

August 5, 2013

Janis Sigman, Program Manager
Washington State Department of Health
Certificate of Need Program
Mail Stop 47852
Olympia, WA 98504-7852
Via email to: fslcon@doh.wa.gov

RE: Input for Revising the Certificate of Need Process

Thank you for accepting comment/encouraging a public dialogue regarding the changes needed to modernize the Certificate of Need process.

Dear Ms. Sigman:

I am the co-chair of Washington Women for Choice, was raised as the eighth born child in a very Catholic family, and have been an outspoken activist on issues related to hospital mergers/religiously-based restrictions since finding out back in 2011 that my personal doctor, who worked for Swedish, would be prohibited from doing abortions because of a pending deal with Providence.

The reason I instantly became so alarmed back in 2011 when I first heard of the Providence/Swedish deal is because I have a deeply personal understanding of the consequences of religious health restrictions: The best friend of one of my sisters died after having been denied an abortion or chemotherapy in a Catholic hospital. My sister's friend was newly pregnant when her cancer was diagnosed, and because abortion was strictly prohibited at the Catholic hospital she entered, she was never given the option to undergo an abortion. Because of the potential risk to the fetus, no chemo was started either. This happened decades ago, and it left a very deep impression on me.

I also happen to own a home on San Juan Island, and thus subsidize the new PeaceHealth-owned and operated hospital/medical facility in Friday Harbor through my property taxes. In Spring of 2012, I was alerted that PeaceHealth had approached Planned Parenthood in Bellingham to say that the bishop wanted them to stop doing lab services for Planned Parenthood patients, an action that caused me to investigate the contract under which the new hospital on San Juan Island would be operated and funded. After getting access to the agreement between PeaceHealth and the San Juan Island hospital district commissioners through a public records request, I asked the ACLU to review it as well. I subsequently drafted and was one of more than a hundred signatories to a letter asking State Senator Kevin Ranker to seek an opinion from the Attorney General with respect to whether the agreement entered into by the hospital district commissioners on San Juan Island with PeaceHealth violated WA state law or the Washington State

Constitution. (A formal AG opinion as to whether the provisions of the Reproductive Privacy Act were violated is in the works.)

Having spent a lot of time on these issues in my roles as an activist, taxpayer, patient, and concerned citizen, here are the situations I believe a revised Certificate of Need process needs to address:

- **Misrepresentations about governance structure that will apply once a transaction is completed and misrepresentations about what services will and won't be provided over the life of any contracts with public entities.**
 - As an example, with the Swedish/Providence transaction, Swedish officials were very clear in saying prior to the deal's completion that it was an "affiliation" and that Swedish would remain secular and largely independent, and that the only service affected would be "elective" abortions. As a result of the completed transaction, Swedish now is a division within Providence, reporting up a chain of command that is subject to the Catholic bishops' "moral" authority. "Swedish" is now described internally as a brand within the broader Providence family, and the legal, ethics, HR, and communications functions/departments (among others) between the Providence and Swedish brands have been co-mingled. This is completely contrary to what was represented before the transaction was finalized. (I have first-hand knowledge, having met with senior Swedish officials, together with other activists, both before and shortly after the deal was completed.)
 - From conversations with Swedish patients, physicians, and staff, I know that women are not able to get abortions even in situations where Swedish doctors believe it is the best thing to do medically, e.g., when a miscarriage is underway or when there are severe fetal abnormalities. (Read Cienna Madrid's 2/20 story in *The Stranger*; the patient "Mary" is someone I know; her deeply personal story only came to light because I suggested sharing it would make a difference for other women.) Instead of a doctor being able to provide services based on what's best for a patient, Swedish doctors are bound by organizational prohibitions (no nonemergency abortions when there's a fetal heartbeat, e.g.) that are contrary to best medical care standards. The net effect is a compromised health system with a culture that fosters secrecy and shame and that results in reproductive-age women not getting the best care possible.
 - On San Juan Island, where I live part-time and pay taxes to support the new Catholic owned and run hospital/medical facility, PeaceHealth officials have said that "No services are being lost (from what was offered previously at InterIsland Medical Center) and that "what happens between a doctor and patient is absolutely private."

This is a combination of nonsense and doublespeak that defies common sense. PeaceHealth says on its website that it follows the Ethical and Religious Directives for Catholic Health Care. And very specifically and adamantly, PeaceHealth physicians and anyone who practices in the PeaceHealth PeaceIsland facility under a lease agreement (as an ob-gyn from Anacortes does currently) is prohibited from assisting patients who want to exercise their rights under Washington's Death with Dignity Laws, is prohibited from performing abortions, and is prohibited from doing "research" that may make use of embryonic stem cells. Furthermore, according to PeaceHealth CEO Nancy Steiger, all of the physicians that were hired from the previous Interisland Medical Center in Friday Harbor were specifically questioned prior to being employed by PeaceHealth whether they had EVER performed abortions or participated with Death with Dignity. The truth is that PeaceHealth's ownership and control means that physicians who previously provided abortion services or assisted with Death with Dignity (and who should have an absolute right to not disclose whether they ever did or did not to a prospective employer) can no longer do what they believe is in the best interests of their patients. They also cannot enroll their patients in clinical trials where potential treatments are derived from embryonic stem cells. And as to respecting the "sanctity" of the doctor/patient relationship, PeaceHealth violates it every day by requiring physicians to provide services in conflict with best practices as recommended by the American Congress of Obstetricians and Gynecologists. It's also absurd to say that what happens between a patient and doctor is strictly and completely confidential even from hospital administrators in an era of electronic medical records and integrated care.

Recommendation: The Department of Health should require disclosure statements from all parties to a Certificate of Need Process regarding current or potential restrictions to health care. A question that may get at this: "Are physicians or staff ever prohibited from providing and/or referring patients to legal medically indicated services for reasons rooted in religious doctrine? An example would be any restrictions by policy on contraception or abortion or on assisting patients to exercise their rights under Washington's Death with Dignity Act? Explain."

For now, chief executives of health care corporations seeking Certificate of Need approval should be required to disclose, under penalty of law, what restrictions will apply to reproductive health care, to end-of-life care, and to treatments that are derived from embryonic stem cells over a ten-year term. New statements should be gathered at 10-year intervals from all major health care corporations operating in the state. Any changes to such policy statements should

be subject to the review of the DOH, with the potential for the Certificate of Need to be revoked for any material misrepresentations.

The department should also consider tracking with the National Institute of Health and/or other health care oversight entities to consider when or whether it makes sense to require facilities to more broadly or even more specifically disclose whether they impose any other restrictions for religious reasons. E.g., Jehovah's Witness adherents may not support blood transfusions. If and when a major health care network that operates subject to the principles of the Jehovah's Witness faith tradition starts to operate in this state, it may make sense to ask about blood transfusions. Similarly, hospitals that make policy based on other religious faiths may limit distribution or use of porcine products or bovine products in medical interventions. (E.g., thyroid dysfunction is often treated with porcine-based medicine.) The focus now is on Catholic health care because of the huge number of Catholic owned and run- health care entities in WA State, but over time, the DOH should be vigilant in ensuring that religious-based restrictions of any kind do not interfere with the rights of patients to access medicine that is consistent with the best care standards of leading medical groups.

Consumers and even major purchasers of health care have no way of knowing what kind of organizational restrictions on appropriate, legal services are in place now, nor how restrictions might change or be imposed for a given facility as a consequence of a change of ownership or control.

- I've met with senior executives from some of Washington's major employers and they have assured me privately that they want their employees to be able to access all medically appropriate, legal services easily and cost-effectively and with complete transparency and disclosure. When told about the restrictions required by compliance with the Ethical and Religious Directives for Catholic Health Care, these senior corporate officials were aghast. None of the senior corporate leaders I met with in late 2012 or early in 2013 were aware that large Catholic medical systems/hospitals in Washington State, including those that aggressively market ob/gyn services, forbid common services including tubal ligations, vasectomies, and even contraception. As a senior executive said to me, "How can this be? Why would anyone condone forcing a woman who needs a Cesarean section and who wants a tubal ligation to have to undergo a completely separate operation and a second round of anesthesia somewhere else?" And when I described what happens in the case of ectopic pregnancies in hospitals that strictly follow the ERDs, there were audible gasps. (Women with ectopic pregnancies admitted to hospitals like Franciscan that follow the ERDs strictly are told the

Fallopian tube must be removed; in facilities not subject to the ERDs, the preferred treatment for ectopic pregnancies in “simple” cases is the administration of methotrexate; more invasive procedures occur only as medically indicated and appropriate.)

It’s clear that private companies are beginning to understand that if they are complicit in allowing a women’s fertility to be compromised unnecessarily because of agreements they make with institutions that restrict services for religious reasons not shared by the patient, there is moral and may be legal liability. Similarly, if a patient is forced to endure multiple procedures at different facilities because of institutional prohibitions based on religious beliefs that are not even disclosed, there is moral and may be legal liability.

It’s my belief that the state has a responsibility to avoid moral or legal complicity with any situation where a patient is denied medically appropriate care or is forced to face undue financial hardship because of religious objections that conflict with best standards of medical care.

Recommendation: The Department of Health should publish a report card annually that lists the 10 major health care providers/entities in the state by revenue and acute care bed count, and what restrictions, if any, are imposed on medical/procedures/interventions for faith-based reasons. At a minimum, this report card should summarize any restrictions on ob-gyn and reproductive health care, on whether or not a patient’s legal health care directives will be honored without restriction, and on whether physicians can assist patients in exercising their rights under Death with Dignity without restriction.

Furthermore, because religious restrictions (against abortion or tubal ligations, e.g.) can result in an undue financial burden on patients, consumers, and other health care purchasers (including the State – which pays for a huge percentage of new births), health-care entities should be required to list the 20 most common health procedures for ob-gyn care and the average costs for those procedures over the past three years. The cost data and the restrictions data can help reproductive age patients and health care purchasers to make much better, more informed decisions about where to receive ob-gyn care.

Similarly, health care providers should have to disclose on their web site, in a prominent place, whether they allow, without restriction, physicians to assist patients in exercising their rights under Washington’s Death with Dignity Law.

The bottom line is that the Department of Health has a responsibility to see that the rights of Washingtonians as patients and as taxpayers are respected, both at the time a proposed transaction is under review and as transactions that have already been approved are implemented. Washingtonians should be able to access care in the communities where they live consistent with standards of care advocated by leading medical professionals, with due regard for constraints due to economic or logistical factors.

On San Juan Island, for example, it is not appropriate to require that the new hospital provide neurosurgery, but it defies reason and fairness that the new hospital/medical facility should be a step backwards for reproductive-age patients who need and want access to reproductive health services consistent with best medical care standards advocated by leading medical professionals, including the American Congress of Obstetricians and Gynecologists.

Similarly, in a county like San Juan where the number of residents over age 65 is almost twice the average of the state as a whole, and where 75 percent of voters supported the Death with Dignity Initiative, it defies reason that residents should systematically be denied access to end-of-life services, including counseling and referral for services consistent with Death with Dignity, at the only taxpayer-subsidized health care facility in the area.

Overall, the Department of Health should take seriously its responsibility to ensure that the needs and rights of patients and taxpayers throughout the state are respected in an ongoing and systematic manner both at the time a transaction is contemplated and as it is implemented over the life of any agreements with state agents or agencies. Some of the subsidy agreements now in force span 50 years; the timeline for regulatory oversight to ensure compliance with state law should be at least as long.

Sincerely,

Monica Harrington

Cc: Governor Jay Inslee
Attorney General Bob Ferguson
State Senator Kevin Ranker
Additional media contacts