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February 28, 2007

Uwe E. Reinhardt, Ph.D.
c/o Cynthia McGettigan
Commission on Rationalizing New Jersey's
Health Care Resources
Department of Health and Senior Services
P.O. Box 715
Trenton, N.J. 08625-0715

Dear Professor Reinhardt:

Congratulations on your appointment to head the Commission on Rationalizing New Jersey's Health Care Resources. We have high hopes for the Commission's role in ensuring that New Jersey residents receive health care that is high quality, affordable, accessible, culturally competent, and respectful of their informed decisions regarding treatment. I would like to meet with you to discuss this Department's work and how it can be of value to the work of the Commission.

I understand that the Commission's work will cover the broad spectrum of health care resource allocation and will probably include recommendations regarding the consolidation of hospitals. This office has been examining hospital consolidations that involve sectarian hospitals. These consolidations pose the risk that services that conflict with the religious beliefs of the institution — reproductive health and end-of-life services, for example — will be eliminated in the newly consolidated hospital. The failure to provide these and other services leaves communities without access to comprehensive, integrated, hospital-based services. We recently worked with the Department of Health and Senior Services, the Attorney General's Office, St. Mary's Hospital, PBI Regional Medical Center, and reproductive health care advocates to ensure that critical services would be preserved within Passaic City after a consolidation of St. Mary's and PBI. I have enclosed a memorandum we drafted, which includes an overview of the laws and regulations related to reproductive health and end-of-life services potentially at risk in such a consolidation. The memorandum also suggests questions that must be answered to identify services that may be at risk in such mergers.

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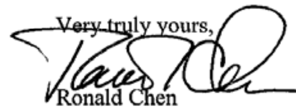
Catherine Weiss, Director of the Division of Public Interest Advocacy, has a great deal of experience in this area, and we would like to meet with you to discuss these matters further. Would you be so kind as to contact my assistant, Maritza Rodriguez, to schedule a mutually convenient time to meet?

Thank you in advance for your time. I look forward to talking about these important issues and the difficult work you are undertaking.

Very truly yours,



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IMPACT OF HOSPITAL CONSOLIDATIONS ON AVAILABILITY OF SERVICES

Consolidations involving sectarian and secular hospitals pose the risk that the communities the hospitals serve will lose critical services as a result of religious restrictions in the sectarian hospitals. For Roman Catholic hospitals, the *Ethical and Religious Directives* (Directives) outline Catholic doctrine and establish practices for health care in Catholic facilities. The Directives limit reproductive health and end-of-life options. A community's potential loss of services includes: sterilization procedures (both male and female), infertility treatments, emergency contraception, STD/HIV counseling related to risk reduction (use of condoms), contraceptive services, abortion procedures, confidential services for minors, and adherence to advance directives outlining a patient's treatment decisions in the event that the patient cannot speak for him or herself. (United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 2001.) The Directives are not interpreted in the same way by all sponsors of hospitals (e.g., the religious order that runs the hospital), so an individualized assessment is necessary.

The Department of the Public Advocate has conducted a review of the relevant laws and regulations related to each of the reproductive health and end-of-life services potentially at risk in consolidations involving sectarian hospitals. We also suggest questions that can help identify at-risk services.

Before evaluating the potential loss of particular services, interested parties should evaluate how affected communities access health services in general. How many people in the affected communities use the hospitals involved for general health care? If the hospital or its

clinics provide primary care, the hospital probably offers a wider array of services to a greater number of people than if it only provides acute care. It follows that more services for more people will be at risk where a consolidation involves a hospital that provides primary care. The second issue concerns insurance coverage. While other secular hospitals may still operate in or close to the affected communities, individuals may not be able to use them because of the limits of their insurance coverage. It is therefore important to determine whether community residents generally carry insurance that allows them to choose care at the remaining non-sectarian hospital(s).

STERILIZATION

BASIC FACTS

Twenty-seven percent of women who use contraception rely on tubal ligation; this is the second most common form of birth control, after the pill. Vasectomies are relied upon by 9.2% of women who use birth control. All told, more than a third (36.2%) of women practicing contraception in the United States rely on sterilization. (Guttmacher Institute, *Facts in Brief: Contraceptive Use*, 2006.) A woman who chooses to rely on tubal ligation has many reasons for obtaining this procedure at the time of childbirth, especially if the delivery is by cesarean section: she may require only one surgical procedure instead of two; she will be exposed to the risks of anesthesia once instead of twice; and the overall costs to her (and to her public or private insurer) will be lower if no separate admission or outpatient visit is required for sterilization. For these and other reasons, approximately half of tubal ligations in the United States are performed immediately after childbirth. (Andrea P. MacKay et al., *Tubal Sterilization in the United States, 1994-1996*, Family Planning Perspectives, July/August 2001.)

LEGAL BACKGROUND

The New Jersey Conscience Law (N.J.S.A. §§ 2A:65A-1 to -3) prohibits any person or entity from requiring that an individual, hospital, or other health care facility perform sterilizations. This law does not apply to non-profit, non-sectarian hospitals open to the public. The mandates in New Jersey specifically regarding the practice of sterilization are related to Medicaid; these regulations detail a number of protective measures intended to ensure that the

individual undergoing sterilization has given her informed consent and is not being coerced. (N.J.S.A. §§ 10:52-2.13, 10:54-5.41, and 10:66-2.15.)

POTENTIAL QUESTIONS

1. Do the hospitals involved perform tubal ligations and/or vasectomies? How many does each perform per year?
2. How many women give birth at each hospital per year? For each hospital, what percentage of those women have tubal ligations at the time of childbirth?
3. Does each hospital counsel women with regard to tubal ligation? What if a patient requests a tubal ligation?
4. Do the hospitals provide tubal ligations other than for a patient admitted for childbirth? If so, how many does each perform per year?

INFERTILITY TREATMENTS

LEGAL BACKGROUND

While the State requires that certain insurance providers cover treatments for infertility, it does not require health care providers to offer infertility treatments. Medicaid does not cover infertility treatments unless they are being used for a purpose unrelated to becoming pregnant. (N.J.S.A. §§ 10:52-2.5(f), 10:54-5.15(b), and 10:66-2.5(a).)

QUESTIONS

1. Does the secular hospital provide any infertility services that will be lost when it closes? What kinds? How many women receive infertility services from the secular hospital?
2. Does the sectarian hospital provide infertility services? If so, what kinds? How many women receive services from the sectarian hospital?

EMERGENCY CONTRACEPTION

BASIC FACTS

Emergency contraception (EC) is a concentrated dose of hormones that can prevent pregnancy if taken shortly after unprotected sex. It is most effective when taken within 72 hours. The FDA has approved Plan B, the only approved EC in the U.S., as an over-the-counter medication for those 18 and older; minors need a prescription. (Guttmacher Institute, *State Policies in Brief: Emergency Contraception*, November 2006.)

Legal Background

All emergency health care facilities must provide each sexual assault victim with (1) medically and factually accurate and objective oral and written information about EC and sexually transmitted diseases (STDs); (2) an oral explanation of her option to receive EC at the health care facility; and (3) EC, if she so requests, unless it is contraindicated. The facility does not have to provide EC if the victim is pregnant. (N.J.S.A. § 26:2H-12.6c.)

All emergency health facilities must have written policies and procedures to ensure (1) that all relevant personnel are trained to provide the required information and EC on request to a sexual assault victim and (2) that personnel do in fact provide the required information and EC. (N.J.S.A. § 26:2H-12.6d.)

The State must develop, produce, and distribute to all affected facilities written information about EC and STDs. The information must be clearly written and readily comprehensible to a sexual assault victim and explain: (1) the nature and effectiveness of EC, where it can be obtained, and treatment options and (2) the symptoms and effects of STDs and treatment options. (N.J.S.A. § 26:2H-12.6e.)

Potential Questions

1. How many victims a year are treated at the hospitals for harms caused by sexual assaults?
2. What are the hospitals' written policies and procedures on EC?
3. Do the hospitals provide information on EC to any patients? In what circumstances?
4. Do the hospitals provide EC to any patients? In what circumstances?

Abortion

Basic Facts

In the United States, most women who terminate their pregnancies do so in the first trimester (88.6%). For those women who have an abortion after the first trimester, 6.4% terminate between 13 and 15 weeks, 3.8% between 16 and 20 weeks, and 1.2% after 20 weeks. (Guttmacher Institute, *In Brief: Facts on Induced Abortion in the United States*, May 2006.) Most abortions nationally take place in abortion clinics (71%); others occur in other types of clinics (22%), hospitals (5%), and private doctors' offices (2%). (Guttmacher Institute, *State*

Facts About Abortion: New Jersey, 2006). While most abortions do not occur in hospitals, women may need to be treated in a hospital because they are too sick or high-risk for outpatient surgery or because of complications during an abortion. In New Jersey, 31% of pregnancies end in abortion. (Guttmacher Institute, *Contraception Counts: New Jersey*, March 2006.)

New Jersey has the 16th highest rate of teenage pregnancies in the U.S. Of the 23,080 teenage pregnancies in New Jersey in 2000, 53% ended in abortions. (Guttmacher Institute, *Contraception Counts: New Jersey*, March 2006.) Because of a variety of factors, teenagers are more likely to have later abortions, when medical risks associated with the procedure are significantly higher. (Guttmacher Institute, *In Brief: Facts on Induced Abortion in the United States*, May 2006.)

LEGAL BACKGROUND

The Board of Medical Examiners (Board) has promulgated regulations governing the provision of abortion services. The regulations delineate, based upon the stage of pregnancy, the skills and experience necessary for an individual to perform an abortion and the standards required for a facility to provide abortion services. Only licensed doctors can perform abortions. After the first trimester (up until 14 weeks LMP (from the last menstrual period) or 12 weeks gestational age), any termination procedure other than the most common one -- dilation and evacuation (D&E) -- must be performed in a hospital. Between 15 and 18 weeks LMP, a D&E procedure can be performed in a hospital or licensed ambulatory care facility (LACF). To perform abortions for women between 19 and 20 weeks LMP, an LACF must demonstrate to the Board that it and the doctor performing the procedure satisfy a number of criteria, including that the doctor must have admitting and surgical privileges at a nearby hospital with an operating room, blood bank, and intensive care unit, and this hospital must be accessible within 20 minutes' driving time during the usual operating hours of the clinic. To end a pregnancy after 20 weeks LMP, a doctor must receive permission from the Board to perform a D&E in an LACF and satisfy stringent requirements. (N.J.A.C. §13:35-4.2.)

The New Jersey Conscience Law prohibits any individual, hospital, or other health care facility from being required to perform an abortion. This law does not apply to non-profit non-sectarian hospitals open to the public. (N.J.S.A. §§ 2A:65A-1 to -3.)

Minors, like adults, have a constitutional right to obtain abortions. *Planned Parenthood v. Farmer*, 165 N.J. 609 (2000). A married or pregnant minor can consent on behalf of herself or

her child to medical care or surgical procedures by a hospital or doctor. (N.J.S.A. § 9:17A-1.) A pregnant minor does not need the consent of her parent(s) for abortion, prenatal care, or childbirth services. *Farmer*, 165 N.J. 609.

POTENTIAL QUESTIONS

1. Does the sectarian hospital have any affiliations with abortion providers?
2. Does the secular hospital have any affiliations with abortion providers?
3. If the sectarian hospital will not take affiliations, will another hospital willingly affiliate with and satisfy the 20-minute driving requirement from all facilities in the area that provide abortions after 18 weeks LMP?
4. Will the consolidated or surviving hospital admit women for abortions if they are too sick or high-risk to be treated in any available outpatient setting? If so, will the hospital require some review process and case-by-case determination to justify the admission?
5. Will the consolidated or surviving hospital admit women with abortion complications? Will the hospital allow the medical staff to complete an incomplete abortion? Will the hospital admit and treat such patients as a matter of course or only after some review process and case-by-case determination?

HIV/STD/CONTRACEPTIVE COUNSELING AND SERVICES

BASIC FACTS

Clinics associated with hospitals often provide general health care, including services related to family planning, STDs, and HIV/AIDS. These services include counseling, testing, and contraceptive services. Religious restrictions may affect a number of services upon which the community relies, such as contraceptive counseling and services (prescriptions, condoms, IUD insertions, Depo-provera shots, etc.) and provision of condoms for STD and HIV/AIDS risk reduction.

LEGAL BACKGROUND

New Jersey mandates HIV/AIDS counseling or testing only in limited circumstances. The primary health care provider for a pregnant woman or a woman who has given birth in the past four weeks, or a doctor who makes a diagnosis of pregnancy, must provide the patient with information on HIV and offer testing. When advising a patient about test results, the doctor must make every effort to counsel the patient on a number of issues, including methods to prevent transmission. If the provider "cannot follow through" with counseling or further care, then the

doctor must refer the patient to someone who can and will provide counseling and care. (N.J.S.A. § 26:5C-16; N.J.A.C. § 8:61-4.1.)

Minors, like adults, have a constitutional right to obtain contraceptive services. (*Carey v. Population Services*, 431 U.S. 678 (1977); *Planned Parenthood v. Farmer*, 165 N.J. at 635.) A minor may consent to medical or surgical services if she is pregnant or married; if she thinks that she has an STD; if she is at least 13 years old and is or thinks she is infected with HIV or has or thinks she has AIDS; or if her treating doctor believes she was sexually assaulted. (N.J.S.A. §§ 9:17A-1, 9:17A-4.)

Certain funding streams also require confidential counseling and services. For example, Title X of the federal Public Health Service Act requires that providers receiving funds offer an array of confidential contraceptive services. (42 U.S.C.S. § 300(a); 42 C.F.R. § 59.11.) Certain grants under the Ryan White CARE Act require that a grantee provide counseling both before and after testing on how to avoid exposure to and transmission of HIV. (42 U.S.C.S. § 300ff-62.) A Ryan White grantee must agree that it will carry out all testing for HIV disease (including testing *not* funded through the federal grant program) in accordance with the counseling mandate and other requirements of the Act. (42 U.S.C.S. § 300ff-63.)

Potential Questions

1. What services related to STDs, HIV, and contraception will be lost with the consolidation or dissolution of the secular hospital? What services will survive?
2. Does the secular hospital have a teen client population at its clinics? For what services?
3. Does the sectarian hospital have a teen client population? For what services?
4. What funding streams support any STD, HIV, or contraceptive services at the hospitals?

Potential Confidentiality/Parental Notification Concerns

Basic Facts

While confidentiality is important in health care generally, it is particularly important in treating minors. Studies over the past 30 years have consistently demonstrated the importance young people place on confidentiality when it comes to reproductive health issues. Studies have also shown that without confidentiality, young people will often forego important health services, placing their health and well-being in danger. (Cynthia Dailard et al., *Teenagers'*

Access to Confidential Reproductive Health Services, The Guttmacher Report on Public Policy, November 2005.)

LEGAL BACKGROUND

Doctors (and others licensed by the Board) must maintain the confidentiality of treatment records and cannot release records except to a patient or her authorized representative, which in the case of a minor is her parent or guardian. A parent or guardian, however, is not considered an "authorized representative" for the purposes of treatment related to pregnancy (including prenatal care or abortion), STDs, or substance abuse unless explicitly designated by the minor patient. (N.J.A.C. § 13:35-6.5.) Marriage and family therapists, alcohol and drug counselors, psychologists, and social workers are not required to release records or information about a minor if they are related to termination of pregnancy, STDs, or substance abuse. (N.J.A.C. §§ 13:34-18.3(h), 13:34C-4.3(h), 13:42-8.6(b), 13:44G-12.4(a)(1)(i).)

A minor receiving services from a Medicaid provider has a right to confidential reproductive health care. (42 U.S.C.S. §1396d(a)(4)(C); 42 C.F.R. §§431.301, 431.305, 440.240(b), 440.250(c); N.J.A.C. § 10:49-9.7.)

A minor does not have the right to confidentiality in all circumstances, however. The attending doctor of a minor who appears to have been sexually assaulted must notify her parents immediately unless the doctor believes that it is not in the best interests of the child. (N.J.S.A. § 9:17A-4.) Upon the direction of a treating doctor, medical staff may, but are not required to, notify a minor's parent about the treatment given or needed without a minor's consent and even against her express wishes. (N.J.S.A. § 9:17A-5.)

POTENTIAL QUESTIONS

1. What is the sectarian hospital's policy with regard to confidentiality in treating minors? Under what circumstances would the hospital involve a parent or guardian over the minor patient's objection?
2. What is the secular hospital's policy with regard to confidentiality in treating minors? Under what circumstances, if any, has the hospital involved a parent or guardian over the minor patient's objection?

End of Life

Basic Facts

When an individual is in the hospital, a number of issues may arise relating to the end of life. The Directives outline the ethical norms prescribed by the Catholic Church for determining whether or not to use procedures designed to prolong life. Life-sustaining treatments that may be implicated include artificial nutrition and hydration (feeding tube), mechanical ventilation, renal dialysis, cardio-pulmonary resuscitation, and antibiotics.

Legal Background

A hospital must ask at the time of admission and at other appropriate times whether a patient has an advance directive (AD) and where it is located. (N.J.S.A. §26:2H-65(a)(1); N.J.A.C. § 8:43G-5.2(a)(5).) An AD outlines a patient's advance treatment decisions in the event that she cannot speak for herself. A hospital must provide interested patients and families with information about ADs and assist them in discussing and executing ADs. (N.J.S.A. § 26:2H-65(a)(2); N.J.A.C. § 8:43G-5.2(a)(10).) A hospital must also advise its patients and their families of its policies regarding withholding and withdrawing life-sustaining treatment. (N.J.S.A. § 26:2H-65(b); N.J.A.C. § 8:43G-5.2(a)(10).) If a patient has an AD, it must be entered in the medical record, and medical professionals treating the patient must be notified. (N.J.A.C. § 8:43G-5.2(a)(7) and (8).)

A private, religiously affiliated health care institution that declines to participate in withholding or withdrawing life-sustaining measures must establish written policies defining the circumstances in which it will decline to participate in such actions. (N.J.S.A. § 26:2H-65(b); N.J.A.C. § 8:43G-5.2(a)(4)(i).) The policies and practices must be communicated to the patients and families before a patient's admission or as soon after as possible. (N.J.S.A. § 26:2H-65(b); N.J.A.C. § 8:43G-5.2(a)(4)(ii).) If there is a conflict between a hospital's policies and the legal rights of the patient, and a resolution is not possible, the institution must take all reasonable steps to transfer the patient to another institution that can accommodate the patient's needs in an appropriate, timely, and respectful manner. (N.J.S.A. § 26:2H-65(b); N.J.A.C. § 8:43G-5.2(a)(4)(iii).) Doctors, nurses, and other health care professionals may decline, based on sincerely held convictions, to participate in withholding or withdrawing measures used to sustain life. (N.J.S.A. §§ 26:2H-62(b) and (c).)

POTENTIAL QUESTIONS

1. Do the hospitals discuss ADs with patients? Assist them with execution? How many per year?
2. Do the hospitals follow ADs?
3. How do the hospitals advise families considering whether to disconnect a loved one from life support if there is no legally binding document?
4. Would the hospitals follow an instruction to withhold nutrition and hydration?
5. Do the hospitals have sufficient staff members who are willing to participate in the procedures necessary to withdraw life support?
6. What are the hospitals written policies on these issue?

CONCLUSION

The expansion of sectarian hospitals, through consolidations with or takeovers of secular hospitals, can result in the loss of reproductive health and end-of-life services. A community seeking to maintain or improve its access to comprehensive, hospital-based care should ascertain what services are at risk and devise strategies for preserving those services.