

# The Nation.

## **NAFTA AT 5**

Lori Wallach and  
Michelle Sforza

## **GRAY DAVIS &**

## **JERRY BROWN**

Alexander Cockburn

## **WHEN ALI WAS KING**

David Levi Strauss

# IMMACULATE CONTRACEPTION

**As Catholic ownership of  
health services grows,  
women's choices decline.**

**by JENNIFER BAUMGARDNER**

## ARTICLES

## IMMACULATE CONTRACEPTION

by JENNIFER BAUMGARDNER

Enter the glass doors at 222 West 14th Street in New York City, and the chaos of traffic horns and tire-screeches, jackhammers and concentrated humanity recedes into a hush. In the serene offices of Elizabeth Seton Childbearing Center, surfaces are awash in blue hues, the lighting is dim and the women at the desk are friendly and concerned. A receptionist is telling a nurse about a delivery the day before. The mother-to-be was getting a due-date manicure and facial and began having contractions during the appointment, the receptionist explained. “She said she wanted to look fabulous when she came in here to have the baby!”

At Elizabeth Seton, women are meant to feel fabulous, too. Oven mitts adorn the cold stirrups of the exam table. Clients are encouraged to labor wherever they like—each suite of birthing rooms contains a queen-size bed, a whirlpool bath and comfy chairs. Partners can assist the mothers or wait with family inches away in a room equipped with a kitchen where they can cook or have a party after the baby is born. Women giving birth have access to La Leche League (for breast-feeding support) and *doulas* (experienced mothers who assist new mothers), along with a midwife, a nurse and an acupuncturist. Other services include sibling preparation, infant massage and postpartum yoga. Gay mothers are welcome and make up a small percentage of

Seton’s clientele. In short, Seton is a feminist’s dream.

Unless, that is, you need a tubal ligation after your childbirth, which is the best time to do the procedure. Or any sort of contraception, even family-planning counseling. Why? This birthing center, founded in 1996, receives funding from St. Vincent’s, a Catholic hospital. And Catholic hospitals do not condone these services.

Elizabeth Seton—a midwifery clinic built on the principles espoused by *Our Bodies, Ourselves* and which claims to offer “full scope, well-woman gynecologic[al] services”—is not alone in its restrictive practices. Catholic HMOs, hospitals and affiliates, which together play an ever-larger role in healthcare delivery, are effectively eliminating virtually every health-related feminist victory of the past thirty years. The “Ethical and Religious Directives”—Catholic healthcare’s seventy commandments, drafted by the Church’s American Bishops—prohibit abortion, birth control, most vasectomies, tubal ligation and the morning-after pill even for rape victims. The result is a healthcare system that effectively bypasses not just *Roe v. Wade* but *Griswold v. Connecticut*, the 1965 Supreme Court decision that allowed married couples to seek contraception.

Legislative tolerance of such restrictions is growing. The 1997 Balanced Budget Act applies the "conscience clause"—which originally meant that individuals would not have to perform procedures (such as abortions) to which they have moral objections—to the institution of managed care. As a result, health plans for federal employees may opt not to include reproductive care on religious or moral grounds. In South Dakota pharmacists are legally allowed to deny a woman a prescription if they have reason to believe it will be used to terminate a pregnancy.

Yet, to understand why midwifery clinics like Elizabeth Seton choose to play dumb when asked about birth control, one has to look beyond the antifeminist legislative climate to the changing face of our healthcare system. Hospitals fall into three categories: federal (such as Veterans Affairs hospitals), for-profit and nonprofit—including religious-affiliated and secular institutions. According to the records of the Catholic Health Association, 10 percent of nonfederal hospitals and 15 percent of nonfederal hospital beds are Catholic. And Catholic hospitals are the largest nonprofit healthcare provider. The Catholic Church currently owns five of the ten largest hospital corporations—amounting to more than 800 hospitals and healthcare systems and caring for more than 70 million patients.

Most significant, more and more hospitals are merging in an effort to cut costs, and when one of the two joining forces is Catholic, its practices frequently become the new standard. In the past few years, 40 percent of some 5,200 nonfederal hospitals have either merged or entered into an agreement to do so. Catholic hospital networks are expanding the most rapidly through mergers, with one survey observing a 12 percent growth rate among participating systems in 1997. According to a study by the nonprofit social justice group Catholics for a Free Choice, in the past eight years nearly one hundred mergers have occurred in which a non-Catholic hospital has aligned with a Catholic hospital. In half of those instances, reproductive health services have remained largely unchanged (that is, intact at the formerly non-Catholic facility, and still nonexistent at the formerly Catholic one), while in the other half such services have been either cut back or wiped out completely.

"This is stealth elimination," says Susan Berke Fogel, legal director of the California Women's Law Center, a nonprofit spearheading an aggressive campaign to bring attention to Catholic encroachment on reproductive freedom. She is most galled by the Catholic Church's assertion that because its hospitals are nonprofits rather than businesses, they are exempt from antidiscrimination law. A recent California Supreme Court decision ruled in favor of a Catholic hospital that was sued for not complying with fair employment laws. "Look, I don't argue with the importance of allowing hospitals to be nonprofits so that the communities will reap the benefits rather than shareholders," says Berke Fogel. "But that shouldn't be license to discriminate, either in the types

of services they provide or in hiring based on race or gender."

Berke Fogel also points out that Catholic hospitals, far from being autonomous, are drawing much of their funding from federal sources such as Medicaid and Medicare. "The reality is that they are accumulating huge amounts of money that is exempt from taxation," she says. "We, the taxpayers, are subsidizing their expansion. Their revenues aren't required to go back into health-care but can go into religious institutions. The public is simply not benefiting from these transactions." For example, the nuns who operate the Daughters of Charity, the largest owner of Catholic hospitals, commanded a pot of \$2 billion in cash and investments as of March 1998. A reproductive health ideology that would work only for a celibate (or for the barefoot and pregnant) seems rather out of touch with women's needs. But low-income women disproportionately depend on Catholic hospital care, and as Catholic HMOs proliferate, they are serving a growing number of Medicaid patients—a "very frightening prospect for low-income women," says Berke Fogel.

Whether poor women should be subject to the morals of the Vatican was the question put forth on a recent crisp fall morning in Manhattan, as New York City lurched forward with its roll-over into mandatory managed care for 1.2 million Medicaid beneficiaries, two-thirds of whom are women. Pro-choice advocates and reporters gathered at City Hall on Octo-

ber 27 to give testimony in support of a bill to protect women on Medicaid from being auto-assigned (if the beneficiary doesn't choose a plan within a given time frame) into plans that don't directly provide contraception and family-planning services. Unfortunately the bill—opposed by the mayor as well as by Fidelis, a major Catholic HMO that wouldn't be able to comply with its provisions—is unlikely to pass.

When advocates talk of the merger crisis, they often remark on the dangerous blurring of the line between church and state. Yet groups such as the California Women's Law Center and New York's Center for Reproductive Law and Policy have not found such constitutional arguments very effective. Although there have been gains in the courts in some states—as in the recent New Mexico Supreme Court decision that medically necessary abortions for Medicaid recipients must be covered because of the state's Equal Rights Amendment—there is no legal precedent for protesting denial of access on the basis of the US Constitution. "Look, the law is not on our side," says Frances Kissling, president of Catholics for a Free Choice. "No hospital—Catholic or non-Catholic—is required to perform an abortion, and most of them don't. They're not required to provide contraception or reproductive healthcare. The only thing a hospital has to do is treat a patient who comes in through the door in a life-threatening situation."

Leaving aside for a moment that denial of reproductive care can have catastrophic consequences, what if a woman's situation is life-or-death, in conventional terms? When Elliot Hospital in Manchester, New Hampshire, went Catholic in May 1998, Dr. Wayne Goldner was refused permission to perform an emergency abortion to a patient after her water broke at fourteen weeks. She was forced to ride eighty miles in a taxi to Hanover

*More hospitals are merging in an effort to cut costs, and when one is Catholic, its practices frequently become the new standard.*

to have the procedure. Goldner, who has spoken out on the issue and for whom abortion is a small fraction of his practice, has had his house picketed and lost his teaching position, and there was a bomb threat at his young daughter's school. And last September Michelle Lee, a 26-year-old awaiting a heart transplant, was denied an emergency abortion in Louisiana, amid disagreement over whether she faced the 50 percent chance of death required for the procedure by state law. The Louisiana State University hospital that turned her down is not Catholic but has a conservative religious culture. "At a lot of hospitals," says Maureen Britell of the National Abortion Federation, "whether they're Catholic or not, the board of directors has a strong link to a Catholic or religious organization."

Catholics for a Free Choice has been tracking the mergers for years and has perhaps the most comprehensive analysis of how activists should respond. The CFFC approach is pragmatic: Mergers are a trend that will continue. Therefore, people concerned about women's healthcare should either try to block the mergers or make sure that access to abortion and contraception is mandated in the deal structure. Services are preserved when the community and the doctors stand firm, Kissling says. A CFFC report also cites ways in which doctors and administrators have worked the system by creatively interpreting the Church's Directives. Strategies include setting aside an area of the facility for reproductive health services or having a "virtual merger"—"a close collaboration that does not merge assets or establish one governing body."

CFFC's approach takes into account an often overlooked nuance of the merger issue, which is that there can be a flip

side to glorifying procreation: At some Catholic hospitals, a woman having a baby is treated like the Virgin herself. Staffers at Elizabeth Seton stress that they want the center to be aligned with St. Vincent's, emphasizing its thoughtful, pro-mother care. "This is a besieged profession," adds Pat Burkhardt, the former clinical director of Elizabeth Seton, now director of New York University's Nurse-Midwifery Program, "and St. Vincent's is consciously pro-midwife," whereas many secular hospitals are not. She believes that pro-choicers in Catholic institutions simply become adept at working the system. "There are hospitals out there that quietly make referrals," says Burkhardt. "You don't want to get the news out because that would get them shut down, but, you know, Catholic women have for years chosen to ignore the Pope and the Catholic hierarchy's stance on birth control."

There is still the question of why, in at least half the Catholic/non-Catholic mergers, the secular hospitals roll over so quickly, observes Catholics for a Free Choice's Kissling, who opened the first abortion clinic in New York's Westchester County nearly thirty years ago. "I would expect the Catholic hospital to get its values, as bad as they are, visible in the merged institution," she says. "But where is the non-Catholic hospital in standing up for women's rights?"

Bring up women's rights, and many defenders of the hospitals in question respond with a blank stare. It isn't about sexism, they say, it's about cost. Reproductive care is just too expensive.

Obviously that's not the right question—we are talking about access to basic health services—but for the sake of argument, are contraception, tubal ligation, vasectomy and abortion profitable?

Like any medical treatment, in and of themselves, they're not. But according to a 1997 study by Planned Parenthood of New York City, the money saved in terms of prevention is enormous. Among the findings are that for every 1,000 members who receive contraception, the managed-care organization will save \$1.2 million annually for pregnancy-related care averted. A 15 percent increase in the number of oral contraceptive users in a health plan would produce enough savings in pregnancy costs alone to provide oral contraceptives for all users in the plan. Birth control pills and exams cost between \$285 and \$804 per patient per year, while the average cost of delivering an unintended pregnancy is \$3,200.

Even so, some question whether reproductive care is "medically necessary," the sine qua non of insurance reimbursement. "About 60 percent of women access healthcare through these services," responds Alice Berger at Planned Parenthood of New York City in an "Is the Pope Catholic?" tone. Furthermore, she says, it's ultimately quite costly for the insurance companies if women don't get the services. "The sequelae are unintended pregnancy, STDs, later-term abortions, cancer that's not detected early enough—very serious stuff that translates into big dollars," Berger says.

Yet the majority of commercial plans do not provide reversible

family-planning methods in their benefits, which means millions of women are paying out of pocket for diaphragms, the pill and condoms. In fact, women spend 68 percent more on healthcare per year than men do—this, while symmetrically making around 70 cents to the male dollar. And then there's the fact that just five weeks after the erection-helper Viagra became available, nearly half of the 270,000 very expensive prescriptions sold were paid for by some form of insurance. Meanwhile, although Congress forbids abortions in military hospitals even if the servicewoman pays for the procedure out of pocket, the Washington Feminist Faxnet reported in early October that the Pentagon earmarked \$50 million to bankroll Viagra for US troops and military retirees. Is potency a medical necessity? I guess God knows, because according to Brian Mulligan at the Catholic Healthcare Network, even the Vatican supports Viagra.

One bright spot in the bleak landscape: A proposed merger in Kingston, New York, between a Catholic and a secular hospital fell apart, largely due to community-based resistance to the threatened loss of reproductive services. Citizens held rallies, wrote hundreds of letters to the editor, signed petitions and decorated the town with lawn signs that read "PEOPLE OF ALL FAITHS USE OUR HOSPITAL!" Lois Uttley, director of the Merger-Watch project, which coordinated community efforts, was thrilled with the victory. But it drove home the lesson that advocates of reproductive freedom, who are accustomed to focusing on legal rights, now have to fight in new arenas. "New York is a pro-choice state—on paper," says Uttley, who, in alliance with the California Women's Law Center, was awarded a Ford Foundation grant to expand her community organizing efforts nationally. "But we have four regions in this state where access is in peril right now. We can no longer focus purely on legislation."

After Dr. Barnett Slepian, an OB-GYN who performed abortions, was slain in his Buffalo-area home by a sniper with a high-powered rifle, representatives from various reproductive rights organizations tossed around the scary facts and figures. Two-thirds of all OB-GYNs who perform abortions are over the age of 65 and will soon be retiring; in 84 percent of US counties, there are already no providers. The precedent has been set to treat abortion and related services as unseemly and therefore marginalized to easily targeted women's clinics. Doctors who perform abortions are picked out of their crowd of peers and terrorized. An OB-GYN at the Cleveland Clinic told me that while he is personally pro-choice, he wouldn't have a public profile as such, because he believes that the atmosphere in his community (medical and otherwise) would not defend a doctor who supported reproductive freedom. "I am counting on others to take the risk," says the doctor, who asked not to be identified. "And I fear that I am part of the problem by not standing by this procedure that I want to have available, but won't do myself."

As abortion opponents focus on providers, so must abortion rights supporters. "Most of the people in med school now were born at or around the time of *Roe v. Wade*," says Kiersta Kurtz-Burke, a student at Tulane who is also the national coordinator for the Southeast region of Medical Students for Choice. Besides pushing medical schools to include training in the very simple abortion procedure, MSC also raises historical consciousness by screening the Dorothy Fadiman documentary *When Abortion Was*

## Choose Action

If the many groups organizing locally to block mergers involving Catholic hospitals or to preserve reproductive services when they do occur, most work with Albany, New York's, MergerWatch (518-436-8408; [www.fpaofnys.org](http://www.fpaofnys.org)) and use the guide written by director Lois Uttley. Merger-Watch's partner in the national push is the California Women's Law Center (213-637-9900). Washington, DC's, Catholics for a Free Choice (202-986-6093) provides an insider's analysis of Catholic healthcare and strategies for reform.

Meanwhile, Medical Students for Choice (510-540-1195), founded by California student Jody Steinauer in 1993, attends to the abortion-provider shortage. There are currently 5,000 members and MSC groups at about 100 medical schools. Nursing Students for Choice, pioneered by the Abortion Access Project (617-661-1161) in Massachusetts, focuses on midlevel organizing to help create a medical atmosphere in which a woman's right to choose is viable. Similarly, the National Abortion Federation (202-667-5881) coordinates Nurse Practitioners for Choice (a joint effort with National Association of Nurse Practitioners in Reproductive Health), Midwives for Choice and Physician Assistants for Choice. All these groups focus on basic outreach and grassroots activism to support pro-choice healthcare.

The Pro-Choice Public Education Project (914-934-0148), composed of forty-seven organizations, is trying to goose a complacent post-*Roe* generation with a national advertising blitz. Using Barbara Kruger-style posters with stark statistics such as "77% of anti-abortion leaders are men. 100% of them will never be pregnant," PEP is raising \$6 million a year to insure that this pro-choice ad campaign is as ubiquitous as the anti-choice "Life, What a Beautiful..." thing. —JB

*Illegal* and bringing in older doctors to recount tales of the days when fifty women might be in the septic ward due to botched illegal abortions. MSC also tries to bridge the fact that most medical students are pro-choice and yet few want to take on what they see as a harrowing life as a provider. "Providing abortions can be integrated as a small part of your family practice," says Kurtz-Burke. "You might have a regular patient who at some point doesn't want to be pregnant." In the next couple of years, the first waves of some 5,000 doctors belonging to MSC will be setting up family and OB-GYN practices across the country. Meanwhile, doctors aren't the only hope for women needing abortions. The National Abortion Federation reports that in New York, which has no "physician only" law, physician assistants (PAs) are providing abortions. Vermont has a long history of PAs doing abortions with as good an outcome, if not better, as those performed by doctors. Nurse practitioners can also be trained in the procedure in Vermont, and just a few months ago, the first modern mid-

wife was trained in surgical abortion. With nonsurgical "medical" abortion on the not-so-distant horizon (RU 486 is due here in late 1999), even more midlevel healthcare providers will be able to terminate an unwanted pregnancy.

Feminists of the second wave declared that women would never be free unless they could control their own bodies, a fierce belief that became law in 1973. But Congress doesn't have to ban abortions if the American Medical Association treats the procedure as beyond the bounds of medical training. The Catholic Church doesn't have to bother swaying the opinion of the majority of Americans who believe in a woman's right to choose if it owns the hospital they go to. Strategies for attaining reproductive human rights have changed with the times, shifting away from a focus on legislation and the courts and toward community organizing and consciousness raising. But after all the years of feminist struggle, we face a grim and familiar reality: Women are getting screwed. ■