application of the Christian ethical concept of 'material cooperation' to the hospitals' activities." Boozang, *supra* note 2, at 1440 (discussing alternatives which allow sterilizations for non-contraceptive reasons specifically).

The doctrine of "material cooperation" is extremely difficult to describe. The ERDs distinguish between "formal," "implicit formal," and "material cooperation." ERDs, *supra* note 12, at 29.

If the cooperator intends the object of the wrongdoer's activity, then the cooperation is formal, and therefore, morally wrong. . . . Implicit formal cooperation is

the local bishop decides to prohibit a service under the ERDs, patients' rights to obtain and refuse services will likely be eliminated post-merger.

In sum, many non-sectarian hospitals have been forced to follow the ERDs upon merger.<sup>48</sup> Although we know the effect sectarian/non-sectarian merger can and has had on reproductive health care services,<sup>49</sup> the question of what effect merger will have on patients' rights to refuse unwanted medical treatment and create advance directives remains unanswered. An argument that these patient rights will be preserved in *some* cases because a particular bishop *may* choose not to honor ERD 24 which prohibits Catholic hospitals from honoring advance directives in conflict with Catholic teaching<sup>50</sup> does not fully answer the question. In order to answer the question, Part II surveys Church teaching and bishop activity on issues of artificial nutrition and hydration to determine the most likely merger response to ERD 24.

## PART II. PATIENT DIRECTIVES AND ARTIFICIAL NUTRITION AND HYDRATION (ANH) —WHAT WILL *REALLY* HAPPEN WHEN CATHOLIC AND NON-SECTARIAN HOSPITALS MERGE?

Most likely, local bishops will follow ERD 24 and deny patients their rights to refuse unwanted medical treatment and create advance

attributed when, even though the cooperator denies intending the wrongdoer's object, no other explanation can distinguish the cooperator's object from the wrongdoer's object. If the cooperator does not intend the object of the wrongdoer's activity, the cooperation is material and can be morally licit. . . . When the object of the cooperator's action remains distinguishable from that of the wrongdoer's, material cooperation is mediate and can be morally licit.

*Id.* Even though material cooperation may not be immoral, the ERDs suggest measures to avoid scandal in morally licit cooperation. "First, the object of material cooperation should be as distant as possible from the wrongdoer's act. Second, any act of material cooperation requires a proportionately grave reason." *Id.*

What "material cooperation" means then is anyone's guess. Commentators rarely describe it. *But see* Boozang, *supra* note 2, at 1440 (providing a marginal discussion of material cooperation). It seems likely that morally licit material cooperation would not be overcome by the creative solutions anyway. First, since it is not clear whether spatial or management "distance" is required for morally licit material cooperation, a joint operating agreement may not satisfy the "distance" consideration since the activities of the two hospitals would be governed by one agreement. Secondly, what constitutes a "proportionately grave reason" is unclear; financial need may not constitute such a reason.

48. *See supra* note 27 and *infra* note 50 and accompanying text.

49. The effect merger may have on reproductive health care services has been well discussed. *See generally*, Bucar, *supra* note 10; Ikemoto, *supra* note 1; Gallagher, *supra* note 20. The effect merger currently has on reproductive health services is being tracked by MergerWatch. *See generally*, MERGERWATCH, *supra* note 2.

50. *See supra* note 23 and accompanying text (describing ERD 24).

directives. However, the argument that some bishops may not follow ERD 24 looms ominously. First, although some Catholic commentators contend that Catholic teaching does not require ANH to be provided in every circumstance, a close analysis suggests that Catholic teaching requires the provision of ANH in *nearly* every circumstance.<sup>51</sup> Secondly, an examination of Catholic and bishop activity and statements regarding the withholding or withdrawal of ANH suggests that most bishops will follow ERD 24 and disregard patients' rights to refuse ANH, to have ANH withdrawn, or to direct that ANH be withheld or withdrawn when they become incompetent.<sup>52</sup>

A. *Catholic teaching on the withdrawal or withholding of life-sustaining medical treatment*

First, "there is presently a conflict among Catholic authorities and theologians over the morality of allowing a patient to forego artificial nutrition and hydration."<sup>53</sup> Traditionally, Catholic theology has applied an extraordinary versus ordinary means test to determine whether life-sustaining treatment should be withheld or withdrawn.<sup>54</sup> However, some Catholic theologians have begun to use a useless versus not useless test for determining when life-sustaining treatment should be withheld or withdrawn.<sup>55</sup> Both tests are ambiguous and neither definitively determines when and in what circumstances ANH may be withheld or withdrawn.

1. *The traditional extraordinary versus ordinary means test*

Under the traditional test, "'ordinary means' are those which are effective and can be employed without undue burden. 'Extraordinary means' are those which either are futile or whose use involves too grave a burden."<sup>56</sup> Accordingly, under this traditional test, extraordi-

51. See *infra* notes 53-70 and accompanying text.

52. See *infra* notes 71-90 and accompanying text.

53. Peter J. Ausili, *Withholding or Withdrawing Artificial Nutrition and Hydration from Terminally Ill and Permanently Unconscious Patients: Some Recent Case Law and Contemporary Catholic Theology*, 32 CATH. LAW. 55, 81 (1988).

54. See *id.* at 78. Catholic ethicists "date the use of the terms ordinary or extraordinary to the 17<sup>th</sup> century and stress that the terms make ethical . . . , rather than medical, distinctions." Ginny Cunningham, *Science Hasn't Made it Any Easier to Die; Today Advanced Medical Technologies Can Compound Suffering in Ways that Earlier Generations Were Spared*, U.S. CATH., Jul. 1, 1996, at 19.

55. See, e.g., MARYLAND CATHOLIC CONFERENCE, A PASTORAL LETTER: CARE OF THE SICK AND DYING I (1993).

56. Moria M. McQueen and James L. Walsh, *The House of Lords and the Discontinuation of Artificial Nutrition and Hydration: An Ethical Analysis of the Tony Bland Case*, 35 CATH. LAW. 363, 373 (1994).

nary means are "morally optional" while ordinary means are "morally obligatory."<sup>57</sup> The traditional test provides that "life-sustaining measures may be withheld or withdrawn when morally justified."<sup>58</sup>

Under the traditional test, it is unclear whether ANH is extraordinary, ordinary, morally optional, or morally obligatory and when withholding or withdrawing ANH becomes morally justified. In fact, one Catholic commentator advocates that the traditional test should no longer be used because it has not allowed "a systematic categorization of typical medical treatments by Catholic theologians, particularly because of rapid advances in medical technology."<sup>59</sup> In the Catholic/non-sectarian merger context, the inability to identify whether ANH is morally optional, in which case it could be withdrawn if morally justified, or morally obligatory under the traditional extraordinary versus ordinary test is problematic. Quite possibly, Catholic hospital administrators and bishops could hide behind the ambiguity of the test rather than take a specific position on the provision of ANH and ERD 24.

## 2. *The useless versus not useless test*

On the other side of the Catholic conflict over ANH, some Catholic theologians use a useless versus not useless test to determine whether life-sustaining treatment should be withdrawn or withheld.<sup>60</sup> "A medical treatment is 'useless' to a particular patient if it cannot bring about the effect for which it is designed."<sup>61</sup> A health care provider should not administer a useless treatment because to do so would be "both ineffective and inappropriate."<sup>62</sup> Conversely, a not useless medical treatment would bring about the effect for which it is designed.<sup>63</sup> A health care provider should not consider a treatment useless simply because it "fails to achieve some goal beyond what should be reasonably expected."<sup>64</sup>

To determine whether ANH is a useless or not useless medical treatment, health care providers must determine whether it can

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57. Asuili, *supra* note 53, at 78.

58. *Id.*

59. *Id.* "It is now recognized . . . by ethicists as well as the medical community and courts that the right to accept or refuse treatment is not dependent on the description of medical procedures as 'ordinary' or 'extraordinary' . . . because these are legally indistinguishable." ARTHUR S. BERGER, *WHEN LIFE ENDS: LEGAL OVERVIEWS, MEDICOLEGAL FORMS, AND HOSPITAL POLICIES* 26 (1995).

60. *See, e.g.*, MARYLAND CATHOLIC CONFERENCE, *supra* note 55, at 8-10.

61. *Id.*

62. *Id.*

63. *Cf. id.* (inferring "not useless" from "useless" as defined).

64. *Id.*

achieve the “reasonably expected” effect for which it was designed.<sup>65</sup> With ANH, the “reasonably expected” portion of the test is key to determining whether it should be administered:

a feeding tube is used to provide nutrients to a patient no longer capable of eating; the tube is useful when it delivers these nutrients to the patient who, in turn, absorbs them. It is useless if the patient becomes incapable of absorbing the nutrients the tube delivers. Moreover, a feeding tube should not be described as useless if the nutrients it provides are unable to cure an underlying pathology; the feeding tube should not be expected to restore the patient to consciousness or to remove any other debility not related to the need for nutrients.<sup>66</sup>

Following this reasoning, ANH would almost never be removed because it could only be deemed useless if the patient were not able to absorb the nutrients.

The useless versus not useless construction of ANH is extremely troublesome in the Catholic/non-sectarian merger context. Since ANH would almost never be deemed useless, advance directives to the contrary would not be followed because they would conflict with Catholic teaching.<sup>67</sup> Even more troubling is the nondescript and ambiguous manner in which the test is described.<sup>68</sup> As with the extraordinary versus ordinary test, Catholic hospital administrators and bishops could hide behind the ambiguous language of the test rather than take a position on ERD 24.

The ambiguity problems the useless versus not useless test could create in the merger context is compounded by the physician-centered approach of the test.<sup>69</sup> Catholic health care officials could argue that a patient’s advance directive requiring the withholding or withdrawal of ANH may be honored because the bishop in that patient’s jurisdiction may choose not to follow ERD 24.<sup>70</sup> However, if patients must rely on physicians to determine whether ANH is useless

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65. See *supra* notes 61-64 and accompanying text (setting forth the useless v. not useless test for determining whether medical treatment should be administered).

66. MARYLAND CATHOLIC CONFERENCE, *supra* note 55, at 8-9.

67. See ERDs, *supra* note 12, at 14 (ERD 24).

68. See *supra* notes 61-64 and accompanying text (describing the useless v. not useless test as applied to ANH).

69. See MARYLAND CATHOLIC CONFERENCE, *supra* note 55, at 9 (“Patients and their loved ones need to rely on health care professionals who can help them decide which forms of treatment are effective and, thus useful, and those which are ineffective and, thus, useless.”).

70. See *supra* notes 44-45 and accompanying text.

or not and Catholic teaching provides that ANH is virtually never useless, Catholic hospital policy would supercede a physician's recommendations. Therefore, patients' advance directives would not be effectuated.

### B. Catholic and bishop activities and statements regarding ANH

The argument that advance directives requiring that ANH be withheld or withdrawn may be honored because a particular bishop may choose not to follow ERD 24 becomes suspect upon examination of Catholic and bishop activities and statements regarding ANH. First, Catholic organizations have submitted *amicus curiae* briefs against withdrawing or withholding ANH in several ANH cases.<sup>71</sup> Secondly, Catholic organizations and bishops have opposed state and federal legislation that gives patients the right to decide for themselves.<sup>72</sup> Finally, and most convincingly, NCCB has publicly expounded a pro-ANH position.<sup>73</sup>

#### 1. Catholic amicus briefs against withholding or withdrawing ANH

First, Catholic organizations have petitioned the courts *amicus curiae* advocating for the provision of ANH when patients requested that it be withdrawn.<sup>74</sup> For example, in *Cruzan v. Missouri Health Department*,<sup>75</sup> both the Catholic Lawyers Guild of the Archdiocese of Boston and the United Catholic Conference submitted briefs *amicus curiae* against withdrawing Nancy Cruzan's ANH.<sup>76</sup> State Catholic organizations have entered *amicus* briefs in several state ANH cases as well.<sup>77</sup> These *amicus* briefs suggest Catholic opposition to withdrawing or withholding ANH.

Although Catholics appear to be opposed to the withdrawal or withholding of ANH, other religious groups appear not to be. For example, in *Cruzan*, the Evangelical Lutheran Church in America and the General Board of Church and Society of the United Methodist Church submitted *amicus curiae* advocating withdrawal of Cruzan's

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71. See *infra* notes 74-79 and accompanying text.

72. See *infra* notes 80-86 and accompanying text.

73. See *infra* notes 87-90 and accompanying text.

74. See, e.g., *Cruzan v. Mo. Health Dep't*, 497 U.S. 261, 264 (1990); *In re Jobes*, 529 A.2d 434, 436 (N.J. 1987); *In re Quinlan*, 355 A.2d 647, 651 (N.J. 1976).

75. 497 U.S. 261 (1990).

76. See *id.* at 264.

77. See, e.g., *Jobes*, 529 A.2d at 436 (New Jersey Catholic Conference submitted *amicus curiae* against withdrawal); *Quinlan*, 355 A.2d at 651 (New Jersey Catholic Conference submitted *amicus curiae* against withdrawal).

ANH.<sup>78</sup> Since all religions do not advocate identical positions on the withdrawal or withholding of ANH, a Catholic/non-sectarian merger would likely circumvent the religious choice of non-Catholic patients in the area served by the merged facility.<sup>79</sup>

2. *Catholic and bishop opposition to federal and state patients' rights legislation*

Catholic organizations and bishops have also opposed federal and state legislation purporting to give patients the rights to make advance directives, appoint surrogate decision makers, and make end-of-life decisions for themselves.<sup>80</sup> For example, the United States Catholic Conference originally opposed the Patient Self-Determination Act which requires hospitals that receive federal funding to inform patients of state law and hospital policy regarding advance directives.<sup>81</sup> Similarly, the Maryland Conference of Catholic Bishops opposed certain portions of the proposed Maryland Health Care Decisions Act (MHCDA) which sought to give patients the rights to create advance directives and appoint an agent to make health care decisions

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78. See *Cruzan*, 497 U.S. at 264. Several other religions either do not oppose ANH withdrawal or withholding or oppose them for reasons other than the Catholic Church's reasons. See Caryle Murphy, *When Is It Time to Die? Faiths, Families Weigh End-of-Life Issues*, WASH. POST, Nov. 2, 1998, at C1. For example, the Seventh-day Adventist, Episcopal, Lutheran Church-Missouri Synod, Southern Baptist, and Islamic faiths generally allow the withdrawal of ANH with varying restrictions. See *id.*

79. See *infra* notes 96-187 (suggesting that ERD compliance in a Catholic/non-sectarian merger circumvents the religious freedom of non-Catholics).

80. See *infra* notes 81-86.

81. See Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249, 255 (1997) (discussing the Patient Self-Determination Act (PSDA), Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 §§ 4206, 4751 (codified in scattered sections of 42 U.S.C.)). Under PSDA, all health care facilities that receive federal monies, like Medicaid, are required to "maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization." PSDA, 42 U.S.C. § 1396a(w)(1) (1991). In addition, the facility must "provide written information to each adult individual concerning [the patient's] rights under State law" about surrogate decision-making and advance directives and the provider's policy. *Id.* § 1396a(w)(1)(A). The provider must also comply with its state's law regarding advance directives and must provide the patient with information about that state law. See *id.* § 1396a(w)(1)(D).

The U.S. Catholic Conference dropped its original opposition to PSDA after "the mandate that each state enact an advance directive statute was removed and a committee amendment was added to ensure that state conscience clause grounds would continue to be valid." Larson & Eaton, *supra*, at 255. See also PSDA, § 1396a(w)(3) ("Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.").

for them.<sup>82</sup> The Maryland Catholic Conference also opposed Maryland's Life-Sustaining Procedures Act<sup>83</sup> which predated MHCDA and gave patients the right to provide for the refusal of life-sustaining procedures in their wills.<sup>84</sup> Likewise, the New York State Catholic Conference opposed the New York Family Health Care Decisions Act.<sup>85</sup> This

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82. See Diane E. Hoffman, *The Maryland Health Care Decisions Act: Achieving the Right Balance?*, 53 MD. L. REV. 1064, 1091-92 (1994). Senate Bill 664, the precursor to MHCDA, "included a single advance directive form that would allow individuals either to appoint an agent, leave instructions for receipt of health care or do both." *Id.* at 1089. The Maryland Catholic Conference opposed the inclusion of patients who had "inevitably fatal conditions" into Senate Bill 664's advance directive form. *Id.* at 1091. The Conference maintained that "[a]cceptance of this concept, in [its] view, would embrace . . . the 'ethic of euthanasia.' [The Conference believed that] [l]eaping to final decisions in the matters of living will, durable power of attorney, and surrogate decisionmaking are perilous enough . . . ." *Id.* at 1091-92 (quoting Letter from Richard J. Dowling, The Maryland Catholic Conference, to Hon. Stephen J. Braun, Chairman, Durable Power of Attorney Work Group, House Environmental Matters Subcomm. and Subcomm. Members 7 (Mar. 16, 1993)). See also MARYLAND CATHOLIC CONFERENCE, *supra* note 55, at 1 (writing in response to MHCDA and insinuating that MHCDA marks "the increasing tendency of our society to devalue human life"). See also *infra* notes 102-16 (fully discussing MHCDA as it creates patient rights to create advance directives and appoint surrogate decision-makers).

83. See MD. CODE ANN., HEALTH-GEN. § 5-601 *et seq.* (1988 Supp.), *repealed by* MHCDA, MD. CODE ANN., HEALTH-GEN. § 5-601 *et seq.* (1997).

84. See Wendy Ann Kronmiller, Comment, *A Necessary Compromise: The Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act*, 47 MD. L. REV. 1188, 1205-09 (1988). The Life-Sustaining Procedures Act (LSPA) allowed patients to declare in their wills that "life-sustaining" procedures could be withheld or withdrawn. MD. CODE ANN., HEALTH-GEN. § 5-602 (1988 Supp.). The LSPA defined a "life-sustaining" procedure as one that "afford[s] a patient no reasonable expectation of recovery from a terminal condition" and "would secure only a precarious and burdensome prolongation of life." *Id.* at § 5-601(e). However, the LSPA provided that "food and water" had to be administered. *Id.* at § 5-602(c). The LSPA did not define "food and water." See Kronmiller, *supra*, at 1206. Therefore, the Society for the Right to Die encouraged patients to include declarations to withhold or withdraw ANH because it believed ANH was different from "food and water." See *id.* But see *id.* at 1207 (maintaining that the Environmental Matters Committee's report on the LSPA bill "indicates that the legislators meant to include AN&H with 'food and water'").

Interestingly, the LSPA was only passed after the Maryland Catholic Conference (MCC) relinquished its opposition to the bill. See *id.* MCC maintained that living wills were not contrary to Church teaching, but it feared that the LSPA would "crack open the door to serious abuses affecting the sacredness of human life." *Id.* (quoting Richard Dowling's, Executive Director of MCC, testimony on LSPA). MCC finally supported LSPA "in part [because of] the 'strengthening' of the Act by its sponsors, who essentially had adopted the Bishops' Committee guidelines." *Id.* at 1208. In particular, the LSPA's definition of "life-sustaining" procedure was "adopted verbatim" from a letter that Richard J. Dowling sent to Delegate Larry Young, the Chairperson of the Environmental Matters Committee. *Id.*

85. See Letter from John M. Kerry, New York State Catholic Conference, to Hon. Joseph Lentol, Chairperson, Assembly Codes Comm. and Comm. Members (June 23, 1997) in New York Catholic Conference, *End of Life Decisionmaking*, (visited Sept. 30, 1998) <<http://www.nyscatholicconference.org/budget/family.html>> (discussing New York Family Health Care Decisions Act). The Conference opposed the bill because "the Catholic



law, which seeks to allow patients to appoint surrogate decision makers, was opposed because it did not distinguish ANH from other forms of medical treatment.<sup>86</sup> Bishop and Catholic opposition to advance directive legislation suggests that bishops generally oppose the withdrawal or withholding of ANH; therefore, bishops will most likely follow ERD 24 and prohibit those directives that are against Catholic teaching.

### 3. NCCB's pro-ANH position

Although Catholic bishops and theologians have continually discussed and debated the Church's teaching on ANH,<sup>87</sup> "Church teaching . . . has not definitively resolved the question of the propriety of withholding or withdrawing artificial nutrition and hydration . . ." <sup>88</sup> Even though the Church's position on ANH may not be definitively resolved, the NCCB, author of the ERDs, "opposes the increasingly widespread practice of removing" ANH and advocates "'a presumption' in favor of artificial feeding for people regarded to be permanently unconscious."<sup>89</sup> Given NCCB's pro-ANH position for permanently unconscious patients, combined with Church and NCCB pressure to follow the ERDs in general,<sup>90</sup> bishops will most likely follow ERD 24 and ignore patients' advance directives to the contrary.

In sum, the ambiguity of the Church's teaching on ANH, Catholic opposition to withdrawing or withholding ANH and to advance directive legislation, and NCCB's pro-ANH position pose grave problems for patients who unknowingly enter a community hospital which is actually part of a merged facility that follows the ERDs. Arguably, patients seek health care knowing that they have the rights to refuse unwanted medical treatment and create advance directives.

Church teaches that morally sound decisions concerning medical treatment for the incapacitated need to be made by a community of the patient's family, health care providers and religious and moral advisors. Therefore, in theory the concept of surrogate decision-making is not contrary to Catholic teaching." *Id.* However, the Conference did oppose the bill because it did not protect patients without surrogates, it did not distinguish ANH from other medical treatment, it did not offer "higher decision-making standards" for "abortion, sterilization, and treatment of pregnant patient[s] to the detriment of the unborn child," and it did not prohibit physician-assisted suicide. *Id.*

86. *See id.*

87. *See supra* notes 53-66 and accompanying text.

88. Asuili, *supra* note 53, at 57.

89. Religious News Service, *Matters of Life or Death Are Also Questions of Ethics and Morals: Comatose Patients: Catholic Bishops Come Out in Favor of Continued Artificial Feeding of People Regarded to be Permanently Unconscious*, L.A. TIMES, Apr. 4, 1992, at B4.

90. *See supra* notes 37-43 and accompanying text.

When a merged facility disregards their rights, patients will lose access to health care services to which they have legal rights to.<sup>91</sup>

### PART III. ARTIFICIAL NUTRITION AND HYDRATION: THE CONFLICT BETWEEN PATIENTS' RIGHTS AND PROVIDERS' INTERESTS

Patients generally have the right to refuse medical treatment, including artificial nutrition and hydration (ANH).<sup>92</sup> However, the manner in which patients can choose to refuse such treatment varies from state to state.<sup>93</sup> Physicians generally have statutory rights to object to a patient's request to withdraw ANH on conscience clause grounds; however, most states require physicians to notify the patient of their decision not to honor the patient's request and to transfer the patient to a provider that will honor the request.<sup>94</sup> However, the courts may find for patients when a merged provider refuses to honor a patient's request to withdraw or withhold ANH.<sup>95</sup> The rights of patients to refuse ANH and create advance directives and health care institutions' religious objections to their requests come into direct conflict when a sectarian hospital merges with a non-sectarian hospital. This conflict can only be resolved after an examination of both patients' rights and providers' interests.

A competent patient has a "constitutionally protected liberty interest in refusing unwanted medical treatment."<sup>96</sup> This liberty interest includes a "constitutionally protected right to refuse lifesaving hydration and nutrition."<sup>97</sup> In other words, artificial nutrition and hydration is a form of medical treatment which competent patients have the right to refuse.<sup>98</sup> Although all competent patients have a constitutionally protected right to refuse medical treatment, the procedures by

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91. See *infra* notes 92-117 and accompanying text.

92. See *infra* notes 96-98 and accompanying text.

93. See *infra* notes 99-117 and accompanying text.

94. See *infra* notes 121-36 and accompanying text.

95. See *infra* notes 143-76 and accompanying text.

96. *Cruzan v. Mo. Dep't Health*, 497 U.S. 261, 278-79 (1990). To arrive at this holding, the *Cruzan* Court examined common-law doctrine and the Constitution. First, the Court examined various state cases to conclude that the common-law doctrine of informed consent encompasses a competent individual's right to refuse medical treatment. See *id.* at 278. Secondly, the Court reasoned that the constitutionally protected liberty interest to refuse unwanted medical treatment could be inferred from its prior Fourteenth amendment decisions. See *id.* at 278. A full discussion of *Cruzan* is outside the scope of this paper. But see generally John Kenneth Giselson, *Right to Die, Forced to Live: Cruzan v. Dir., Missouri Department of Health*, 7 J. CONTEMP. HEALTH L. & POL'Y 401 (1991) (discussing *Cruzan* in detail).

97. *Cruzan*, 497 U.S. at 279.

98. Cf. *supra* notes 96-97 and accompanying text.

which they may decide to refuse medical treatment vary from state to state.

All but three states have living will legislation.<sup>99</sup> Through living wills, patients can dictate their wishes regarding the withdrawal of ANH and other life-sustaining treatments.<sup>100</sup> Moreover, in every state, health care legislation provides statutory rights for patients to appoint a proxy or surrogate decision-maker to make health care decisions according to their wishes when they become unable to do so for themselves.<sup>101</sup>

For example, in 1993, the Maryland General Assembly passed and the Governor<sup>102</sup> signed the Maryland Health Care Decisions Act (MHCDA).<sup>103</sup> MHCDA allows patients to create written or oral advance directives<sup>104</sup> and “authorizes surrogate decision-making for incompetent individuals who did not appoint an agent when they were capable of doing so.”<sup>105</sup> Furthermore, MHCDA regulates health care

99. See Hoffman, *supra* note 82, at 1066. Massachusetts, Michigan, and New York do not have living will legislation. See *id.*

100. See *supra* note 23 (describing advance directives).

101. See Hoffman, *supra* note 82, at 1066-67 (listing Alabama as the only state that does give its patients the right to appoint surrogate decision-makers). However, as of 1997, Alabama's residents have the right to create advance directives. See ALA. CODE § 22-8A-1 *et seq.* (1997).

102. Maryland Governor William Donald Schaefer signed the Maryland Health Care Decisions Act [hereinafter MHCDA] into law on May 12, 1993. See Hoffman, *supra* note 82, at 1066.

MHCDA was enacted in response to the Maryland Court of Appeals' decision in *Mack v. Mack*, 618 A.2d 744 (Md. 1993), which held that an individual's preferences towards life-sustaining treatment could not supersede statutory priority for appointing a guardian. See Karen E. Goldmeier, Comment, *The Right to Refuse Life-Sustaining Medical Treatment: National Trends and Recent Changes in Maryland*, 53 MD. L. REV. 1306, 1307 (1994) (maintaining that MHCDA was enacted in response to *Mack*). Prior to MHCDA, Maryland law provided that a guardian could be appointed for an incompetent patient “according to the following priorities: (1) a person . . . nominated by the disabled person . . . ; (2) his spouse; [or] (3) his parents . . . .” MD. CODE ANN., EST. & TRUSTS § 13-707(a) (1990 Supp.). Furthermore, “among persons with equal priority,” the court was enabled to “select the one best qualified of those willing to serve. For good cause, the court [could] also pass over a person with priority and appoint a person with lower priority.” *Id.* § 13-707(c).

103. MD. CODE ANN., HEALTH-GEN. §§ 5-601-618 (1997).

104. See *id.* § 5-602. “‘Advance directive’ means: (1) a witnessed written document, voluntarily executed by the declarant in accordance with the requirements of this subtitle; or (2) a witnessed oral statement, made by the declarant in accordance with the provisions of this subtitle.” *Id.* § 5-601(b)(1)-(2).

105. Goldmeier, *supra* note 102, at 1335 (citing MD. CODE ANN., HEALTH-GEN. § 5-605(a)(2) (1994)). See also *infra* notes 115-17 and accompanying text.

provider<sup>106</sup> behavior with regard to advanced directives and sets forth penalties for physicians<sup>107</sup> who do not comply with the Act.<sup>108</sup>

First, MHCDA authorizes competent individuals<sup>109</sup> to create advance directives "regarding the provision of health care to that individual, or the withholding or withdrawal of health care from that individual."<sup>110</sup> MHCDA also gives competent patients the right to appoint agents to make their health care decisions for them at the point they become incompetent.<sup>111</sup> A health care provider can never be appointed as an agent by a patient unless the health care provider is also the patient's guardian, spouse, adult child, parent, adult brother or sister, or friend or relative.<sup>112</sup>

When a competent patient becomes "incapable of making an informed decision," her advance directive regarding treatment or agency becomes effective.<sup>113</sup> Accordingly, patients have the responsibility under MHCDA to notify the attending providers of their direc-

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106. MHCDA defines "health care provider" as "a health care practitioner or a facility that provides health care to individuals." MD. CODE ANN., HEALTH-GEN. § 5-601(k)(1) (1997). "Health care provider" also "includes agents or employees of a health care practitioner or a facility that provides health care to individuals." *Id.* § 5-601(k)(2).

107. MHCDA defines "physician" as "a person licensed to practice medicine in the State or in the jurisdiction where the treatment is to be rendered or withheld." MD. CODE ANN., HEALTH-GEN. § 5-601(p).

108. *See infra* notes 118-20 and accompanying text.

109. MHCDA defines a "competent individual" as "a person who is at least 18 years of age and . . . has the same capacity as an adult to consent to medical treatment and who has not been determined to be incapable of making an informed decision." MD. CODE ANN., HEALTH-GEN. § 5-601(f). *See also infra* note 113 (providing MHCDA's definition of "incapable of making an informed decision").

110. MD. CODE ANN., HEALTH-GEN. § 5-602(a). A written advanced directive must be "dated, signed by or at the express direction of the declarant, and subscribed by two witnesses." *Id.* § 5-602(c). In addition, MHCDA provides that a competent person may also make her advanced directive orally. *See id.* § 5-602(d). "An oral advance directive shall have the same effect as a written advance directive if made in the presence of the attending physician and one witness and documented as part of the individual's medical record. The documentation shall be dated and signed by the attending physician and the witness." *Id.* § 5-602(c).

111. *See id.* § 5-602(b) (written); *Id.* § 5-602(d) (orally). An agent appointed by a written advanced directive has priority over any surrogate decision maker appointed by MHCDA's priority provision. *See id.* § 5-605(a)(2).

112. *See id.* § 5-602(b)(2). *See also infra* notes 116-17 and accompanying text (providing the statutory requirements for friend or relative to act as agent).

113. *See* MD. CODE ANN., HEALTH-GEN. § 5-602(e)(1). A patient is "incapable of making an informed decision" when s/he has

an inability . . . to make an informed decision about the provision, withholding, or withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation or the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision.

tives.<sup>114</sup> If a patient has not appointed an agent before s/he becomes incompetent, a "surrogate decision maker" will be appointed for her according to a prioritized list.<sup>115</sup> The surrogate-decisionmaker may be, in descending order of priority, the patient's guardian, spouse, adult child, parent, adult brother or sister, friend, or other relative.<sup>116</sup> If a surrogate decision maker is called upon to make health care decisions for a patient and s/he does not know the patient's wishes regarding treatment, s/he must decide according to the patient's best interest.<sup>117</sup>

In addition to creating patient rights regarding advance directives and surrogate decision-making, MHCDA recognizes health care providers' interests in following patient directives and provides penalties for those who violate the Act. First, a health care provider who "willfully conceals, cancels, defaces, obliterate, or damages" a patient's advance directive or who "falsifies or forges a revocation of the [patient's] advance directive" is guilty of a misdemeanor and may be fined up to \$10,000 and/or imprisoned for up to one year.<sup>118</sup> Secondly, MHCDA does not require a physician to prescribe or render medical treatment that s/he believes is "ethically inappropriate."<sup>119</sup>

*Id.* § 5-601(1)(1). A patient is not classified as "incapable of making an informed decision" under MHCDA simply because s/he is not able to communicate by speech. *Id.* § 5-601(1)(2).

114. *See id.* § 5-602(f)(1). However, if the patient is "comatose, incompetent, or otherwise incapable of communication" any one else can notify the physician of the patient's directive. *Id.*

115. *Id.* § 5-605(a)(2). A surrogate decision maker can also make decisions for a patient if the health care provider is unaware of or cannot locate the patient's agent after a reasonable inquiry, if the agent does not respond in a timely manner, or if the agent is incapacitated or unwilling to make decisions for the patient. *See id.* § 5-605(a)(1)(i)-(v).

116. *See id.* § 5-605(a)(2). A friend or relative can only be a surrogate decision maker for the patient if s/he is competent and if s/he admits by affidavit that s/he has "maintained regular contact with the patient sufficient to be familiar with the patient's activities, health, and personal beliefs." *Id.* § 5-605(a)(3).

117. *See id.* § 5-605(c)(1). To determine the patient's best interest, MHCDA instructs the surrogate decision maker to consider

the *patient's*: [c]urrent diagnosis and prognosis with and without the treatment at issue; [e]xpressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments; [r]elevant religious and moral beliefs and personal values; behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally; [r]eactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and [e]xpressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.

*Id.* § 5-605(c)(2)(i)-(vi) (emphasis added).

118. *See id.* § 5-610(a).

119. *Id.* § 5-611(a). MHCDA does not define "ethically inappropriate." *Id.* § 5-601. Even if a provider objects to a patient's advance directive or surrogate's instruction, that

However, a health care provider must "make every reasonable effort to transfer" a patient if the health care provider does not wish to follow the patient's directive *and* the agent or surrogate decision maker requests a transfer.<sup>120</sup>

In some contexts, physicians may object to procedures that patients otherwise have rights to. As they currently exist in federal and state statutory law, conscience clauses allow health care providers to object to performing abortions and related services on moral or religious grounds.<sup>121</sup> Increasingly, living will legislation provides conscience clause rights to physicians so they may object to advance directives on moral, ethical, or religious grounds; however, physicians are generally required to inform and transfer the patient.<sup>122</sup> Furthermore, some conscience clause statutes include only physicians while others include physicians and hospitals.<sup>123</sup>

First, the federal "Church Amendment" permits health care providers<sup>124</sup> and physicians to refuse to provide or participate in the provision of abortions and sterilizations on religious or moral grounds.<sup>125</sup> Although the Church Amendment provides physicians and health care providers with a right of religious or moral conscience, this right

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provider *must* prescribe or render the treatment while the patient is awaiting transfer if failure to comply with that instruction would likely result in the death of the individual. *See id.* § 5-613(a)(3).

120. *Id.* § 5-613(a)(1)(iii). However, the provider must comply with the instruction until the transfer is effectuated if the failure to comply would likely result in the patient's death. *See id.* § 5-613(a)(3). The provider is only required to transfer if the agent or surrogate decision-maker requests it. *See id.* § 5-613(a)(1)(ii).

121. *See* Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, 179-80 (1993).

122. *See* KING, *supra* note 23, at 153.

123. *See id.* at 182.

124. The "Church Amendment" only covers those providers who receive a "grant, contract, loan, or loan guarantee under the Public Health Service Act [42 U.S.C.A. § 201 *et seq.*], the Community Mental Health Centers Act [42 U.S.C.A. § 2689 *et seq.*] or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C.A. § 6000 *et seq.*]." 42 U.S.C. § 300a-7(b) (1991).

125. *See* 42 U.S.C. § 300a-7. The "Church Amendment" prevents public officials and public authorities from requiring individual providers to "perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions." *Id.* § 300a-7(b)(1). Furthermore, the "Church Amendment" provides that public officials and public authorities may not require an "entity" to "make its facilities available for the performance of any sterilization procedure or abortion" if doing so is against the "religious beliefs or moral convictions" of the entity. *Id.* § 300a-7(b)(2)(A). Entities do not have to "provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion" either. *Id.* § 300a-7(b)(2)(B).

may only be exercised in the context of abortions and sterilizations.<sup>126</sup> In other words, the federal conscience clause right does not extend to withdrawing or withholding ANH.

Similarly, state law often allows providers conscience rights to reproductive health care as well.<sup>127</sup> For example, Maryland law allows providers, identified as persons, hospitals, hospital directors, or hospital governing boards,<sup>128</sup> to object to performing or participating in the provision of abortions, sterilizations, or artificial inseminations.<sup>129</sup> Maryland's "conscience clause" statute does not identify the basis upon which providers can object to the included procedures.<sup>130</sup> However, since the Maryland statute closely mirrors the Church Amendment, it seems likely that the objection would need to be based on religious or moral conviction. Nonetheless, the Maryland statute, like the Church Amendment, is restricted to reproductive health services only.<sup>131</sup>

However, nearly every state has included conscience clause rights to object to end-of-life treatment in its living will legislation.<sup>132</sup> Some

126. *See id.* § 300a-7. The Church Amendment is limited to abortions and sterilizations because the Amendment was passed in response to the Supreme Court's decision in *Roe v. Wade*, which held that women have a fundamental constitutional right to abortion. *See Wardle, supra* note 121, at 180-81. *See also* *Roe v. Wade*, 410 U.S. 113, 166 (1973).

127. *See Wardle, supra* note 121, at 179-80.

128. *See* MD. CODE ANN., HEALTH-GEN. § 20-214 (a)(1) & (b)(1) (1991 Supp.). The statute does not limit coverage to a particular receipt of state or federal funding, contract, or grant. *See generally id.*

129. *See id.*

130. *Id.*

131. *See supra* note 126 and accompanying text (describing Church Amendment's limitations).

132. *See generally, e.g.*, ALA. CODE § 22-8A-8 (WESTLAW through End of 1998 Reg. Sess.); ALASKA STAT. § 18.12.050 (WESTLAW through End of 1998 2<sup>nd</sup> Spec. Sess.); ARIZ. REV. STAT. ANN. § 36-3205 (West, WESTLAW through End of 1998 2<sup>nd</sup> Reg. Sess. and 5<sup>th</sup> Spec. Sess.); ARK. CODE ANN., § 20-17-207 (WESTLAW through End of 1997 Reg. Sess.); CAL. HEALTH & SAFETY CODE § 7190 (West, WESTLAW through End of 1997-98 Reg. Sess. and 1<sup>st</sup> Ex. Sess.); COLO. REV. STAT. ANN. § 15-18-113 (West, WESTLAW through End of 1998 2<sup>nd</sup> Reg. Sess.); CONN. GEN. STAT. ANN. § 19a-580a (West, WESTLAW through End of 1997 4<sup>th</sup> Sp. Sess.); DEL. CODE ANN. tit. 16, § 2508 (WESTLAW through End of 1997 Reg. Sess.); D.C. CODE ANN. § 6-2427 (WESTLAW through Laws 12-1 to 12-104, 12-113, 12-114, 12-125 to 12-127, and Act 12-138 of the 1997-98 12<sup>th</sup> District Council Sess.); FLA. STAT. ANN. § 765.308 (West, WESTLAW through End of 1998 2<sup>nd</sup> Reg. Sess.); GA. CODE ANN. § 31-32-8 (WESTLAW through End of 1998 Reg. Sess.); HAW. REV. STAT. ANN. § 327D-11 (LEXIS, WESTLAW through the 1998 Reg. Sess. of the Nineteenth Legis.); IDAHO CODE § 39-4508 (LEXIS, WESTLAW through End of 1998 Reg. Sess.); 755 ILL. COMP. STAT. ANN. 40/35 (West, WESTLAW through P.A. 90-609, apv. 6/30/1998); IND. CODE ANN. § 16-36-4-13 (West, WESTLAW through End of 1998 2<sup>nd</sup> Reg. Sess.); IOWA CODE ANN. § 144A.8 (West, WESTLAW through End of 1997 Reg. Sess.); KAN. STAT. ANN. § 65-28,107 (WESTLAW through End of 1997 Reg. Sess.); KY. REV. STAT. ANN. § 311.633 (Baldwin, WESTLAW through End of 1997 1<sup>st</sup> Ex. Sess.); LA. REV. STAT. ANN. § 1299.58.7 (West, WESTLAW

living will conscience clauses affirmatively require the physician to notify the patient that s/he will not honor the patient's directive.<sup>133</sup> Furthermore, if a physician refuses to honor a patient's advance directive, the conscience clauses generally require the physician to transfer or assist in the transfer of the patient to a physician or provider that will honor the patient's directive.<sup>134</sup> While nearly every living will con-

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through End of all 1997 Reg. Sess. Acts); ME. REV. STAT. ANN. tit. 18-A, § 5-809 (West, WESTLAW through End of 1997 2<sup>nd</sup> Sp. Sess.); MD. CODE ANN., HEALTH-GEN. § 5-613 (LEXIS, WESTLAW through End of 1998 Reg. Sess.); MASS. GEN. LAWS ANN. ch. 201D, § 14 (West, WESTLAW through End of 1998 2<sup>nd</sup> Annual Sess., Ch. 203 appr. 7/31/1998); MINN. STAT. ANN. § 145B.06 (West, WESTLAW through End of 1998 1<sup>st</sup> Sp. Sess.); MISS. CODE ANN. § 41-41-215 (WESTLAW through End of 1998 Reg. Sess.); MO. ANN. STAT. § 404.830, 459.030 (Vernon, WESTLAW through End of 1997 2<sup>nd</sup> Ex. Sess.); MONT. CODE ANN. § 50-9-203 (WESTLAW through End of 1997 Reg. Sess.); NEB. REV. STAT. § 30-3428 (WESTLAW through End of 1998 1<sup>st</sup> Sp. Sess.); NEV. REV. STAT. § 449.628 (WESTLAW through 1997 Reg. Sess., adj. July 7, 1997); N.H. REV. STAT. ANN. §§ 137-H:6, 137-J:1, 137-J:8 (WESTLAW through End of 1997 Reg. Sess.); N.J. STAT ANN. §§ 26:2H-62, 26:2H-65 (West, WESTLAW through L.1998 c.107); N.M. STAT. ANN. § 24-7A-7 (WESTLAW through End of 1998 1<sup>st</sup> Sp. Sess.); N.Y. PUB. HEALTH LAW § 2984 (McKinney, WESTLAW through the Laws of 1998, Chapters 1, 3, 5 to 9, 11 to 49, 51, 52, 59 to 76, 79 to 124, 126 to 150, 152 to 167, 169, 171 to 200, 202 to 212, 214, 216 to 218, 220, 222 to 279, 281 to 354, 356 to 371, 373 to 380, 382 to 424, 426 to 546, 548 to 561, 563 to 566, 568 to 588 and 591 of 221<sup>st</sup> Sess.); N.D. CENT. CODE §§ 23-06.4-08, 23-06.5-09 (Michie, WESTLAW through End of 1997 Reg. Sess.); OHIO REV. CODE ANN. §§ 1337.16, 2133.10 (Baldwin, WESTLAW through 1998 portion of 122<sup>nd</sup> G.A., Files 1 to 187, apv. 7/1/1998); OKLA. STAT. ANN. tit. 63, § 3101.9 (West, WESTLAW through End of 1998 1<sup>st</sup> Ex. Sess.); OR. REV. STAT. § 127.625 (WESTLAW through End of 1997 Reg. Sess.); PA. STAT. ANN. tit. 20, § 5409 (Purdon, WESTLAW through Act 1998-48); R.I. GEN. LAWS § 23-4.10-6 (LEXIS, WESTLAW through End of 1998 Reg. Sess.); S.C. CODE ANN. § 44-77-100 (WESTLAW through End of 1998 Reg. Sess.); S.D. CODIFIED LAWS § 34-12D-11 (WESTLAW through End of 1998 Reg. Sess.); TENN. CODE ANN. §§ 32-11-108, 34-6-214 (WESTLAW through End of 1998 Reg. Sess.); UTAH CODE ANN. § 75-2-1112 (LEXIS, WESTLAW through End of 1998 Gen. Sess.); VT. STAT. ANN. tit. 14, § 3459 (WESTLAW through End of 1997 Adj. Sess.); VA. CODE ANN. § 54.1-2987 (Michie, WESTLAW through End of 1998 Reg. Sess.); WASH. REV. CODE ANN. § 70.122.060 (West, WESTLAW through End of 1998 Reg. Sess.); W. VA. CODE § 16-30-7 (LEXIS, WESTLAW through End of 1998 1<sup>st</sup> Ex. Sess.); WIS. STAT. ANN. § 154.07 (West, WESTLAW through 1997 Act 338, published 7/3/1998); WYO. STAT. ANN. § 35-22-104 (WESTLAW through End of 1998 Reg. Sess.).

133. See, e.g., ALA. CODE § 22-8A-8(a); ALASKA STAT. § 18.12.050(b); ARIZ. REV. STAT. ANN. § 36-3205(C)(1); DEL. CODE ANN. tit. 16, § 2508(g)(1); GA. CODE ANN. § 31-32-8 (b); KY. REV. STAT. ANN. § 311.633(2); MD. CODE ANN., HEALTH-GEN. § 5-613(a)(1); MINN. STAT. ANN. § 145B.06(a); MISS. CODE ANN. § 41-41-215(7)(a); N.J. STAT. ANN. § 26:2H-62(b); N.M. STAT. ANN. § 24-7A-7(g)(1); N.D. CENT. CODE § 23-06.5-09(2); OR. REV. STAT. § 127.625(2)(a); PA. STAT. ANN. tit. 20, § 5409(a); TENN. CODE ANN. § 32-11-108(a); VT. STAT. ANN. tit. 14, § 3459(b).

134. See, e.g., ALA. CODE § 22-8A-8(a) (reasonably cooperate or assist in transfer); ALASKA STAT. § 18.12.050(a) ("take all reasonable steps to transfer"); ARIZ. REV. STAT. ANN. § 36-3205(C)(1) (transfer); ARK. CODE ANN. § 20-17-207 ("take all reasonable steps to transfer"); CAL. HEALTH & SAFETY CODE § 7190 ("take all reasonable steps to transfer"); COLO. REV. STAT. ANN. § 15-18-113(5) (transfer); CONN. GEN. STAT. ANN. § 19a-580a ("take all reasonable steps to transfer"); DEL. CODE ANN. tit. 16, § 2508(g)(3) ("shall not impede the transfer"); D.C. CODE ANN. § 6-2427(b) ("effect the transfer"); FLA. STAT. ANN. § 765.308(1) ("shall make reasonable efforts to transfer"); GA. CODE ANN. § 31-32-8(b)(1)-



science clause statute covers physicians, some cover providers and facilities as well.<sup>135</sup> Furthermore, a few of the conscience clauses

(2) (attempt or permit transfer if next of kin or legal guardian so requests); HAW. REV. STAT. ANN. § 327D-11(b) ("make the necessary arrangements to effect the transfer"); IDAHO CODE § 39-4508 (assist in obtaining other care); 755 ILL. COMP. STAT. ANN. 40/35 (assist); IND. CODE ANN. § 16-36-4-13(e) (transfer); IOWA CODE ANN. § 144A.8(1) ("take all reasonable steps to effect the transfer"); KAN. STAT. ANN. § 65-28,107(a) (transfer); KY. REV. STAT. ANN. § 311.633(2) (shall not impede the transfer and must supply medical records if patient, family, or guardian requests transfer); LA. REV. STAT. ANN. § 1299.58.7(B) ("make a reasonable effort to transfer"); ME. REV. STAT. ANN. tit. 18-A, § 5-809; MD. CODE ANN., HEALTH-GEN. § 5-613(a)(2) (assist); MASS. GEN. LAWS ANN. ch. 201D, § 14 (transfer); MINN. STAT. ANN. § 145B.06 (no duty to transfer); MISS. CODE ANN. § 41-41-215(7)(c) ("make all reasonable efforts to assist in the transfer" unless patient refuses assistance); MO. ANN. STAT. § 459.030 ("shall not impede" the transfer); MONT. CODE ANN. § 50-9-203 ("take all reasonable steps to transfer"); NEB. REV. STAT. § 30-3428(1) (may transfer); NEV. REV. STAT. § 449.628 ("shall take all reasonable steps as promptly as practicable to transfer"); N.H. REV. STAT. ANN. § 137-H:6(II) ("make the necessary arrangements to effect the transfer"); N.J. STAT. ANN. § 26:2H-62(b) ("effect an appropriate, respectful and timely transfer"); N.M. STAT. ANN. § 24-7A-7(G)(3) ("immediately make all reasonable efforts to assist in the transfer" unless patient refuses assistance); N.Y. PUB. HEALTH LAW § 2984(3)(b) (transfer); N.D. CENT. CODE § 23-06.4-08 ("take . . . all reasonable steps to transfer"); OHIO REV. CODE ANN. § 1337.16(B)(2)(a) ("shall not prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer"); OKLA. STAT. ANN. tit. 63, § 3101.9 ("take all reasonable steps to arrange" other care); OR. REV. STAT. § 127.625(c) ("make a reasonable effort to transfer"); PA. STAT. ANN. tit. 20, § 5409(a) ("make every reasonable effort to assist in the transfer"); R.I. GEN. LAWS § 23-4.10-6 ("shall make the necessary arrangements to effect the transfer"); S.C. CODE ANN. § 44-77-100 ("shall make a reasonable effort to locate a physician or health care facility that will effectuate the [advance directive] and has a duty to transfer the patient to that physician or facility"); S.D. CODIFIED LAWS § 34-12D-11 ("shall make a reasonable effort to locate and to transfer the [patient] to a physician or health-care provider willing to honor the [advance directive]"); TENN. CODE ANN. § 32-11-108(a) ("make every reasonable effort to assist in the transfer" at patient's request); VT. STAT. ANN. tit. 14, § 3459(b) ("actively assist in selecting another health care provider or physician who is willing to honor the agent's directive"); VA. CODE ANN. § 54.1-2987 ("shall make a reasonable effort to transfer"); W. VA. CODE § 16-30-7(b) ("effect the transfer"); WIS. STAT. ANN. § 154.07(1)(a)(3) (failure or refusal to "make a good faith effort" to transfer will constitute unprofessional conduct); WYO. STAT. ANN. § 35-22-104(b) ("attempt to effect the transfer").

135. See, e.g., ALA. CODE § 22-8A-8(a) (including health care providers); ALASKA STAT. § 18.12.050(b) (including health care facilities with regard to do-not-resuscitate orders); ARIZ. REV. STAT. ANN. § 36-3205 (including providers); ARK. CODE ANN. § 20-17-207 (including providers); CAL. HEALTH & SAFETY CODE § 7190 (including providers); CONN. GEN. STAT. ANN. § 19a-580a (including providers); DEL. CODE ANN. tit. 16, § 2508 (including providers and facilities); D.C. CODE ANN. § 6-2427(a) (including health facilities); FLA. STAT. ANN. § 765.308(1) (including facilities); IDAHO CODE § 39-4508 (including facilities); 755 ILL. COMP. STAT. ANN. 40/35 (including facilities); IOWA CODE ANN. § 144A.8 (including providers); KY. REV. STAT. ANN. § 311.633(2) (including facilities); LA. REV. STAT. ANN. § 1299.58.7(D) (including providers); ME. REV. STAT. ANN. tit. 18-A, § 5-809(a) (including institutions); MD. CODE ANN., HEALTH-GEN. § 5-613(a) (including providers); MINN. STAT. ANN. § 145B.06(a) (including providers); MISS. CODE ANN. § 41-41-215(6) (including institutions); MO. ANN. STAT. § 404.830(2) (including hospitals and other health care facilities); MONT. CODE ANN. § 50-9-203 (including providers); NEB. REV. STAT. § 30-3428(1) (including organizations); NEV. REV. STAT. § 449.628 (including providers); N.H. REV.

specifically recognize the ability of health care institutions to create religious or morally motivated policies against ANH withdrawal or withholding; however, these clauses generally require the institution to inform the patient of its policy as soon as possible.<sup>136</sup>

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STAT. ANN. § 137-J:8(2) (including health providers); N.J. STAT. ANN. § 26:2H-65 (including institutions); N.M. STAT. ANN. § 24-7A-7 (including providers); N.Y. PUB. HEALTH LAW § 2984(3) (including private hospitals); N.D. CENT. CODE §§ 23-06.4-08, 23-06.5-09 (including providers); OHIO REV. CODE ANN. §§ 1337.16, 2133.10 (including health care facilities); OKLA. STAT. ANN. tit. 63, § 3101.9 (including providers); OR. REV. STAT. § 127.625 (including providers); PA. STAT. ANN. tit. 20, § 5409 (including providers); R.I. GEN. LAWS § 23-4.10-6 (including providers); S.C. CODE ANN. § 44-77-100 (including facilities); S.D. CODIFIED LAWS § 34-12D-11 (including providers); UTAH CODE ANN. § 75-2-1112 (including other providers); VT. STAT. ANN. tit. 14, § 3459 (including providers and all provider employees); WASH. REV. CODE ANN. § 70.122.060 (including facilities); W. VA. CODE § 16-30-7 (including providers and all provider employees); WIS. STAT. ANN. § 154.07 (including inpatient health care facilities).

136. See, e.g., DEL. CODE ANN. tit. 16, § 2508(f) ("A health-care institution may decline to comply with an [advance directive] if the [advance directive] is contrary to a written policy of the institution which is based on reasons of conscience and if the policy was communicated to the patient or [the patient's surrogate]."); 755 ILL. COMP. STAT. ANN. 40/35 ("If the policies of a health care facility preclude compliance with a decision to forgo life-sustaining treatment, the facility shall take all reasonable steps to assist the patient . . . in effectuating [transfer to a facility that will honor the directive]."); IOWA CODE ANN. § 144A.8(2) ("If the policies of a health care provider preclude compliance with [an advance directive] . . . , the provider shall take all reasonable steps to effect the transfer of the patient to [a facility that will honor the directive]."); LA. REV. STAT. ANN. § 1299.58.7(D) ("If the policies of a health care provider preclude compliance with [an advance directive] . . . , then the provider shall take all reasonable steps to transfer the patient to a provider [that will honor the advance directive]."); MISS. CODE ANN. § 41-41-215(5) ("A health-care institution may decline to comply with an [advance directive] if [it] is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient [or her/his agent]."); MO. ANN. STAT. § 404.830(2) ("No [facility] shall be required to honor a[n advance directive] if [it] is contrary to the . . . facility's institutional policy based on religious beliefs or sincerely held moral convictions unless the . . . facility received a copy of the [advance directive] prior to commencing the current series of treatments or current confinement."); MONT. CODE ANN. § 50-9-203 ("If the policies of a health care facility preclude compliance with [an advance directive], that facility shall take all reasonable steps to transfer the patient to a facility in which the [advance directive] can be carried out."); NEB. REV. STAT. § 30-3428(1) (A provider is not obligated to honor an advance directive if it "is contrary to [the provider's] formally adopted policy . . . that is expressly based on the religious beliefs or sincerely held ethical or moral convictions central to the operating principles of the [provider].") The provider may refuse to honor the advance directive only if the provider "informed the [patient] of such policy, if [it was] reasonably possible."); N.M. STAT. ANN. § 24-7A-7(E) ("A health-care institution may decline to comply with an [advance directive] if [it] is contrary to a policy of the health-care institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient."); N.Y. PUB. HEALTH LAW § 2984(3) (A provider is not required to honor an advance directive that "is contrary to a formally adopted policy of the hospital that is expressly based on the religious beliefs or sincerely held moral convictions central to the facility's operating principles . . . , provided: the hospital has informed the patient . . . of such policy prior to or upon admission, if reasonably possible; and the patient is transferred promptly to another hospital that is reasonably

In the Catholic/non-sectarian merger context, a provider conscience clause right to object to advance directives is highly problematic. If the merged facility is the only health care provider in the patient's area, s/he will have to forego her/his advance directive rights in order to be admitted to that facility or travel to a hospital that will honor her advance directive.<sup>137</sup> Moreover, transfer may place undue hardship on the patient.<sup>138</sup> A merged facility that follows the ERDs presents patients with a horrible choice; either they must forego their rights to refuse treatment or they must travel to or be transferred to a foreign hospital.<sup>139</sup> Unlike the situation where a patient chooses to enter a *Catholic* hospital which s/he knows or should know will not honor her/his directive against ANH, the patient who enters a merged facility may not know or have reason to suspect that her/his directive will not be honored.<sup>140</sup>

Some living will statutes require providers to notify patients of their policies against withholding or withdrawing ANH.<sup>141</sup> If a patient enters the merged facility post-merger, s/he should receive notice of the anti-withholding/withdrawing policy upon admission if the hospital abides by the statute. However, some patients will likely be in the non-sectarian hospital before merger. If the hospital is forced to adopt the sectarian hospital's anti-withholding/withdrawing policy upon merger, notification after the fact will do little good. At this point, the patient has already entered the hospital expecting that her/his advance directive will be followed. Now, s/he must either forego her/his advance directive or transfer to a different facility. Further-

accessible under the circumstances and is willing to honor the [advance directive]."); PA. STAT. ANN. tit. 20, § 5409(a) (" . . . [I]f the policies of the health care provider preclude compliance with [an advance directive], the . . . provider shall so inform the [patient].").

New Jersey law requires health care institutions to adopt policies concerning advance directives and provide them to interested patients and families. See N.J. STAT. ANN. § 26:2H-65(2). In addition, health care institutions must develop policies to inform their staff of the policies. See *id.* § 26:2H-65(6). Finally,

[a] private, religiously-affiliated health care institution may develop institutional policies and practices defining circumstances in which it will decline to participate in the withholding or withdrawing of specified measures utilized to sustain life. Such policies and practices shall be written, and shall be properly communicated to patients and their families and health care representatives prior to or upon the patient's admission, or as soon after admission as is practicable.

*Id.* § 26:2H-65(6)(b).

137. See, e.g., *supra* note 20 (providing an example of one patient's dilemma).

138. See, e.g., *supra* note 20 (providing an example of the undue hardship imposed).

139. See, e.g., *supra* note 20 (providing an example of the choice a patient must make). Because the merged facility may be the only provider in the area, the patient may have to travel great distance.

140. See, e.g., *infra* notes 143-87 and accompanying text.

141. See *supra* note 136 and accompanying text.

more, if a merger severely or completely eliminates provider choice in the patient's area, the patient will have no choice but to forego her/his advance directive or travel to another hospital. However, the one case addressing this type of policy in a Catholic/non-sectarian merged facility, found for the patient and ordered the hospital to withhold ANH from the patient according to her request.<sup>142</sup>

In February, 1985, Beverly Requena was diagnosed with amyotrophic lateral sclerosis (ALS).<sup>143</sup> Mrs. Requena entered Riverside Hospital in Boonton, New Jersey on April 4, 1985.<sup>144</sup> A few months later, Riverside Hospital merged with St. Clare's Hospital, and "the Roman Catholic religious order of sisters which controlled St. Clare's . . . ended up as the controlling force of the new [merged] entity."<sup>145</sup>

At some point after her admittance to Riverside, after Riverside became St. Clare's/Riverside Medical Center (hereinafter Hospital), Mrs. Requena began to lose her ability to swallow.<sup>146</sup> As Mrs. Requena began to lose her ability to swallow and eat normally, she notified the Hospital that "she [would] refuse to accept feeding by a nasogastric tube<sup>147</sup> or other artificial device."<sup>148</sup> The Hospital immediately informed Mrs. Requena that her decision "conflicted with its 'pro-life' values."<sup>149</sup> The Hospital's board of trustees had "unanimously adopted" an anti-ANH withholding policy on September, 11, 1986.<sup>150</sup>

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142. See *In re Requena*, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986), *aff'g* 517 A.2d 886 (N.J. Super. Ct. Ch. Div. 1986).

143. See *Requena*, 517 A.2d at 887. The court defined ALS as a disease which involves degeneration and hardening of portions of the spinal cord. It is characterized by progressive loss of control of the muscles of the body and by increasing paralysis. There is no cure for the disease. Its course is relentless. Death within a few years of onset is the inevitable result of ALS. Although the victim progressively loses the ability to control bodily movements and functions, [her/]his mind typically remains clear until death.

*Id.*

144. See *id.*

145. *Id.*

146. At the time of trial, Mrs. Requena could not eat normally; however, she had "some limited ability to suck in nutrient fluids through a straw." *Id.* at 888. The trial court noted that the limited ability to suck nutrients through a straw would "soon be entirely gone." *Id.*

147. A nasogastric tube is a soft rubber or plastic tube that is inserted through the nose into the stomach and is used to instill liquid food or water. See MILLER-KEANE ENCYCLOPEDIA & DICTIONARY OF MED., NURSING, & ALLIED HEALTH 983 (5th ed. 1992).

148. *Requena*, 517 A.2d at 887. Mrs. Requena made her decision and notified the Hospital on or before July 15, 1986 because her decision "was first communicated to the Hospital's management" on that day. *Id.* at 888.

149. *Id.*

150. *Id.* at 889. The policy stated:

BE IT RESOLVED by the Board of Trustees that it does hereby reaffirm the policy of the former St. Clare's Hospital that food and water are basic human needs and that such fundamental care cannot be withheld from patients in the Medical

When the Hospital could not dissuade Mrs. Requena of her request, it "offered to assist her in transferring to another institution" that would honor her request.<sup>151</sup>

The Hospital most likely offered to assist Mrs. Requena's transfer because it believed that its "strong institutional policy"<sup>152</sup> against withholding ANH outweighed Mrs. Requena's right to decline ANH.<sup>153</sup> Another hospital<sup>154</sup> was willing to accept Mrs. Requena and honor her request to withhold ANH.<sup>155</sup> The other hospital could have provided "supportive and compassionate" care.<sup>156</sup> Mrs. Requena could have been "safe[ly] transport[ed]" to that hospital.<sup>157</sup> Moreover, one of Mrs. Requena's treating physicians at the Hospital would have continued as her treating physician at the new hospital.<sup>158</sup> Although the transfer seemed to be the "ideal solution,"<sup>159</sup> the court chose not to transfer Mrs. Requena for several reasons.<sup>160</sup>

First, Mrs. Requena did not want to leave the Hospital because she had received "professionally good and personally compassionate" care during her stay.<sup>161</sup> Secondly, she trusted and liked the nurses and staff at the Hospital and was "familiar with the physical surroundings."<sup>162</sup> Finally, the transfer would have been "emotionally and psychologically upsetting" and would have involved "significant elements of rejection and casting out."<sup>163</sup> For these reasons, the court ordered that Mrs. Requena could not be transferred and could stay at the Hos-

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Center and that neither the Medical Center nor personnel will participate in the withholding or withdrawal of artificial feeding and/or fluids.

*Id.*

151. *Id.*

152. *Id.* at 887.

153. *See id.* at 889 ("While asserting its own policy, the Hospital has readily recognized the right of Beverly Requena to decline artificial feeding.")

154. The other hospital, St. Barnabas, had facilities and treatment skills that were equal to the Hospital. *See id.*

155. *See id.* The hospital that agreed to accept Mrs. Requena and honor her wish, St. Barnabas Hospital, was located seventeen miles from the Hospital. *See id.*

156. *Id.*

157. *Id.*

158. *See id.*

159. *Id.* ("It would fully respect both the patient's desire not to be fed artificially and the Hospital's desire not to participate in the withholding of such feeding. It would also provide good medical care for the patient during the final stages of her illness.")

160. *See infra* notes 161-64 and accompanying text.

161. *Requena*, 517 A.2d at 889.

162. *Id.*

163. *Id.* The court explained that if Mrs. Requena were transferred "she [would] experience extra suffering over and above the grim suffering necessarily inherent in her disease and in her choice of no artificial feeding." *Id.* at 890.

pital until her death, and the Hospital could not administer artificial feeding against her will at the point it would become necessary.<sup>164</sup>

Aside from ruling that the Hospital must honor Mrs. Requena's request to withhold ANH, the court, in dicta, discussed the Hospital's policy.<sup>165</sup> Although the court suspected the Hospital would criticize its decision,<sup>166</sup> the court believed that the patient's legal and moral right to "decide for herself" must prevail.<sup>167</sup> The court believed that

the key moral and legal value involved in this case [was] the personal worth, dignity and integrity of the individual human being who happens to be a patient. The right to make informed, autonomous decisions about one's own treatment is a crucial part of that personal worth, dignity and integrity. In the context of this case, this means that Beverly Requena, and she alone, has the right to decide what treatment she will receive. Health care providers must assist her in making her decision by supplying her with information about her condition, her prognosis, her treatment alternatives. They may and should counsel her and caution her with respect to her decision. But in the end, *the decision must be hers alone and it must be uncoerced.*<sup>168</sup>

Although the court recognized that the Hospital did not intend its policy to interfere with Mrs. Requena's right to decide for herself, it found the "policy [to be], in fact, coercive."<sup>169</sup>

In addition to being coercive, the court opined, in dicta, that the Hospital was also being judgmental.<sup>170</sup> The court was "somewhat concerned that there [was] a completely unintended but real moral rejection of Mrs. Requena as a person by the Hospital . . . .

. . . [It is], in effect, telling this poor woman that it is wrong for her not to accept more suffering."<sup>171</sup> "In the final analysis," the court

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164. *See id.*

165. *See id.* at 890-93.

166. *See id.* at 891. Despite the suspected criticism, the court maintained its "respect and admir[ation of] the work, the motivation and the general values of the Hospital and its personnel." *Id.*

167. *Id.*

168. *Id.* (emphasis added).

169. *Id.* The court also opined that the Hospital had tended to turn the case into a "'pro-life' versus 'anti-life' issue where one [did] not truly exist." *Id.* at 891. Furthermore, the court maintained that "part of the Hospital's insistence on what it perceives as a pro-life position in this case is a mistaken fall-out from the abortion controversy which is ongoing in our society." *Id.* at 892.

170. *See id.*

171. *Id.*

opined, "it is fairer to ask [the Hospital] to give than it is to ask Beverly Requena to give."<sup>172</sup>

The Appellate Superior Court agreed with the lower court's final analysis, but it apparently disagreed with the trial court's dicta regarding the Hospital's policy.<sup>173</sup> The Appellate Court found that the trial court had not invalidated the Hospital's policy but rather had made a fact specific finding that Mrs. Requena's request be honored.<sup>174</sup> The Appellate Court "construe[d] the [Hospital's] policy as valid and enforceable only if it does not conflict with a patient's right to die decision and other protected interests."<sup>175</sup> The Hospital was free to apply its policy but only in "circumstances where it is reasonable and equitable to apply it without undue burden to the patient."<sup>176</sup>

172. *Id.* at 893. The court also suggested that if the Hospital and staff would just "re-think[ ] more carefully their own attitudes, the health care workers at the Hospital might find it possible to be more fully accepting and supportive of Mrs. Requena's decision." *Id.* Just in case reflection did not work, the court called upon the staff and Hospital, "as they turn[ed] with loving compassion to the work of helping Beverly Requena, to recall the beautiful words of Jesus: 'Come to me, all you who are weary and find life burdensome, and I will refresh you.'" *Id.* (citing the Bible at Matthew 11:28).

173. *See id.* at 870.

174. *See id.*

175. *Id.*

176. *Id.* In fact, the Appellate Court found that the policy could only be valid when the Hospital "present[ed] a reasonably convenient and suitable alternative health care facility which [would] reasonably comply with the patient's decision." *Id.* The Appellate Court upheld the trial court's fact specific determination that the alternative in Mrs. Requena's case was not "reasonably convenient [or] suitable." *Id.*

At least one Catholic commentator believes *In re Requena* is an anomaly; "[a]lthough a Catholic health care institution has legitimate reason to be concerned over what it may perceive as judicial officiousness, the *Requena* decision should be viewed as a limited exception to otherwise judicial reluctance to interfere with hospital policy decisions." Ausili, *supra* note 53, at 77 n.85. Ausili believes the key issue in *Requena* was the Hospital's failure to notify the patient of its policy before she decided she wanted to withhold ANH. *See id.* Therefore, Ausili believes that a court would be less likely to find in favor of the patient if the hospital provided the patient with adequate notice of its policy. *See id.* Furthermore, for patients who enter the hospital unconscious, the hospital will not have to fear the court will find for the patient because of the patient's attachment to the hospital as it did in *Requena*. *See id.* This "advice" runs precariously close to the coercion Judge Stanton discussed in *Requena*. *See In re Requena*, 517 A.2d at 891. *See also supra* notes 168-69 and accompanying text (discussing Judge Stanton's dicta about coercion).

Ausili's issue about notice raises another concern. Under PSDA, hospitals that receive federal monies are required to maintain policies regarding advance directives and provide patients with information about their policies and state law regarding advance directives. *See* Patient Self-Determination Act, 42 U.S.C. § 1396a(w)(1)(1991). *See also supra* note 81 (discussing PSDA). The PSDA, then, appears to mandate that a hospital give its patients notice of its advance directive policies. Although outside the scope of this note, it would be interesting to consider why the courts have not used the PSDA as a remedy and why Catholic hospitals apparently are not following its mandate.

*In re Requena* is not an isolated example of a Catholic/non-sectarian merged facility's choice to deny a patient's request regarding ANH withholding or withdrawal. For example, a Catholic hospital recently merged with a secular hospital in Cumberland, MD.<sup>177</sup> After the two hospitals merged, Grace Light wanted to remove her adult daughter from ANH.<sup>178</sup> Her daughter had been on ANH in the secular hospital for fifteen months pre-merger because of a heart attack that left her in a permanent vegetative state.<sup>179</sup> However, the management of the merged facility required Ms. Light to attend an ethics committee meeting to determine whether or not her request to withdraw her daughter's ANH could be honored.<sup>180</sup>

As Ms. Light entered the meeting, she found a copy of the ERDs on the table in front of her.<sup>181</sup> "It took Light 15 minutes to persuade the committee to let her daughter be removed from feeding tubes."<sup>182</sup> Although Ms. Light was able to convince the committee to honor her request relatively quickly, she was angered by the hospital's policy; she said, "It was none of their business. . . . They should have stayed over at [the Catholic hospital.]"<sup>183</sup> Regardless of how quickly Ms. Light was able to convince the committee, no patient or surrogate should have to defend their decision to someone else's moral or religious judgment.

*In re Requena* suggests that courts may not be willing to honor providers' conscience clause rights under living will statutes if providers wait to notify patients post-merger. However, the disagreement between the trial court and appellate court as to the hospital's policy could prove problematic in the Catholic/non-sectarian merger context. Although outside the scope of this paper, the issue of whether or not Catholic hospitals have a religious right to maintain their ERD-based policies post-merger needs to be examined.

#### IV. CONCLUSION

The "evidence" contained in this paper, suggests that if Catholic hospitals continue to merge with non-sectarian ones and continue to force ERD compliance from the non-sectarian hospitals, patients'

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177. See Timberg, *supra* note 29.

178. See *id.*

179. See *id.*

180. See *id.*

181. See *id.*

182. *Id.*

183. *Id.*



rights will be *severely* jeopardized.<sup>184</sup> Patients' advance directives are being called into question nearly every day in merged hospitals around the country.<sup>185</sup> Patients may find themselves forced into a situation where they must either choose to forego their advance directive rights or travel or be transferred to another hospital. Even more devastating, when a Catholic hospital merges with a non-sectarian hospital in a rural or sparsely populated area, a patient's choice of provider, and therefore her religious freedom, are eradicated because she simply has nowhere else to go. Ironically, the Catholic Church advocates against this type of religious coercion.<sup>186</sup>

As a result, many non-Catholic clergy have begun to voice their opposition to the Catholic/non-sectarian merger movement.<sup>187</sup> Undoubtedly, the merger of Catholic and non-sectarian hospitals will continue to eradicate non-Catholic patients' abilities to exercise their rights to refuse medical treatment and make advance directives according to their own religious or moral beliefs.

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184. Patients depend on their rights to create advance directives. Recently, a study was conducted to "identify and describe elements of quality end-of-life care from the patient's perspective." Peter A. Singer et al., *Quality End-of-Life Care: Patients' Perspectives*, 281 JAMA 163 (1999). The study found that patients "were afraid of 'lingering' and 'being kept alive' after they no longer could enjoy their lives." *Id.* at 165. "[The study's participants] adamantly denounced 'being kept alive by a machine.'" *Id.* One study participant said, "I wouldn't want life supports if I'm going to die anyway." *Id.* Therefore, it appears that patients do not want their rights to create advance directives jeopardized or eliminated.

185. See, e.g., *supra* notes 177-83 and accompanying text.

186. See Christopher T. Carlson, *Church and State: Consistency of the Catholic Church's Social Teaching*, 35 CATH. LAW. 339, 351 (1992). However, "'traditional Catholic doctrine [states that there is] one true religion and . . . one Church of Christ.'" *Id.* (quoting DECLARATION ON RELIGIOUS FREEDOM). "[The Declaration on Religious Freedom] expressed opposition to coercion by individuals or a state which would force a person to embrace a particular religion." *Id.*

187. See, e.g., Maryland Merger Monitor, Advertisement, *The Community Wants a Full Range of Services*, BALT. SUN, Oct. 29, 1998, at H6 (providing sixty-three signatures of non-Catholic clergy who believe that "the imposition of sectarian Ethical and Religious Directives upon people of other faiths is just not right"); *Don't Impose Religious Rules on Our Non-religious Hospitals*, DAILY FREEMAN—KINGSTON, NY, Feb. 6, 1998, at 10 (providing list of clergy who oppose the imposition of religious rules on non-religious hospitals).

