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When Views Collide: How Hospital Mergers Restrict Access to Reproductive Health Care

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I. Introduction

As access to reproductive health services decreases, the need for such services continues. About half of all pregnancies in the United States are unintended, and roughly half of these unintended pregnancies end in abortion.[1] Nearly half of American women will experience an unintended pregnancy at least once in their lives, and nearly 25 percent of all pregnancies in this country end in an abortion.[2] Approximately 89 percent of women of child-bearing age who do not wish to become pregnant use some form of contraception.[3] While there is clearly a need for women to have access to reproductive health services, since 1973 when *Roe v. Wade* established the right to choose to terminate a pregnancy, there has been an incessant backlash against reproductive rights, resulting in increasingly limited access to reproductive health services.[4]

Supreme Court rulings that uphold restrictive laws, and laws that prohibit public funding of abortions for indigent women hit low-income women and women living in rural areas the hardest.[5] In addition to ever-more restrictive laws, practical barriers limit women's abilities to choose abortion. It is estimated that 87 percent of all U.S. counties lack an abortion provider, in either a clinic or hospital setting.[6] Though abortion is the most common obstetrics surgical procedure, few medical students learn how to perform abortions, and approximately half of all graduating OB/GYNs have never conducted the procedure.[7] Not only is the overall number of abortion providers decreasing in this country, but as of 1999, 91 counties had a Catholic institution as their only hospital provider. For low-income women in rural areas, this often means they have no real choice in a health care provider, and no viable options in terms of accessing abortion services.[8]

There is a real need in the United States for abortion services to be part of a broader health care system that includes a wide range of reproductive health services. Hospital mergers are becoming increasingly common as the health care system in the United States changes, and as health care providers attempt to control costs in an overburdened system.[9] Between 1993 and 2003, there were roughly 170 mergers between non-religious hospitals and Catholic health care providers.[10] In these scenarios where a non-religious hospital merges with a Catholic hospital, frequently the Catholic entity insists that the newly formed entity abide by and be bound by the "Ethical and Religious Directives" (Directives) of the Catholic Church.[11] This not only means that non-religious private hospitals are "swallowed" by a religious health care entity, but reproductive health services often are extremely restricted, or entirely removed from decisions regarding the services that the hospital offers.[12]

These restrictions are usually significant—the Directives dictate basically all reproductive health issues, many of which are essential for women to receive adequate health care services.[13] The Directives prohibit abortion entirely (sometimes allowing the procedure only to save the woman's life), prohibit administering or discussing contraceptive devices (including condoms), and prohibit sterilization procedures and infertility treatment (such as in-vitro fertilization).[14] Perhaps most disturbing, the Directives do not even allow the dissemination of information regarding the morning-after-pill (also known as emergency contraception, or Plan B) for victims of rape or sexual assault, nor do they allow for the referral of such victims for morning-after-pill services.[15]

Women's access to reproductive health services seems to be becoming increasingly restrictive, paradoxically at a time in which science and technology support safe and effective birth control methods, abortion procedures, and sterilization procedures. Hospital mergers between secular and Catholic institutions contribute to the diminishing availability of reproductive health care services offered in this country. Some communities have fought off mergers and succeeded, while in others, doctors become bound by the rules of a religious institution, often the Catholic Church, and are forced to deny women reproductive health care services.[16]

The threat posed by religiously affiliated hospitals to reproductive health services is unnecessary. As "quasi-public" institutions, and often as the only health care provider available to women in rural areas, religiously affiliated hospitals should not be allowed to harm women's health by denying them vital reproductive health care services.[17] Basic reproductive health care is a necessary part of basic primary health care.[18] A merger between a secular hospital and a religious institution may be problematic under legal theories of antitrust

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laws, the First Amendment, and charitable trust laws, because the religious institution may be unsympathetic to reproductive rights, and may prevent the secular hospital from offering reproductive health services to women.

II. Background

A. Mergers

Hospital consolidation is happening all over the United States at a fairly rapid rate.[19] The Catholic influence in hospitals is widespread, and can be found in five of the ten biggest health care systems in this country.[20] Catholic institutions comprise the largest group of non-profit hospitals in the United States. Ascension Health System, the nation's largest Catholic and largest nonprofit health system has net revenues of roughly $7.2 billion. Eighteen percent of all hospitals in the United States are Catholic. Furthermore, in 2000, one study found that there were 48 Catholic managed care plans and, of these, 15 Catholic HMOs contracted to serve Medicaid recipients.[21]

Many of these mergers occur when public and private hospitals claim that they need to merge with religious health care systems in order to stay open.[22] Another reason often given for mergers is the hospital industry's belief that hospitals must grow larger, thus enabling them to lower their costs and increase their "market power."[23] As the entire managed care system changes in this country, many hospital owners view mergers as a way to reduce costs, function more efficiently, and increase the amount of control the hospital has over how much to charge for its services.[24] Notably, mergers involving Catholic institutions tripled between 1997 and 1998, resulting in what some commentators call "merger mania."[25]

Catholic hospitals have tremendous clout in the industry despite, or perhaps because of, their non-profit status. Rather than being victims of hospital consolidation, Catholic hospitals are increasingly part of large health care systems including secular and religious hospitals. These large networks are able to compete in the health care market much more effectively than small, private hospitals.[26] Additionally, Catholic hospitals are generally non-profits, which means they benefit from property, sales, and excise tax exemptions.[27]

When Catholic and secular institutions merge, the Directives will often supersede the rules of the secular institution, and the newly merged hospital is bound by the Directives, which basically prohibit all reproductive health services.[28] If, for example, Catholic health care systems sell "low-performing" hospitals, they can require that, as a condition of the sale, the new institution will continue to be bound by and follow the Directives.[29] Even if two institutions do not fully merge, the Directives can still control when secular health plans, including Medicaid and private insurance plans, contract with Catholic hospitals.[30]

> If, for example, Catholic health care systems sell "low-performing" hospitals, they can require that, as a condition of the sale, the new institution will continue to be bound by and follow the Catholic Directives.

Despite the surge in mergers in the past decade, the Federal Trade Commission (FTC) has taken an increased role in attempting to prevent hospital mergers or dissolving them once they have occurred. The FTC published a report in 2004 that found that many studies have linked rising hospital costs with increased consolidation.[31] The report shows that hospital mergers often increase costs to the consumer and, in particular, they increase costs if the merging hospitals are in the same vicinity.[32] If mergers do not necessarily lower costs for patients, and if they are not necessary for the survival of hospitals, then it is unacceptable that mergers that result in reduced access to reproductive health services are allowed to take place.

B. Impact of Mergers on Reproductive Health Care Services

Mergers between secular and religiously affiliated hospitals have a generally limiting affect on reproductive health services. Choices that women would otherwise normally have in a hospital setting no longer exist, especially in a situation involving the Catholic Church where the Directives control

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what doctors can and cannot do regardless of whether providing a particular service would be in a woman's best interest. Many of these prohibitions on doctors' and patients' choices result in dangerous situations, as doctors cannot freely decide what is medically best for their patients.[33] Many procedures that are widely accepted in the medical field, such as sterilization or abortions for ectopic pregnancies,[34] are not allowed in Catholic hospitals. Thus, women must go elsewhere to seek such procedures.[35]

One example of this dividing-up of procedures, involves sterilization. According to the American College of Obstetricians and Gynecologists (ACOG), the proper time for doctors to perform voluntary sterilizations is generally at the time of delivery.[36] The Directives, however, prohibit sterilization, thus forcing women to seek the operation "at another time, at another facility with an increased risk of infection, experiencing adverse side effects of anesthesia, additional costs, and the risk of another pregnancy."[37] As such, women must either find a hospital in which to give birth that does allow sterilization. This could be difficult or impossible for some low-income women. If a woman is unable to find another hospital in this instance, she will need to endure a second medical procedure at another time and place with a different doctor, thus subjecting herself to a greater risk of harm.[38]

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Access to birth control is also severely limited or eliminated altogether at religiously affiliated hospitals.[39] This is an astonishing fact, given the incredibly widespread use of, and need for, contraceptives in this country. There is clearly a need to continue to promote contraceptive use and educate people about the proper use of contraceptives, given that the United States has the highest teen pregnancy rate in the industrialized world and one of the highest abortion rates, at approximately one million every year.[40] Additionally, 31 percent of women become pregnant by the time they reach twenty years old, resulting in roughly 750,000 births, 80 percent of which are unintended pregnancies.[41] In a 2005 study, the Guttmacher Institute reported that there are 43 million women of childbearing age who do not wish to become pregnant and 89 percent of them use some form of contraceptive method.[42]

Despite this obvious need for hospitals to provide comprehensive reproductive health care, Catholic hospitals are bound by the following Directive regarding contraception: "Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning."[43] Not only are these hospitals excluding non-married couples by only providing information on "natural family planning" to married couples, but they are also promoting methods, such as the "rhythm method," which has an incredibly high failure rate compared to other methods of birth control, such as the Pill.[44] Perhaps more troubling is the fact that Catholic hospitals will not provide the morning-after-pill to women, even if they have been sexually assaulted.[45] It is unconscionable for an institution that holds itself out as a provider of health care services to fail to offer something as fundamental to women's reproductive health as contraceptives.

Another reproductive service eliminated at Catholic hospitals is abortion. Necessary late-term abortions (*i.e.*, abortions performed after the first trimester which are necessary for the woman's health or because of severe fetal abnormalities) often must be performed at hospitals because of the complications involved.[46] Especially if a woman has a medical condition, such as high blood pressure, a hospital setting is necessary for performing an abortion.[47] As with sterilization, when Catholic hospitals refuse to provide women with this service, it puts them at a greater risk by forcing them to travel elsewhere to obtain services, causing dangerous delays.[48]

While obtaining an abortion is still a legal "right" in the United States, in some areas of the country it is a right in name only—in practical terms, it is becoming difficult or near impossible for some women to access these services. According to a Guttmacher Institute study, in 2005 about 87 percent of counties in America did not have an abortion provider.[49] The geographic location in which women live has a tremendous impact on the availability of abortion. For example, in the Midwestern and Southern United States, more than 90 percent of counties were without any abortion providers.[50] A 2000 Guttmacher study found that 94 percent of all abortion providers are located in metropolitan areas, and 34 percent of women live in a county without an abortion provider.[51] The number of abortion providers has dropped for a number of reasons, one of which is the threat of violence directed at abortion clinics since the mid-1970s.[52] By the mid-1990s, at least half of all abortion clinics reported in a survey that they had been hit with intense anti-choice violence, including bomb threats, death threats, and blockades at the entrance of clinics.[53]

Access to reproductive health services is becoming more restricted in general, but it is especially restricted for low-income women. The government reduced access for low-income women first with the Hyde Amendment in 1976, cutting off virtually all public

funding of abortions for indigent women, even if the abortion is deemed medically necessary, and again in 1988 when the government enacted a gag rule on Title X clinics.[54] The government began funding Title X clinics in 1970 to provide vital family planning services to low-income people. However, in 1988, the government changed the law so that Title X clinics were no longer able to offer any sort of information, counseling, or referrals involving abortion – essentially gagging the employees of Title X clinics.[55] The Supreme Court upheld this seeming violation of the First Amendment in *Rust v. Sullivan* in 1991; this is yet another example of how women's access to reproductive health care is unjustly limited for political reasons.[56]

With so few abortion providers in this country, compared to the high number of women who seek abortions,[57] some women depend on hospitals to provide these services.[58] The number of hospitals that performed abortions declined in the late 1990s, and now hospitals that once may have performed abortions might stop such services after merging with a religiously affiliated hospital.[59] This becomes a real problem when women, particularly low-income women, have no other choice of health care provider and are effectively denied most reproductive health care services, like abortion.

These sorts of blanket prohibitions by religiously-affiliated hospitals not only put women's health in danger, but also assume that women will be able to seek care elsewhere. However, as the managed care system changes, these choices are increasingly rare.[60] Often a religiously affiliated hospital will be the *only* choice, especially if a woman is indigent or lives in a rural area.[61] As an issue of practicality, the fewer hospitals that provide reproductive health care, especially in rural areas, the more difficult it will be for women to receive adequate health care.

III. Analysis

A. Legal Theories to Challenge Mergers of Secular and Religiously Affiliated Hospitals

There are a number of legal theories under which doctors or patients can challenge the mergers of secular and religiously affiliated hospitals – some with a higher chance of success than others. Antitrust laws can be effective tools to challenge mergers. Certain antitrust acts prohibit mergers that might adversely impact competition between entities, and thus adversely impact services to customers.[62] In the context of reproductive rights, antitrust issues arise when mergers unfavorably affect reproductive health services.

Strong arguments for First Amendment violations can also be made regarding hospital mergers. Some religiously affiliated hospitals can be considered quasi-public institutions by receiving federal dollars and, as such, should not limit services based on religious beliefs.[63] Finally, a theory of charitable trust laws could be an effective way to challenge mergers between secular and religiously affiliated hospitals. In states where charitable trust laws apply to hospitals, if a merger "significantly alters the mission" of both or one of the hospitals, it could violate charitable trust laws.[64]

i. Challenges Using Antitrust Laws

Lawmakers designed antitrust laws to ensure competition between adversary providers of certain services and to encourage providers to offer customers the highest level of care possible.[65] When two hospitals merge, and the religious directives dictate the service provided by the newly formed entity, the diminished competition between institutions leads to less access to reproductive health care services.[66] Though not a shoo-in for reproductive rights advocates in terms of proving a violation under antitrust laws, this is still a viable option for challenging mergers.[67]

a. Why Hospitals Merge

There is no agreement in the health care industry concerning why hospitals decide to merge.[68] Hospital executives often argue that mergers are increasingly necessary as costs increase for health care providers and are sometimes necessary for hospitals to remain open in certain areas.[69] Additionally, hospital executives also point out that mergers help hospitals contain operating costs, which then translate into savings for health care consumers.[70]

Despite these claims by hospital executives, recent studies provide strong evidence against these arguments, and instead show that generally mergers lead to considerably higher prices for consumers.[71] Some commentators in the health care field argue that mergers are not a reasonable response to supposed financial pressures on hospitals, and that mergers are driven by a desire to increase profits rather than a necessity to continue functioning.[72] Hospital executives also might be more concerned with gaining leverage in a field with more competitors as they might feel compelled to increase their bargaining power to negotiate with the increasing power of managed care organizations and large pharmaceutical companies.[73] These concerns might have some validity, but they are not strong enough to justify reducing reproductive health care services or access to services especially for low-income women.[74]

b. Merger Regulations

The U.S. Department of Justice (DOJ) and the FTC are the two agencies in charge of investigating possible mergers between hospitals.[75] Two federal acts also apply to mergers: Section 7 of the Clayton Act and the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (HSR). The Clayton Act regulates institutional mergers, both interstate and intrastate, by prohibiting any activity that might lead to the creation of a monopoly and to any entities engaged in activities that might affect interstate commerce.[76] The HSR requires a pre-merger report which the DOJ or FTC reviews. These are all generally preventative measures designed to stop a merger before any anti-competitive harm can be done.[77]

"One of the issues the agencies look at is market power—that is the degree to which a hospital might control a geographic region, thus leaving patients with fewer options for health care."

The DOJ and FTC use a set of guidelines to analyze pre-merger deals or mergers that seem to be anti-competitive.[78] One of the issues the agencies look at is market power—that is the degree to which a hospital might

control a geographic region, thus leaving patients with fewer options for health care.[79] If a merger results in a market with less competition and fewer services and options for patients, there could be a potential problem under the Clayton Act.[80] If a merger results in reduced competition, and institutions are able to join together to raise prices, whether through implicit or express collusion, a valid challenge under the Clayton Act could arise.[81] Similarly, if one institution is essentially a monopoly such that consumers have no viable options besides one provider and are forced to pay higher prices, this could be problematic as well.[82]

c. Possibility of Success of Antitrust Challenge

Though a private party or the government that brings a challenge under Section 7 of the Clayton Act does not have to show with certainty that a merger will result in an impermissible level of market power that might lead to anti-competitive results, courts have traditionally been deferential to the hospital industry.[83] Despite this deference, in more recent years the government has challenged large hospital mergers with more frequency due, in part, to a desire of the FTC to prevent hospital mergers that are detrimental to consumers.[84] In the context of larger hospital mergers, or in situations where one hospital becomes the only provider of health care for a geographic region, private actions against hospital mergers might have a better chance of success. If a plaintiff can show that a hospital merger will entirely eliminate certain reproductive health care services and that patients reasonably cannot otherwise find these services in their region, the suit has a viable chance of success.[85]

> "[A] hospital that receives public funds should not refuse reproductive services based on the religious tenants of a hospital because the health needs of a patient should outweigh the desire of a hospital to follow religious directives."

Despite the applicability of antitrust laws to hospital mergers, it is unclear how successful parties will be in bringing these challenges. Success in these cases might turn on whether a plaintiff can prove that the elimination of reproductive health care services can be construed as anti-competitive.[86] If a plaintiff can do so, then the antitrust laws, which are designed to protect consumers from anti-competitive mergers, not to protect the merging institutions, might help in protecting access to reproductive health care at hospitals.[87]

ii. Challenges Under the First Amendment

Mergers between secular and religiously affiliated institutions might also present a number of problems under the First Amendment. Generally, an argument can be made that religiously affiliated hospitals violate the Establishment Clause of the First Amendment by using public funds strictly for religious purposes.[88] As quasi-public institutions, hospitals that receive public funding and tax-exempt status should be required to provide full reproductive services and follow "generally accepted" medical guidelines, not the dictates of a particular religion.[89] Especially in situations where a hospital is the only health care provider in a certain region, hospitals should not be permitted to refuse providing certain reproductive health care services to patients.[90]

a. Public Funding and the Establishment Clause

If a hospital has non-profit status, which many do, it enjoys large benefits through tax exemptions, including property and sales tax.[91] It also generally enjoys a large amount of public funding from federal and state governments.[92] Non-profit hospitals exist, by design, to serve the public and provide for health care services. As such, the public has an acute interest in these hospitals serving the public good.[93] First Amendment issues arise when religiously affiliated hospitals receive public funding,[94] yet restrict access to reproductive health care services.[95]

Catholic hospitals have particularly restrictive mandates regarding reproductive health care. When the government assists or funds these hospitals, it might be in violation of the Establishment Clause of the First Amendment. The Supreme Court has developed extensive First Amendment jurisprudence and, in the context of the Establishment Clause, the Court developed the *Lemon* test in *Lemon v. Kurtzman*.[96] The *Lemon* test has three main prongs: under the first prong, there must be a clear secular purpose for the law; under the second prong, the programs must not advance nor inhibit religion; and under the third prong, there must not be excessive entanglement of the government with religion.[97] A government action must satisfy each prong of the *Lemon* test to pass judicial scrutiny. Failure to satisfy one pong is enough to show an Establishment Clause violation.[98]

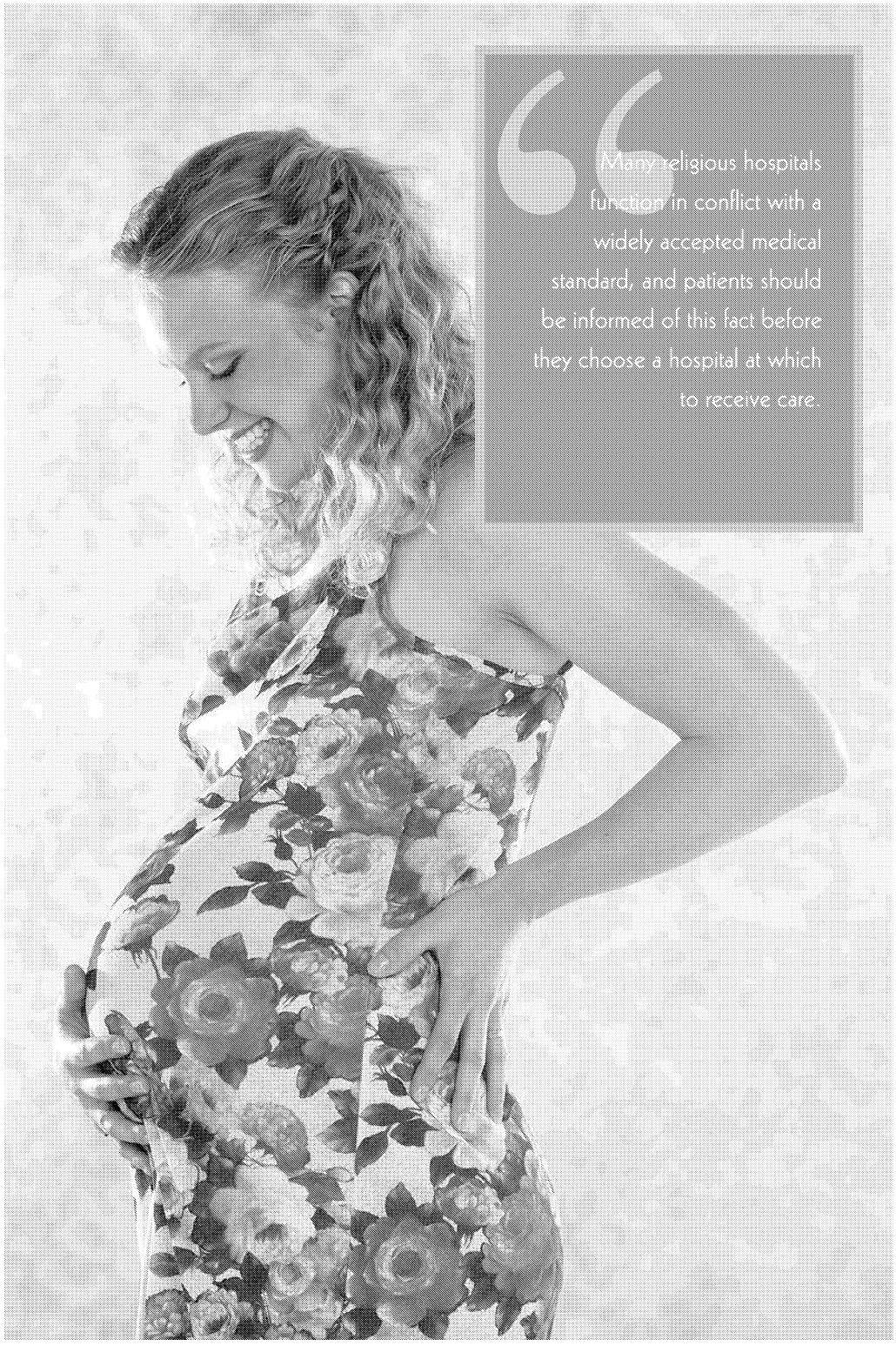
In the context of government funding in health care, strong arguments can be made that such funding advances religion (second prong of *Lemon*). The government might have a secular purpose when funding Catholic hospitals, but the effect of such actions is to advance the Directives of such a hospital. When a Catholic hospital that receives government funds refuses reproductive health care services to a patient, then the government has played a part in helping an institution that refuses to provide a certain type of care based on religion.[99] Especially where Catholic hospitals hold themselves out as, or function as, public or quasi-public institutions, they should be prohibited from endorsing a singular religious viewpoint restricting reproductive health care.[100]

As a policy matter, hospitals that serve the public's needs should not discriminate in the types of services they provide, regardless of religious affiliation. Religiously affiliated hospitals do not exclusively serve patients who happen to have beliefs in line with the institution; they serve the general public and people with a wide range of beliefs.[101] As such, a hospital that receives public funds should not refuse reproductive services based on the religious tenants of a hospital because the health needs of a patient should outweigh the desire of a hospital to follow religious directives.

b. Unjustly Limiting Doctors' and Patients' Choices

The severe restrictions that some hospitals place on reproductive health services force doctors to go "underground" with their medical choices.[102] Physicians for Reproductive Choice and Health (PRCH) reported that many doctors feel compelled to disregard the restrictions at religious hospitals in order to serve their patients' needs as they see fit.[103] Some hospitals force doctors to sign agreements binding them to the religious directives of the hospital, even if it is silently understood that the hospital will not actively interfere with doctors' medical choices. These "don't ask, don't tell" policies can be dangerous for doctors. PRCH warned that doctors take a serious legal risk by choosing to breach such a contract, even if done in good faith.[104]

The phenomenon of "undercover medicine" can be dangerous for patients. If doctors are compelled to practice medicine as they see fit despite strict religious directives, it might force them to alter medical records to hide that a certain procedure had been performed.[105] Such actions might prevent accurate records, making it difficult to find an accurate medical history of the patient in the future.[106]



Patients can be harmed as well when hospitals refuse to provide full information regarding their medical choices or access to certain procedures. Often, patients do not know that religious restrictions at a hospital can prevent them from receiving the type of care they need or desire, creating a barrier to informed consent and successful decision-making regarding reproductive health.[107] Some HMOs have what is known as a "gag rule" which effectively prohibits doctors from letting their patients know what negative effects a merger might have on access to reproductive services; this is especially damaging given that many women are not even aware that a religiously-affiliated institution can deny them certain care.[108]

Many religious hospitals function in conflict with a widely accepted medical standard, and patients should be informed of this fact before they choose a hospital at which to receive care.[109] One example of this involves sterilization. ACOG advises that the best time to perform a desired

sterilization on a woman is right after delivery.[110] When religious hospitals refuse to perform sterilization because of religious directives (very common in Catholic hospitals), women are forced to have the sterilization done at another time and at another facility, thereby increasing the risk of health problems such as side effects and infection.[111] Religious hospitals should at least be forced to disclose this sort of information to patients, so that potential patients are aware of the possible restrictions on the services they can receive.

c. Religious Hospitals Should Not be Saved by Conscience Clauses

In the aftermath of *Roe v. Wade* in 1973, the Catholic Church was at the forefront of the anti-choice movement, working to overturn *Roe*, and doing everything possible to limit women's access to abortion. Congress passed the "Church Amendment," named after its sponsor, Senator Frank Church (D-ID), in an effort to allow health care providers to "opt out" of performing certain reproductive services like abortion and sterilization.[112] At first, the Church Amendment allowed only opting out of abortion and sterilization, but one year later Congress enlarged the opt-out to include *any* service that might conflict with religious or moral beliefs.[113] This "conscience clause," allowed entire hospitals to refuse to provide reproductive health care, which resulted in fewer hospitals, religious or not, performing abortions.[114] Some states have gone even farther, enacting legislation that allows providers to not only refuse certain care based on religious grounds, but also to refuse to provide information or counseling about such procedures.[115] These sorts of provisions undoubtedly limit women's access to reproductive health services and unjustly put the religious interests of hospitals before the interests, rights, and needs of patients.

One disturbing example of a conscience clause at the federal level that prohibits low-income women from receiving vital information regarding their health care is the Balanced Budget Act of 1997 (BBA). The BBA includes an extensive conscience clause that allows MCOs serving Medicaid recipients to refuse to cover counseling, referrals, or costs of procedures that the MCO might object to on "moral or religious grounds."[116] The result of this conscience clause is that many women enrolled in Medicaid might be refused essential information regarding their reproductive health.

This is especially problematic when a religious hospital might be the only health care provider in a given area and women, therefore, have no where else to seek information regarding their reproductive health.[117] Given the consolidation of providers and hospitals in the health care industry, many people no longer have a choice about where they receive their care.[118] Since women's health is at stake, women's access to basic reproductive health care services should be protected over the religious interests of hospitals.[119]

iii. Charitable Trust Theory

The charitable trust theory is an additional theory under which one could challenge a merger or proposed merger. Charitable trust laws can potentially prevent mergers or result in the "divorce" of two hospitals if upon merging the mission of one or both institutions is altered.[120] If providing full reproductive health services was part of an institution, the loss of such services as a result of a merger could be illegal under the theory that the public is the "beneficiary" of the hospital's charitable contributions, and thus has a right to its hospital preserving its stated mission.[121] Likewise, if part of a hospital's mission is to follow the tenants of a religious institution, like the Catholic Church, the merger with a secular institution could alter the religious mission in such a way that charitable trust law does not allow.

Some argue that every merger between a secular and religious hospital results in some loss of reproductive services. If this is the case for a hospital whose original mission includes providing access to reproductive health services, a challenge under charitable trust law could be successful.[122] The use of charitable trust law is limited by the fact that not all states have such laws apply to hospitals and often if a state does have charitable trust law, it applies only to non-profit entities.[123] Still, if a state has applicable charitable trust law, it can be an effective tool in challenging a merger.

A good example of charitable trust law forcing the dissolution of a merger is in the Optima Health case in New Hampshire, discussed in more detail below. The charitable trust theory is one of the main arguments the Attorney General used to prove that the merger between the Elliot Hospital, a secular institution, and Catholic Medical Center (CMC), a Catholic institution, to form Optima Health was not legitimate. According to the Attorney General, each hospital was "bound by a social contract with the community" under New Hampshire law,[124] as charitable non-profit institutions, these hospitals had a fiduciary duty to ensure that the "fundamental charitable mission" of each hospital remain the same.[125] In the case of Optima Health, the Attorney General found that Optima Health failed to reconcile the opposing commitments of each hospital —CMC's commitment to being a Catholic institution, and the Elliot's commitment to providing women with reproductive health services.[126] If mergers elsewhere also alter the mission of a hospital, challenging such mergers under charitable trust laws is a viable option.[127]

B. Case Study: Optima Health

i. The Elliot Hospital and Catholic Medical Center

In 1994 the two largest hospitals in New Hampshire struck a merger deal. The result of the merger between the Elliot Hospital and CMC into Optima Health resulted in years of costly litigation, and an eventual dissolution of the newly merged hospitals in 1997. Large amounts of time, money, and energy were wasted on a deal that seemed flawed from the beginning. This case exemplifies what can happen when finances get in the way of sound policy and decision-making, and when secular hospitals merge with religious institutions.

The Elliot Hospital and CMC both functioned as two of the most important health care institutions in Southern New Hampshire, serving the city of Manchester and its surrounding areas. The Elliot, founded in 1881 by an act of the New Hampshire legislature, has been exempt from property taxes as a public charity for as long as it has existed—something the New Hampshire legislature has continued to reaffirm.[128] In 1974, two Catholic hospitals formed CMC, established as a nonprofit corporation with the intention of carrying on the Catholic mission of the two predecessor Catholic hospitals. One of the main goals under CMC's Articles of Agreement is to "maintain its identity as a Catholic Hospital," and to follow the "Ethical and Religious Directives of the Catholic Health Facilities as promulgated by the National Conference of Catholic Bishops."[129]

ii. The Merger

After a time of antagonistic competition between the Elliot and CMC, the management of the respective institutions began talks of a merger between the two. The management claimed that the initial express reason for the merger was to enable the two hospitals to continue to function as charitable institutions. They also reported projected savings of $150 million if the merger were to go through—savings, management claimed, would help the two hospitals continue in their role of providing quality health care to the Manchester area.[130] Throughout all of the negotiations, the management of both the Elliot and CMC claimed repeatedly that the two institutions would continue to function as self-regulating and independent institutions.[131]

In 1994, Optima Health took over management of the Elliot and CMC, and after the merger gave itself complete control over the two hospitals; Optima Health modified the by-laws of the Elliot and CMC and made the two hospitals subsidiaries of Optima Health.[132] Optima Health also unilaterally decided to discontinue acute care at CMC and to consolidate all acute care at the Elliot campus—an unanticipated move.[133] Also, and perhaps most troubling, Optima's Articles of Agreement included a requirement to preserve CMC's Catholic identity.[134] This is the decision that ultimately would contribute to the dissolution of the merger between the Elliot and CMC.

iii. The Attorney General's Report

In New Hampshire, the Attorney General is statutorily charged with overseeing the state's charitable trusts. As such, the AG produced a report on the Elliot and CMC merger—both nonprofit charitable institutions, bound by a social contract with their respective communities.[135] The report began by stating that the hospitals, as public charities, owed to their communities a certain level of honesty and openness in their dealings and could not, in good faith, exclude the AG or the community from important decisions that may affect the functioning of the hospital.[136]

Among other failures, Optima Health did not fulfill its "duty of candor," as it neglected to include the community in the decisions regarding the merger, did not inform the community of the impact of the merger's affect on the functioning of the hospitals (i.e., did not inform the community that Elliot and CMC were stripped of their independence and became controlled by Optima Health) and did not disclose the inconsistent and opposing ways that each hospital viewed certain reproductive health services (e.g., practices regarding terminating pregnancies).[137] The failure to address the role Catholic doctrine would play in regards to the merged hospitals. This omission seems the most glaring; rather than devising a policy making the secular and religious parts of each institution compatible, Optima Health essentially ignored the problem. Optima Health went ahead with an "unfocused, incomplete and confusing" policy vis-à-vis Catholic moral doctrine and how it would affect the day-to-day operations of the merged institution rather than devising a clear policy on whether or not the Directives would indeed dictate the practices of the newly merged entity.[138]

Prior to the merger, the CEO of the Elliot, Phillip Ryan, had alluded to the fact that the Elliot's policy regarding abortion was the same as CMC's (i.e., that the Elliot did not generally perform abortions). This, in fact, was not true.[139] The Elliot had clinical records documenting abortions that the Elliot doctors had performed.[140] These were clearly procedures that could not have occurred under the Directives of CMC. Despite Ryan's representation to Catholic representatives that the Elliot's policy on abortion mirrored that of CMC's, it did not, and Elliot doctors were unaware that a major change regarding abortion policy would take place after the merger.[141] The Chairman of the Obstetrics Department at the Elliot, Dr. Robert Cervenka, asked Ryan specifically if the merger would affect the ability of Elliot OB/GYNs to perform abortions.[142] Ryan told Dr. Cervenka that the Directives "would apply only within the four walls of CMC" and would not have an affect on the actual practices of Elliot doctors.[143] This, too, was untrue.

Optima Health neglected to address significant and crucial issues for reproductive health, such as policies affecting family planning, sterilization, and abortion—issues that are treated entirely differently by CMC and the Elliot. One doctor who continued to work at the newly merged Optima Health hospital reported that Optima Health assured doctors that they would be allowed to continue to perform medically necessary abortions and tubal ligations. An anti-choice group, known as "Save CMC," found out that the Elliot had scheduled a medically necessary abortion, and began to "rally" around the issue of abortion, demanding that abortions not take place in the hospital.[144] Clearly, the policies regarding abortion at the Elliot did not mirror the policies of CMC: subsequently the Catholic Church demanded that such procedures cease, or it would threaten dissolution of the merger.[145] In response, and in order to ensure the merger went forward, the Trustees of the Elliot adopted a policy that effectively banned abortions at the Elliot for any reason other than saving the life of a woman.[146]

iv. The Dissolution of the Merger

At that point, both of the original identities of each hospital had been significantly altered. Doctors at the Elliot were concerned that the Directives forbiddance of any abortions, including medically necessary abortions, was inconsistent with generally accepted medical treatment.[147] The merger compromised the Elliot's "traditionally secular approach to medicine" by forcing its doctors to follow the Directives of the Catholic Church and by essentially ending all abortion services.[148] Additionally, CMC's mission as

a Catholic hospital, following the Directives of the Catholic Church, had not been maintained either.[149]

Eventually, the newly merged Optima Health divorced and the hospital became two separate entities as they had been prior to the merger. By June 2000, Optima Health officially dissolved, a process which reportedly cost about $10 million, with expected losses in revenue equaling nearly $20 million over five years.[150] This is a fine example of the harm that can arise from hospital mergers, especially mergers that are not done properly. Optima Health failed to adequately assess whether CMC and the Elliot could retain their independent charitable missions upon merging, and in regards to reproductive health, it was clear neither of them could. The merger forced the Elliot's doctors to abide by Catholic Doctrine, denying their patients acceptable levels of reproductive health care. Similarly, the merger forced CMC to compromise part of its mission as a Catholic institution as some Elliot doctors continued to provide some level of reproductive health services.

The pitfalls of this troubled merger could have been avoided had Optima Health executives adequately addressed the issue of maintaining each hospital's identity and mission. Paradoxically, both hospitals lost their identities in a unique way. CMC lost much of its mission as a provider of health care, as most acute care services were moved to the Elliot's campus in Manchester, and though the Elliot maintained its acute care services, its mission changed as Optima Health forced the Directives on it.[151] This failed merger demonstrates the importance of addressing which hospital's identity will prevail in a merger—the secular or the religious. Additionally, in a state with applicable charitable trust laws, the issue of the individual hospital missions must be addressed. Under New Hampshire law, since each hospital had a fiduciary relationship with the community as a result of charitable trust law (both the Elliot and CMC were non-profit institutions), each had to maintain its contract with the community. The Elliot as a secular provider of health care by including a wide-range of reproductive services, and CMC as a Catholic hospital, was bound by the Directives of the Catholic Church.[152]

When a merger involves two completely different health care entities, each with a duty to the community it serves, the public must be included in the decision-making process. Optima Health failed to do this, as it inaccurately represented the situation to the community. Ultimately, huge cost-savings from the merger never actually came to fruition. The public should have reviewed the merger. Ultimately, the effected community held Optima Health accountable for the problematic merger.[153]

IV. Recommendations

The Optima Health merger and its subsequent dissolution exemplifies the way in which a community can have a real impact in fighting mergers that adversely affect them. Under New Hampshire law, as charitable trusts, both hospitals had a fiduciary duty to their communities to "protect their charitable assets and to ensure that those assets are used for purposes consistent with the fundamental charitable missions of the respective institutions."[154] Additionally, as charitable trusts, each hospital owed its community the duty of "candor and inclusion," but this they did not do.[155]

This aspect of the charitable trust law deserves emphasis because it shows that the community being served must be included in the decision-making process regarding mergers, and the mission of a newly merged hospital must reflect the principles and standards of the community in which it functions.[156] When Optima Health failed to fulfill its duty to the community in Southern New Hampshire served by the Elliot and CMC, the respective communities of each hospital stood up for the values the hospitals had previously fostered. The charitable trust laws of New Hampshire gave the communities of the respective hospitals the legal right to keep their hospital's stated mission intact.

Challenging a merger that has already taken place under the charitable trust laws of a state can clearly be an effective way to fight a merger that results in the elimination of women's reproductive health care. In many states, if a hospital is a non-profit, charitable trust laws will apply.[157] If the merging of a religiously-affiliated hospital and a secular hospital would fundamentally alter the mission of a hospital, or prevent the hospital from fulfilling its fiduciary duty to the community, then the merger might be forced to dissolve, as in the case of the Elliot and Optima Health.

Trying to stop mergers before they actually occur is also an effective way to prevent the loss of reproductive health services. Since federal agencies, such as the FTC and DOJ, have the ability to block a proposed merger before it is carried through, they are a good place to begin.[158] This potential "merger-stopper" would require the use of antitrust laws. One would have to have a strong case for the fact that a merger, once completed, would significantly lower the competition in a certain area. If one can also prove that a merger would not only result in the loss of women's reproductive health care, but other health care as well (perhaps, for example, end-of-life care), then the case for anticompetitive results would be even stronger.[159]

Many hospitals merge, not because they have to but for financial gain and greater market power.[160] If the public is aware of a possible merger that could adversely affect reproductive health care, it must work within its community to prevent the merger. In the case of the Optima Health merger, that so fundamentally altered the mission of the Eliot, eventually it was the public and the doctors at the Elliot who came together to fight the merger. The public can work at the grassroots level to prevent mergers, in addition to working on a larger scale, by pressuring their representatives in Congress to be aware of the possible threats of mergers.

Communities can also come together to lobby local government officials to remove tax-exempt status from non-profit hospitals that deny women adequate health care.[161] Religiously affiliated hospitals reap the rewards of tax-exempt status, which results in huge savings on property and sales tax.[162] As the Optima Health merger exemplifies, often mergers end up costing their communities millions of dollars in higher medical costs. It seems unjust that these institutions should enjoy tax-exempt status. A Catholics for a Free Choice poll showed that 78 percent of people think that hospitals should lose their tax-exempt status if they refuse to provide adequate medical care.[163] If hospitals had to either comply with certain standards and provide full reproductive health services or risk losing their tax-exempt status, perhaps they would do more to accommodate the health needs of women.

At the federal level, there have been attempts to pass legislation that would require hospitals that receive federal money to provide adequate reproductive health services. Senator Barbara Boxer (D-CA) and House

Speaker Nancy Pelosi (D-CA) proposed legislation that would have conditioned the receipt of public funds on providing a wide range of reproductive health services, including abortion.[164] Though this legislation did not pass in Congress, it represents a type of law that the public should be pressuring members of Congress to enact. The more awareness people have of the threat of mergers to women's reproductive health care, the more likely they will be able to effectively prevent such mergers.

V. Conclusion

In a time in which the political climate is hostile to women's reproductive health, now more than ever it is vital to ensure that women have access to full reproductive services at hospitals. Non-profit hospitals that receive federal money should not be allowed to evade provision of these services merely because they follow religious teachings, such as the Directives. If the hospital functions as a public institution, the medical needs of women should trump a religiously affiliated hospital's desire to follow religious directives. Especially in the scenario of low-income women, or women who live in rural areas who already have limited access to care, hospitals must provide adequate reproductive health services, for they are often the only choice of health care provider.

Mergers of secular and religious hospitals particularly threaten access to abortion. As a practical matter, it has become increasingly difficult for women to obtain abortion services in certain parts of the country due to a diminishing number of clinics.[165]

This lack of availability forces many women throughout the country to rely on hospitals for abortion procedures. Additionally, women with certain health conditions, such as diabetes, might only be able to obtain an abortion in a hospital if overnight stays are necessary due to possible health complications.[166]

Given the recent Supreme Court decision in *Gonzales v. Carhart*, where the so-called "Partial Birth Abortion" ban was held constitutional, it is clear the assault on women's reproductive rights continues. The need for reproductive services, such as birth control and abortion, is abundantly clear. In terms of public policy, it seems obvious that health care providers should be offering comprehensive reproductive health services to women, no matter where they live or their socio-economic status. Since so many issues involved with women's reproduction have become so politicized, and limiting reproductive rights has become such an integral part of the religious right's political agenda, women's health tends to get lost in the shuffle.

If religiously affiliated hospitals are going to hold themselves out to the public as providers of health care and receive public funds, they must not be permitted to deny women basic reproductive health care. When hospitals receive public money, they should be required to follow generally accepted medical standards, which include providing adequate reproductive health services.[167] Policy makers and government officials must not allow hospitals that use public funds, and function as many people's only provider of health care, to continue to deny women reproductive health services.[168]

The interests of doctors and patients should outweigh a hospital's desire to better its bottom line; rather, access to health care must be a top priority. Access to contraception, abortion, and sterilization are services that should be considered an essential part of basic health care. It is disingenuous to imagine that women's health care can be complete without access to such services. Yet, under the protection of whichever church a hospital may be affiliated with, hospitals deny such necessary care every day. When hospital mergers result in the loss of critical reproductive health services, it is another disconcerting example of how willingly people in power deny reproductive rights, and trivialize the health needs of women. If hospitals have the capacity and technology to provide women with reproductive health services, it is an intolerable injustice that they can so easily deny women such basic care.

1 *See Facts on Induced Abortion in the United States*, Guttmacher Institute (2006), http://www.guttmacher.org/pubs/fb_induced_abortion.pdf [hereinafter *Facts on Induced Abortion*].
2 *See id.*
3 The Guttmacher Institute, Facts in Brief: Contraceptive Use (2005) *available at* http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Feb. 2, 2008) [hereinafter Contraceptive Use]
4 *See, e.g.* Roe v. Wade, 410 U.S. 113, 154, 163-67 (1973) (establishing a right to abortion found within the right of privacy); *see also* Planned Parenthood v. Casey, 505 U.S. 833, 854-55 (1992) (reaffirming the central holding of *Roe*); Stenberg v. Carhart, 530 U.S. 914, 948 (2000). *See generally* Laurence Tribe, Abortion: the Clash of Absolutes 150 (W.W. Norton & Company 1990) (1992) (recognizing the anti-choice movement as a small but powerful political force, working to "chip away" at abortion rights one law at a time).
5 *See generally* Webster v. Reproductive Health Services, 492 U.S. 490, 520 (1989) (upholding a Missouri law that prohibited the use of public funds, government employees, or public facilities for the performance of abortions); Harris v. McRae, 448 U.S. 297, 306-11 (1980) (authorizing the Hyde Amendment, which prohibited the use of Medicaid funds for abortions, even in circumstances where the abortion was considered medically-necessary by a woman's doctor); Maher v. Roe, 432 U.S. 464, 478-80 (1977) (finding that states

were not required to provide abortion services to low-income women through state Medicaid programs, unless the abortion was considered necessary to save the life of the woman, or medically necessary).

6 *See Facts on Induced Abortion*, *supra* note 1. *See generally* Judith Appelbaum & Jill Morrison, *Hospital Mergers and the Threat to Women's Reproductive Health Services: Applying the Antitrust Laws*, 26 N.Y.U. Rev. L. & Soc. Change 1, 10 (2000-2001).

7 *See* Marlene Gerber Fried, *Legal But Inaccessible*, *in* Abortion Wars: A Half Century of Struggle 208, 215 (Ricky Solinger, ed., 1998).

8 *See* Monica Sloboda, *The High Cost of Merging With a Religiously-Controlled Hospital*, 16 Berkeley Women's L.J. 140, 146 (2001).

9 *See id.* at 140.

10 *See* Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 Yale J.L. & Feminism 135, 138 (2003).

11 See *id.* at 138.

12 *See id.*

13 *See* Ethical and Religious Directives for Catholic Health Care Services, 4th ed. (2001), *available at* http://www.usccb.org/bishops/directives.shtml [hereinafter Directives].

14 *See* Appelbaum & Morrison, *supra* note 6, at 6-7.

15 *See id.* at 7.

16 *See generally id.* at 33-35 (describing how members of a community in the Hudson River Valley region of New York state fought a hospital merger of two secular hospitals merging with a Catholic hospital, that would have resulted in the three facilities being dictated by Directives, thereby prohibiting many essential reproductive health care services); Sloboda, *supra* note 8, at 147 (explaining that a woman in California with nine children was denied the right to be sterilized after giving birth to her tenth child because the hospital had recently merged with a Catholic institution).

17 *See generally* Susan Berke Fogel & Lourdes A. Rivera, *Saving Roe is Not Enough: When Religion Controls Health Care*, 31 Fordham Urb. L.J. 725, 739 (2004).

18 *See id.* at 734.

19 *See id.* 729.

20 *See id.*

21 *See id.* at 730.

22 *See* Sloboda, *supra* note 8, at 140.

23 *See* Appelbaum & Morrison, *supra* note 6, at 6.

24 *See id.* at 4.

25 *See id.* at 3-4.

26 *See* William Basset, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. Contemp. Health L. & Pol'y 455, 463 (2001).

27 *See id.* at 464.

28 *See* Fogel & Rivera, *supra* note 17, at 731.

29 *See id.*

30 *See id.*

31 *See* Christopher Snowbeck, *UPMC-Mercy Deal to Test Antitrust Law; Studies Show Mergers Bring Higher Prices*, Pittsburgh Post-Gazette, Oct. 8, 2006, at D1.

32 *See id.*

33 *See* Fogel & Rivera, *supra* note 17, at 734.

34 When a fertilized egg implants outside of the uterus, usually in the fallopian tubes, creating a hazardous situation.

35 *See* Fogel & Rivera, *supra* note 17, at 734.

36 *See id.* at 734-35.

37 *See id.* at 735-36.

38 *See* Jane Hochberg, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 Or. L. Rev. 945, 955 (1996).

39 *See* Appelbaum & Morrison, *supra* note 6, at 7.

40 *See* The National Campaign to End Teen Pregnancy, General Facts and Statistics, *available at* http://www.teenpregnancy.org/resources/data/genlfact.asp (last visited Feb. 7, 2008); *see also*, Lawrence Finer & Stanley Henshaw, *Abortion Incidence and Services in the United States in 2000*, 1, The Guttmacher Institute, http://www.guttmacher.org/pubs/psrh/full/3500603.pdf.

41 The National Campaign to End Teen Pregnancy, General Facts and Statistics, *available at* http://www.teenpregnancy.org/resources/data/genlfact.asp. (last visited Feb. 7, 2008)

42 *See* Contraceptive Use, *supra* note 3.

43 *See* Directives, *supra* note 13, at 52.

44 *See id.*; *see also* Contraceptive Use, *supra* note 3 (stating that "natural family planning methods" have a 25 percent failure rate, compared to an eight percent failure rate for the Pill).

45 Fogel & Rivera, *supra* note 17, at 734.

46 *See id.* at 736-37; *see also* Hochberg, *supra* note 38, at 954.

47 *See* Hochberg, *supra* note 38, at 954-55

48 *See* Fogel & Rivera, *supra* note 17, 736-37.

49 *Facts on Induced Abortion*, *supra* note 1.

50 *See* Finer & Henshaw, *supra* note 40, at 10.

51 *See id.* at 11.

52 *See* Kathryn Kolbert & Andrea Miller, *Legal Strategies for Abortion Rights in the Twenty-First Centur*, *in* Abortion Wars: A Half Century of Struggle 95, 106 (Rickie Solinger, ed., 1998).

53 *See* Fried, *supra* note 7, at 214.

54 *See* Kolbert & Miller, *supra* note 52, at 96; *see also* Rust v. Sullivan, 500 U.S. 173 (1991).

55 *See Rust*, 500 U.S. at 173.

56 *See id.*

57 More than one in five pregnancies in the United States ends in an abortion.

58 *See* Finer & Henshaw, *supra* note 40, at 14-15.

59 *See* Appelbaum & Morrison, *supra* note 6, at 9-10.

60 *See* Bassett, *supra* note 26, at 457.

61 *See* Sloboda, *supra* note 8, at 146-47.

62 *See* Appelbaum & Morrison, *supra* note 6, at 1.

63 *See* Basset, *supra* note 26, at 472.

64 *See* Sloboda, *supra* note 8, at 149.

65 *See* Appelbaum & Morrison, *supra* note 6, at 1.

66 Sloboda, *supra* note 8, at 149.

67 *See id.*

68 *See* Jennifer Connors, *A Critical Misdiagnosis: How Courts Underestimate the Anticompetitive Implications of Hospital Mergers*, 91 Cal. L. Rev., 543, 547 (2003).

69 *See id.* at 547.

70 *See id.* at 548.

71 *See* Snowbeck, *supra* note 31, at D1.

72 *See* Connors, *supra* note 68, at 548.

73 *See id.* at 549.

74 *See generally id.* at 549 (noting that mergers give hospitals more power to control prices, allowing them to drive up prices to the detriment of women and the poor).

75 *See* Appelbaum & Morrison, *supra* note 6, at 16.

76 *See* Connors, *supra* note 68, at 558.

77 *See* Appelbaum & Morrison, *supra* note 6, at 15.

78 *See id.* at 17.

79 *See* Connors, *supra* note 68, at 550.

80 *See* Appelbaum & Morrison, *supra* note 6, at 17.

81 *See id.*

82 *See id.*
83 *See id*; *see also* Conners, *supra* note 68, at 555.
84 *See* Conners, *supra* note 68, at 555; *see also* Snowbeck, *supra* note 31, at D1 (referring to a Federal Trade Commission report that shows mergers actually increase costs for consumers, rather than decrease costs).
85 *See* Appelbaum & Morrison, *supra* note 6, at 36.
86 *See* Sloboda, *supra* note 8, at 149.
87 *See* Conners, *supra* note 68, at 576.
88 *See* Sloboda, *supra* note 8, at 150.
89 *See* Fogel & Rivera, *supra* note 17, at 728.
90 *See generally* Bassett, *supra* note 26, at 471 (arguing that "[i]f patients have little or no choice of hospitals, hospitals cannot retain a distinctive ethical autonomy to deny patients their rights to comprehensive medical care").
91 *See id.* at 464.
92 *See* Fogel & Rivera, *supra* note 17, at 739 (quoting Doe v. Bridge Memorial Hosp. Ass'n, 366 A.2d 641 (N.J. 1976)).
93 *See id.*
94 According to one study, religiously affiliated hospitals received $45 billion in 2002.
95 *See* Molly M. Ginty, *Dangers of Hospital Mergers,* Planned Parenthood Federation of America (2005) *available at* http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/birth-control-access-prevention/hospital-mergers-6526.htm (last visited Feb. 7, 2008).
96 *See* Lemon v. Kurtzman, 403 U.S. 602, 612-13 (1971).
97 *See id.* at 612-13.
98 *See* Edwards v. Aguillard, 482 U.S. 578, 585 (1987) (quoting Wallace v. Jaffree, 472 U.S. 38, 56 (1985)).
99 *See* Ginty, *supra* note 95.
100 *See* Dina R. Lassow, *Hospital Mergers and the Threat to Women's Reproductive Health Services: Using the Establishment Clause of the Constitution to Fight Back*, 14, National Women's Law Center (2006) http://www.nwlc.org/pdf/EstablishmentClause_06.16.06.pdf.
101 *See* Bassett, *supra* note 26, at 471.
102 *See* Eisenstadt, *supra* note 10, at 140.
103 *Id.*
104 *See id.*
105 *See id.* at 141.
106 *See id.*
107 *See* Fogel & Rivera, *supra* note 17, at 741.
108 *See generally* Hochberg, *supra* note 37, at 957 (quoting a study conducted by Catholics for a Free Choice that found that over 40 percent of women polled were unaware that a Catholic hospital might not restrict reproductive health services).
109 *See* Fogel & Rivera, *supra* note 17, at 734.
110 *See id.*
111 *See* Hochberg, *supra* note 38, at 955.
112 *See* Sloboda, *supra* note 8, at 144.
113 *See* Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 Hous. L. Rev. 1429, 1482 (1995).
114 *See* Tribe, *supra* note 4, at 145.
115 *See* Sloboda, *supra* note 8, at 144.
116 *See* Fogel & Rivera, *supra* note 17, at 742.
117 *See* Bassett, *supra* note 26, at 484.
118 *See* Appelbaum & Morrison, *supra* note 6, at 3.
119 *See* Bassett, *supra* note 26, at 459.
120 *See* Sloboda, *supra* note 8, at 149.
121 *See id.* at 150.
122 *See* Cara Matthews, *Reproductive Care at Issue in Hospital Plan*, Gannett News Service, Dec. 8, 2006.
123 Sloboda, *supra* note 8, at 149.
124 *See* New Hampshire Att'y Gen. Report on Optima Health 1 (1998) [hereinafter AG Report].
125 *See id.*
126 *See id.* at 38.
127 *See* Sloboda, *supra* note 8, at 149.
128 AG Report, *supra* note 124, at 13.
129 *See id.* at 14 (quoting Articles of Agreement of Catholic Medical Center, Art. II. A) (capitalization in original).
130 *See id.* at 15.
131 *See id.*
132 *See id.* at 16.
133 *See id.*
134 *See id.* at 17.
135 *See id.* at 1.
136 *See id.* at 2.
137 *See id.* at 5.
138 *See id.*
139 *See id.* at 40, n. 93.
140 *See id.*
141 *See id.*
142 *See id.*
143 *See id.*
144 *See* Julia Eberhart, *Merger Failure: A Five-Year Journey Examined—Optima Health*, Healthcare Financial Management, Apr. 2001, *available at* http://findarticles.com/p/articles/mi_m3257/is_4_55/ai_73328480 9 (last visited Feb. 7, 2008).
145 *See* Sloboda, *supra* note 8, at 146.
146 *See* AG Report, *supra* note 124, at 40.
147 *See id.* at 41, n. 96
148 *See id.* at 42.
149 *See id.*
150 *See* Ebarhart, *supra* note 144.
151 *See* AG Report, *supra* note 124, at 39.
152 *See id.* at 9.
153 *See* Eberhart, *supra* note 144.
154 *See* AG Report, *supra* note 124, at 1.
155 *See id.* at 2.
156 *See id.*
157 *See* Sloboda, *supra* note 8, at 149.
158 *See* Appelbaum & Morrison, *supra* note 6, at 27.
159 *See id.* at 29.
160 *See* Connors, *supra* note 68, at 549.
161 *See* Hochberg, *supra* note 38, at 963.
162 *See* Bassett, *supra* note 26, at 464.
163 *See* Hochberg, *supra* note 38, at 965.
164 *See* Bassett, *supra* note 26, at 516.
165 *See* Appelbaum & Morrison, *supra* note 6, at 8.
166 *See id.* at 9.
167 *See* Fogel & Rivera, *supra* note 17, at 729.
168 *See id.*