

How Do Church Rules Influence Care in Catholic Health Systems? Find Out Here

By Lola Butcher

A Catholic physician with a lengthy career in hospital leadership explains how the wide-ranging Ethical and Religious Directives for Catholic Health Care Services influence patient care and limit physician autonomy. She calls for greater transparency about these limits, both from Catholic healthcare organizations and the physicians who work in them, so patients can make fully informed choices about where they seek care.

KEY WORDS: Catholic healthcare; ERDs; doctor-patient relationship; healthcare delivery.

Patricia Gabow, MD, began her career as a nephrologist at Denver Health and retired from the academic safety-net hospital 40 years later, having served as CEO for the previous two decades. Along the way, she was the hospital's chief medical officer and the long-time principal investigator on a National Institutes of Health-funded study of polycystic kidney disease.

She has written extensively about healthcare and served on the federal Medicaid and CHIP Payment and Access Commission, the Robert Wood Johnson Foundation Board of Trustees, and the Lown Institute Board of Directors, which she currently chairs.

The fact that she is a practicing Catholic is important to understanding her new book, a thoroughly researched critique of the influence of the Catholic Church on American healthcare. The question mark in its title, *The Catholic Church and Its Hospitals: A Marriage Made in Heaven?*, foreshadows her analysis: "Catholic health systems do a lot of good ... but I don't think that they are living up to their historical roots or, in many cases, to their mission statements."

She explains her perspective in this conversation with *Physician Leadership Journal*.

What makes Catholic healthcare worthy of the deep exploration that you conducted?

First of all, there are Catholic hospitals in 46 states. In 20 states, they have more than 20% of the beds. In 35% of counties, they have either the dominant or high share of the market. There are 4.4 million admissions to Catholic healthcare systems every year — that's 14% of all admissions in the country. They have almost 500,000 births, which is about

13% of births. And four of the top 10 healthcare systems in the nation are Catholic.

Until I read your book, I was unfamiliar with the ERDs — the Ethical and Religious Directives for Catholic Health Care Services — that are a central part of your critique. Why are they important?

When I started talking about the ERDs, many of my friends in healthcare said, "What?" And if those of us who are in the healthcare sphere don't know about them, certainly most patients have no clue.

ERDs first came about in 1948, and the first published version was a simple list of do's and don'ts, mostly don'ts. There have now been six editions, the most recent in 2018.

They are written by the United States Conference of Catholic Bishops, which consists of about 300 bishops, the male hierarchy of the Catholic Church in the United States. Originally, they were mainly about how to make Catholic healthcare competitive in terms of quality, but they fairly quickly evolved into something more than that.

How many ERDs are there, and why are they important?

There are 77 of these rules, and I think anybody who is in healthcare should read them all because they will be surprised. The current edition has six parts. The first part, which is about social responsibility, states that Catholic healthcare should distinguish itself in the care for the poor, the vulnerable, the immigrant, and the refugee.

That part also says that every employee has to obey the ERDs; they must comply with them, whether they are Catholic or not.

The second part, which is about pastoral care, probably doesn't affect patient care as much as the other five parts. The third part really gets into the doctor-patient relationship. There are some conflicting statements in there, such as "we respect the individual's choice," but it has to be in compliance with the ERDs. Or "we honor advanced directives," but they must be in compliance with the ERDs.

The fourth section is where most patient care issues lie because it covers the beginning of life. The Catholic Church believes life begins at conception, and from that and their view of marriage flows a whole series of prohibitions: no form of artificial contraception, no tubal ligation, no vasectomy, no assisted reproductive technology, and, of course, no abortion. So that really affects a lot of care delivery.

The fifth component deals with the care of the seriously ill and dying. And while it's very clear that the church prohibits medical-aid-in-dying, it's also very clear that just because a treatment exists, you don't have to use it. And it points out that you can give pain medications as needed to address pain, even if that hastens death. The somewhat controversial part of that chapter is that you have to give artificial nutrition, even to someone in a persistent vegetative state.

The last part covers collaborative arrangements. It starts out by saying Catholic facilities should really do business with Catholic facilities, but if they have to do business with a secular institution, it has to follow the ERDs.

So, if a woman wants to have a tubal ligation, for example, she should make sure she avoids a Catholic health system?

If you look at websites — and I've looked at a lot of websites and have also quoted studies in my book — most Catholic hospitals don't say on their landing page that they are Catholic. You could probably find that information, but you have to click through a number of pages to do so. And 75% don't say they follow the ERDs. And even if they do say they follow the ERDs and link to the United States Conference of Catholic Bishops' site, those are not in language that the average person is going to understand.

That lack of transparency is reflected in what patients think, which is really important when you talk about all the prohibitions of care. About 70% of patients don't think there would be any difference at all in their care between a Catholic hospital and a secular hospital; 60% of women think they could get birth control pills or tubal ligation; and 27% think if they went in for a delivery and they had a fetal abnormality that would be an indication for an abortion, that they would get [an abortion]. Of course, they wouldn't get any of that.

What explains that lack of transparency?

I have no data for this, but I've been in healthcare for 40 years, and I think it's a business decision to preserve market share. Think about this: If you are a pregnant woman choosing a place for your delivery, and you know that if something goes wrong — a miscarriage, an ectopic pregnancy, a fetal abnormality — or you want a postpartum tubal ligation, you are not going to be treated the same way at that hospital as you would someplace else, would you pick that as your first choice as your place to go? Probably not.

There are federal laws requiring price transparency, which is about your financial well-being. I think we need federal laws about care transparency because those are issues about your health and maybe even your life. Let's get our priorities aligned here.

In your view, how has the decline in the number of women religious — from some 180,000 in 1968 to about 42,000 in 2021, at which time the median age was 81 — influenced Catholic healthcare?

Of course, not all nuns are exactly the same; however, there are things that distinguished them as a group that were important in creating the culture of early Catholic healthcare in this country.

First of all, they almost all took a vow of poverty. Secondly, most of them took a vow of service, or at least part of their persona was service. Because of that, many of them were on the front lines taking care of people, and they saw what real suffering was.

I don't think we could expect a lay group to have vows of poverty, but many of the administrators and leaders in current Catholic healthcare have not been on the ground caring for patients, and that can't help but make a difference.

I think many of the early nuns truly believed that you had to do what Jesus would have done, and I think Catholic healthcare has lost that, and that losing the nuns changed the culture.

In your book, you applaud the U.S. bishops "for emphasizing in Part 1 of the ERDs the central role of care for the poor and fair treatment of employees, including just compensation." But you also call them to task: "They must enforce compliance with this obligation with the same fervor that they have for other aspects of the ERDs." Tell us why you say that.

There has been a lot more focus on the part of the ERDs that relates to the beginning of life than on the first part. In

2022, *The New York Times* ran a series of three articles called “Profit Over Patients.” Just by hearing that title, most of us would probably say, “That’s going to be about the for-profit healthcare systems in America,” but all three articles were about Catholic systems: the Providence system in the Northwest, Bon Secours Mercy Health, and Ascension.

The articles really were about behavior: about billing patients, about their investment income, about their walking away from facilities that serve the poor. That those stories focused on Catholic systems was sort of shocking.

If you’re going to take care of poor people, you would be taking care of a lot of Medicaid patients because those are a lot of poor people. But studies have shown that if you compare the percentage of Medicare patient discharges for Catholic systems with that of other not-for-profits and for-profit systems, the Catholic systems are the lowest: 7.2% compared to 8.3% for other not-for-profits and 9% for the for-profits. So that doesn’t look like you are inviting the poor from the roadside into your system.

Perhaps the Catholic systems are providing a lot of community benefit, including charity care?

I recently did a study with a group from Johns Hopkins looking at this. When we looked at community benefit, excluding Medicaid shortfall, the Catholic systems provided \$57,500 in community benefit per bed while other religious healthcare systems provided \$84,200 per bed.

And I chair the board of the Lown Institute, which has done a study on what they call the “fair-share deficit” for tax-exempt systems. What’s your tax exemption worth, and how much do you give in community benefit? They also excluded Medicare shortfall and research and education.

When they looked at that, all of the big Catholic systems had large fair-share deficits. The biggest one, CommonSpirit Health, was over \$900 million in a year. You could do a lot of charity care with that amount of money.

It seems like there is a pattern emerging here.

The other thing is that the Catholic systems pay their CEOs very richly, sometimes \$10 or \$12 million a year. In my book, I look at CEO salaries compared to front-line workers because Part 1 of the ERDs says that you treat workers fairly — that is a very important Catholic social

teaching. But in some of these institutions, the ratio between the CEO’s salary and that of a front-line worker is a 400-fold difference.

So, when you put this all together, it is clear that Catholic health systems play an important part in American healthcare, and they certainly are doing good.

Are they living up to the model that nuns started decades or a century ago? I would say probably not.

What can physician leaders who are concerned about this do?

I’m a practicing Catholic, and I’m not here saying the church should change its theological views. That’s not going to happen. What I’ve always believed as a leader in healthcare is not to ask for the impossible because you waste a lot of effort. However, I think physicians should be clear that they have a professed oath to put the patient first, and that has certain implications.

First of all, they should push for transparency. They should tell patients upfront what they cannot do — what morally they cannot do themselves for reasons of personal conscience or what they cannot do because they are within a Catholic healthcare system. And they should work with their legislatures to say transparency is very important. When physicians speak to legislative groups about things that relate to the care of the patient, I think legislators listen.

They should also refer patients who require care that cannot be delivered in the Catholic health system. Right now, the ERDs forbid referrals, so I think that Catholic physicians should push their associations to examine this boundary between the physicians’ oath, their own consciences, and employment contracts.

If they are Catholics, I think physicians should work with their bishops to say, “A: We should be transparent,” and “B: We should live up to the first part of the ERDs and be exemplary in our care for the poor, the vulnerable, and the immigrant.” ■■

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