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January 27, 2020

Dear Regents,

Please find attached the Working Group on Comprehensive Access (WGCA) Chair's Report of Findings and Recommendations. The topic of whether and how the University affiliates with organizations that have policy-based restrictions on care has been of great interest to the University for the past several months. Indeed, while I had hoped the Working Group, under Chancellor Gillman's highly-regarded leadership, might identify a common set of recommendations values, and guidelines to govern these affiliations, in fact the Working Group did not arrive at a consensus, nor did all members feel they could endorse the final report. Following the transmittal of the Chair's report on December 20th, several members submitted additional letters further stating their perspectives and in some cases raising additional questions. These letters, along with a legal analysis from Deputy General Counsel Nosowsky, have been appended to the attached report.

The Working Group contributed significant time, effort and thought to this issue and I appreciate the dedication of every individual, including Regent Lansing, for the thoughtful and comprehensive feedback on this issue.

As referenced in the report, a more thorough analysis of the impacts associated with current and potential future affiliations, including affiliations with employee health plan providers, is recommended before any decision is finalized. Therefore, I have tasked Dr. Carrie Byington, in her roles as the Executive Vice President of UC Health and Chair of the Executive Steering Committee on Health Benefits Programs, with conducting additional fact-finding regarding potential impacts on patient care, teaching and university financials, both between UC Health and other health providers and within our employee health plans.

Tomorrow, Tuesday January 28th, we will initiate the public consultation process by posting the attached document on the WGCA website. Until then, the report, accompanying letters, and legal opinions are embargoed.

Comments will be requested via a web-based form on the WGCA website or emailed to me directly at president@ucop.edu. We will compile the feedback and impact analyses over the coming months and I will then be prepared to make a recommendation to the Board for its consideration at the May regents meeting.

I welcome your thoughts and opinions on this matter and look forward to hearing from you in the coming weeks as we all move forward on this very important issue.

Sincerely,

Janet Napolitano
President

UNIVERSITY OF CALIFORNIA

Working Group on Comprehensive Access Chair's Report of Findings and Recommendations with Responses from Working Group Members and UC Legal

Published: 1/28/2020

Note: Separate materials submitted to the President of the University of California have been merged into one document for ease of review.

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UCI University of California, Irvine

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December 18, 2019

The Honorable Janet Napolitano
President
University of California
1111 Franklin Street, 12th Floor
Oakland, California 94607-5200

Dear President Napolitano:

I hereby transmit the Chair's Report of Findings and Recommendations of the Working Group on Comprehensive Access (WGCA).

The members of the WGCA made extraordinary efforts to prepare a document that all members could endorse. Unfortunately, despite our best efforts, a number of members informed me yesterday that they could not associate themselves with this document. All members had previously agreed that under that scenario the document would be submitted as a chair's report rather than as a report of the full working group. We also agreed that any member of the group who wished to explain their non-endorsement and offer independent advice would be free to write to you directly.

The members of the WGCA worked tirelessly, reviewing extensive materials and engaging in vigorous discussion and debate. I am grateful to them all for their service and dedication to the University. The members of the Office of the President who assisted our efforts as staff and university counsel went above and beyond the call of duty, often spending late nights and weekends on this effort. To them I offer my deep admiration and respect, as well as the gratitude of the working group.

You will see that the report presents two options for the values, principles, guidelines, and compliance/monitoring efforts that should govern UC Health affiliations with non-UC organizations. I believe that the report provides the background and analysis to assist the University in choosing between these options or choosing the best among these options. The

members of the working group agree that there should be a broader solicitation of input from internal and external stakeholders before a final decision is made. There is more information about how the report reflects the views of working group members in the "Message From the Chair" at the beginning of the report.

It is to the great credit of the University of California that we are discussing and debating these important and consequential issues, and I commend you for convening this group.

Respectfully submitted,

Howard Gillman
Chair, Working Group on Comprehensive Access
Chancellor, University of California, Irvine

Enclosure

WORKING GROUP ON COMPREHENSIVE ACCESS

CHAIR'S REPORT OF FINDINGS AND RECOMMENDATIONS

12-20-2019

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Participants[1]

Working Group Member	Title	Campus/Organization
Kum-Kum Bhavnani	Academic Council Chair	Academic Senate
Carrie L. Byington[2]	Executive Vice President	UC Health
Howard Gillman (Chair)	Chancellor	UCI
Michele Goodwin	Chancellor's Professor of Law	UCI
Gabriel Haddad	Chair of Pediatrics / Physician-In-Chief and CSO	UCSD/Rady Children's Hospital
Sam Hawgood	Chancellor	UCSF
Sandra Hernandez	External Advisor, Health Services Committee	Advisor to Board of Regents
Steven Hetts	Advisor to Health Services Committee and Chief of Interventional Neuroradiology	Advisor to Board of Regents/UCSF
Vanessa Jacoby	Associate Professor of Obstetrics, Gynecology, and Reproductive Sciences	UCSF
Sherry Lansing	Regent, Chair, Health Services Committee	Board of Regents
Mark Laret	President and Chief Executive Officer	UCSF Health
Donald Larsen	Chief Executive Officer	UCR Health
David Lubarsky	Vice Chancellor and Chief Executive Officer	UCD Health
Robert May	Academic Council Past Chair	UC Academic Senate
Kelsey Martin	Dean	UCLA School of Medicine
Advisory Member		
John Stobo	Past Executive Vice President	UC Health
Staff		
Michael Crawford	Director of UC Health Communications	UCOP
Elizabeth Engel	Chief Strategy Officer	UC Health
Eileen Foster	Sr. Program and Strategy Manager	UCOP
Claire Holmes	SVP External Relations and Communications	UCOP
Zoanne Nelson	AVP and Chief Strategy Officer	UCOP
University Counsel		
Daniel Gerber	Principal Counsel – Health Affairs	UC Legal
Rachel Nosowsky	Deputy General Counsel – Health Affairs and Technology Law	UC Legal

[1] Participation in the working group does not denote endorsement of the statements in the chair's report.

[2] Dr. John Stobo and Elizabeth Engel were replaced by Dr. Carrie L. Byington effective 10/31/2019 upon her transition into the role of EVP UC Health

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MESSAGE FROM THE CHAIR

In August of 2019 President Napolitano charged members of the Working Group on Comprehensive Access to develop recommendations that "would ensure UC's values are upheld when its academic health systems collaborate with other health systems" and "to ensure that UC personnel will remain free, without restriction, to advise patients about all treatment options and that patients will have access to comprehensive services."

For three months the members of the working group vigorously discussed and debated how best to respond to the president's charge. The members reviewed a wide range of materials, perspectives, and arguments.

While there was important agreement on many issues, it was clear early on that the working group was divided on a central question, which we all agreed was best described as follows: "Whether UC should affiliate at all with organizations whose institutional policies (a) prohibit the use of contraception, abortion, assisted reproductive technology, gender-affirming care for transgender people, and the full range of end-of-life options and (b) permit non-clinicians to make clinical decisions affecting the health and safety of individual patients irrespective of the professional judgment of health care providers and/or the informed decisions of patients."

Some members of the working group believed that such policy-based restrictions on care raised sufficient concerns that UC should not affiliate with such an organization. Others believed that the University should be allowed to pursue such affiliations under new principles and guidelines designed to be fully responsive to the president's charge.

The working group went through many iterations of a report, and I personally made every effort to accommodate the perspectives and concerns of all sides. Nevertheless, some working group members were not prepared to stand behind the document. At our last working group meeting, a few days before the submission deadline, I was urged by all sides to attempt one final draft, whereby each side would be free to offer its own separate set of values, principles, and guidelines which might govern UC Health affiliations with non-UC organizations. The agreed-upon plan was to have a report that identified two possible options moving forward and provided the University enough background to assess how best to proceed. Over the next few days each side presented their preferred language for values, principles, guidelines, and compliance/monitoring, and their suggestions were incorporated.

As agreed by the Working Group, upon completion of this final version, each member would indicate whether or not they could endorse the report, and if a sufficient number of members decided not to endorse, then the report would become the "Chair's Report of Findings and Recommendations" of the Working Group on Comprehensive Access rather than a report of the working group itself. After being informed that some members had decided against endorsement, I made slight edits to the last draft of the report in order to take out language that suggested it represented the views of the entire working group.

Readers should know that (a) the language used to describe the main point of disagreement was supported by every member of the working group, (b) the sections of the report outlining the arguments on both sides of this issue were overwhelming proposed or edited by each side, and (c) the proposed options were written by the individuals who were most committed to their preferred option. Thus, with

respect to the main responsibilities given to the working group — in particular the task of providing written recommendations regarding the terms under which UC academic health systems may enter into affiliations with other health systems—each sides' views are represented in this Chair's Report.

I am making no recommendations as chair on how the University should proceed. From the beginning I viewed my role as facilitating important conversations, clearly identifying the issues, being respectful of all sides of the debate, finding any points of agreement, and producing a report that would be of some service. I submit this report in the hope that it assists the University in its deliberations, and is a useful part of a larger process of soliciting input from a wide range of stakeholders. No single report will adequately and comprehensively capture all the perspectives and arguments that should be considered.

The issues associated with affiliations and comprehensive access are of great importance. Ultimately, these are matters of core values and fundamental principles. People of goodwill who have dedicated their lives to acting with the highest integrity in serving patients and advancing public health can hold passionately divergent views on the proper way of proceeding. Academic medical centers around the country routinely make decisions about these questions without inviting the larger debate about core values and fundamental principles. It is to the great credit of the University of California that we are discussing and debating the right questions. In so doing, we will not only be more intentional in our own practices, but hopefully can help deepen and improve the national conversation.

Respectfully submitted,

Howard Gillman
Chair, Working Group on Comprehensive Access
Chancellor, University of California, Irvine

EXECUTIVE SUMMARY

INTRODUCTION

In August 2019, the President of the University of California (UC) appointed the Working Group on Comprehensive Access (WGCA) "to ensure UC's values are upheld when its academic health systems collaborate with other health systems" and "to ensure that UC personnel will remain free, without restriction, to advise patients about all treatment options and that patients will have access to comprehensive services." The Working Group was asked to produce policy recommendations that protect academic freedoms, enable appropriate care regardless of a patient's presenting location, and encompass respect for a diversity of opinions. The WGCA, comprised of a UC regent, chancellors, deans, faculty, Academic Senate representatives and health leadership, was provided 90 days to review current practices and recommend improvements.[3]

The WGCA engaged in detailed and extensive deliberations, reviewing a broad range of materials and viewpoints. The following report outlines the recommendations made by various members of the WGCA and identifies issues and areas where members did not reach agreement.

RECOMMENDATIONS

1. The members of the working group are divided on the value statements, principles, and guidelines that should govern UC Health affiliations with non-UC organizations. Two options have been developed and are presented. The chair recommends adoption either of one of these two options or some best combination of the two.

   Each of the options is designed to:

   a. Memorialize UC's commitment to the highest levels of evidence-based care;

   b. Uphold our constitutional obligation to be independent of political and sectarian influence in the administration of our affairs;

   c. Advance our commitment to promote diversity, practice inclusion, and fight discrimination;

   d. Fulfill our public service mission to expand access to care and reduce disparities in access and outcomes;

   e. Improve the overall quality of care;

   f. Protect academic freedom; and

   g. Align our actions with the University's fundamental mission and values.

   However, the options differ with respect to the basic question of whether UC should affiliate at all with organizations whose institutional policies (a) prohibit the use of contraception, abortion, assisted reproductive technology, gender-affirming care for transgender people, and the full range of end-of-life options and (b) permit non-clinicians to make clinical decisions affecting the

[3] University of California Office of the President. *UC President Convenes Group to Develop Recommendations Regarding Terms of Agreements with Other Health Systems.* August 2, 2019.

health and safety of individual patients irrespective of the professional judgment of health care providers and/or the informed decisions of patients.

For some WGCA members, such institutional policy-based restrictions on care are sufficient bases for prohibiting any UC affiliation because they discriminate against women and LGBTQ+ people, lead to poor health outcomes, decrease access to services that lower the quality of care for UC patients in these facilities, compromise UC physicians' ability to practice medicine based on scientific evidence, and deny patients' autonomy in decision making. For other WGCA members, such affiliations are necessary to train our clinicians, improve access to UC quality care especially for underserved populations, mitigate health disparities, support population health management, and dedicate the specialized care of our medical centers to those patients who most need them. These members recommend that the University be allowed to pursue such affiliations under guidelines designed to ensure that UC personnel comply with all UC policies and values in whatever location they practice and that patients in such settings have greater access to comprehensive services.

On this issue the chair has summarized, after extensive input from working group members, the main arguments on either side of this important question, in order to facilitate continued deliberation at the University level.

2. To ensure compliance with the chosen principles and guidelines governing affiliations, members of the working group have proposed two options for how UC Health locations might (a) engage in a set of prerequisites before affiliations are entered into and (b) adopt effective monitoring mechanisms to ensure ongoing compliance with principles and guidelines.

3. The members of the working group also recommend gathering additional input from the University community, key external stakeholders and the broader public until deliberations and decisions are completed by the President and Board of Regents on the principles and guidelines that should govern UC Health's affiliations with non-UC health services organizations.

BACKGROUND

The University of California operates the largest training program in the state for health professionals. UC's medical students, residents and other trainees broaden their educational and field experience by rotating through a variety of settings, including non-UC facilities. UC's clinical expertise is often sought out by other health care organizations to strengthen or augment clinical capabilities and enable the provision of cutting-edge care and clinical trial access to thousands of people living in California closer to home than would otherwise be feasible, thus improving the quality of care and reducing health disparities. UC also provides services to underserved populations throughout the state, often in conjunction with other providers. UC clinicians practicing in some non-UC facilities are essential to emergency care and public health. UC clinicians at non-UC facilities may serve as the entry point to higher levels of care, facilitating timely and emergent transfers to UC for critically ill or otherwise complex patients whose medical problems can best be treated at tertiary or quaternary health care facilities. For all of these reasons, UC clinicians provide services at many non-UC facilities.

Last spring, the University withdrew from negotiations to expand its relationship with Dignity Health after widespread concerns were raised about Dignity Health's institutional policy restrictions on care,

which disproportionately limit care for women and LGBTQ+ patients and prohibit participation in the California End of Life Option Act. As a result of this discussion, the University began addressing the concerns raised by reviewing existing health contracts, implementing interim guidelines for health affiliations with organizations that have policy-based restrictions on care (see Appendix A), and establishing the WGCA.

The WGCA has been informed that UC Health acknowledges that the language used in many current and recently expired contracts with Catholic and Catholic-affiliated health care organizations appears to require UC personnel to adhere to the Ethical and Religious Directives for Catholic Health Care Services (ERDs) (see Appendix B) or Statement of Common Values (SCV) (see Appendix C) and that such language prohibits UC personnel from delivering some types of care and performing certain procedures at non-UC facilities guided by their own personal judgement and the informed decision of the patient. The University expects that its personnel working or training at any clinical site — whether or not it is owned or operated by the University — will always practice medicine and make clinical decisions consistent with applicable legal standards and the standards of care, using their own professional judgment and considering the needs and wishes of each individual patient.

The recommendations contained in this report are intended to expressly articulate the values that govern conduct and outline clear expectations and guidelines for arrangements under which UC faculty, staff or trainees provide health care services or receive training at non-UC facilities.

SCOPE AND DELIVERABLES

The members of the WGCA include a UC Regent, chancellors, deans, faculty, Academic Senate representatives and UC Health leadership. In the letters of invitation to join the working group, the members were tasked with "developing recommendations that will guide future collaborations to ensure that UC personnel will remain free, without restriction, to advise patients about all treatment options and that patients will have access to comprehensive services." The WGCA was provided 90 days to complete this task.

Specifically, the WGCA was charged with the following responsibilities:

- Identify common types of agreements between UC's academic health systems and other health systems where patient access to care might be limited due to policy restrictions on services provided, and provide an overview of the nature and number of current collaborations and potential areas of concern regarding patient access to care in training and health services agreements;

- Review current practices and relevant system-level policies applicable to training and health care services provided under UC's agreements with other health systems;

- Produce written recommendations regarding the terms under which UC academic health systems may enter into affiliations with other health systems to ensure patients under the care of UC personnel at outside facilities are not unduly constrained or delayed from accessing the care they need. These recommendations should include the following:

  - A statement of UC Health's core values that will govern its affiliations with other health systems to ensure appropriate patient access to care;
  - A set of affiliation guidelines to ensure that those values are incorporated into our academic health systems' agreements; and
  - A mechanism to oversee the implementation of these agreements to monitor compliance with agreed-upon terms.

- Consider whether future modifications to existing UC policy may be warranted based upon the work group's recommendations; and

- Provide insight and recommendations for further community engagement on this topic.

The group was also asked "to produce policy recommendations that protect academic freedoms, enable appropriate care regardless of a patient's presenting location, and encompass respect for a diversity of opinions."

UC HEALTH AFFILIATIONS

WHY AFFILIATE

The WGCA considered a number of arguments emphasizing the importance of affiliations between UC Health and non-UC Health entities.

According to UC Health leaders, although UC Health is one of the largest health systems in the state, access to our health facilities is limited by capacity and geography. Relationships with other health care organizations allow UC to care for more patients; improve the quality of care and available clinical options for people living in California (including UC employees and retirees); extend UC quality care to underserved areas of California; support population health management as required through the Affordable Care Act; dedicate the quaternary medical centers to those patients who most need them; offer more clinical trials – which may be a patient's last hope – to patient populations who otherwise would be unable to participate; and provide a diversity of training experiences to health professions students, residents and fellows, who, throughout their careers, will practice at a wide range of facilities, including county and community hospitals, Veterans Administration hospitals, primary care and specialty clinics, and a variety of ancillary services providers.

Many UC hospitals are consistently operating at or beyond capacity, and often are treating patients who do not require the exceptional specialized tertiary and quaternary care at which we excel and that is necessary to support our academic mission. Affiliations with lower-cost and lower-acuity providers can save UC Health inpatient beds for those who truly need our specialized services and can expand access to our services into communities not immediately adjacent to our hospitals. As one example: UC Davis could only accommodate approximately 6,000 of the 12,000 transfer requests it received last year.

For patients, affiliations with UC Health expand and improve the care they receive — both general services and UC-quality subspecialty care — in ways that otherwise would not exist in their communities

or with their existing health providers. These services are life-sustaining and life-saving for the people of California. Health leaders point out the following examples.

- UC Davis' joint venture cancer centers at Mercy Merced and Adventist Rideout allow UC to offer clinical trials to patients in regions that would otherwise have no access to these cutting-edge experimental treatments.

- UCLA provides stroke and heart services at hospitals in downtown Los Angeles, and also provides emergency department, urology, radiology, anesthesiology services, and hospitalists to Martin Luther King Jr. Community Hospital in Compton, CA.

- UCSF offers telestroke services to small and rural hospitals that would otherwise not have access to state of the art stroke care.

- UC San Diego Health has a management services agreement with El Centro Regional Medical Center which has significantly enhanced the delivery of high-quality health care to patients in the Imperial Valley, the poorest county in the state.

- UC Riverside provides cardiac imaging interpretation services in the Inland Empire to St. Bernadine's, which otherwise would not have access to those services.

- UC Irvine medical students, family medicine residents, and School of Medicine faculty operate the UCI Outreach Clinic in collaboration with the Lestonnac Free Clinic, a faith based freestanding clinic serving the uninsured, which offers health care, wellness education, social services, basic medications and referrals.

More generally, given that many HMO patients are unable to access care outside of the HMO's established network, affiliation agreements help optimize the care available to patients across California and extend the care that can be delivered from UC owned and operated facilities. These arrangements also lower costs for the health system and our health plans.

With respect to our educational mission, UC's own health systems do not currently have sufficient capacity to place all our clinical trainees (e.g., medical, nursing, and pharmacy students and residents) in UC-owned settings where they can obtain necessary field experience. Non-UC options are limited by the competitive framework and alliances of health care organizations that are part of the health ecosystem in the geographies surrounding our campuses. UC Riverside operates a community based medical school program without its own medical center; accordingly, the school of medicine relies solely upon affiliations to build its clinical platform for training medical students and residents. UC Davis partners with hospitals in rural Northern California to expose students and trainees to rural practice in critical access hospitals – helping to improve the very limited access to care plaguing the northern reaches of our state due to insufficient physician supply – and to provide a pipeline to place physicians in underserved areas.

UC Health locations are also operating within a health care marketplace that puts at risk the fundamental viability of unaffiliated health care entities, including the UC medical centers themselves. Government and private payers are rapidly divesting from the educational and research missions they once recognized as essential to a functioning and ever-evolving health delivery system. At the same time, they are reducing clinical reimbursement rates and increasingly emphasizing value-based care and

other financing models that require health systems to have large networks to serve far more individuals than a freestanding hospital or academic medical center can do on its own.

The Association of American Medical Colleges has concluded that academic medical centers have four options in the face of these pressures: "form a system; partner with others in a collaborative network model; merge into a system; or be prepared to shrink in isolation."[4] UC Health has increasingly focused on systemwide efforts to take advantage of its scale, but such efforts alone are insufficient to meet the challenges. There is no current consideration given to separating our medical centers from the University so that they can merge with other health systems. These changing dynamics in the health care environment have led the UC Health system to actively develop affiliations over the past decade.

Finally, other health systems are necessary participants in the University's employee health benefits plans, since the University's academic health systems cannot serve every community where UC employees and retirees are located.

COMMON TYPES OF AFFILIATIONS AND AGREEMENTS

In the health care setting, an affiliation is generally an agreement between institutions to collaborate on an initiative or to provide a specific service. In common use, an "affiliation" can be a very minor relationship, a significant integration or anything in between.

UC Health systems enter into many types of affiliations with other health systems. Generally, these can be categorized as follows:

- Clinical care services affiliations;
- Research affiliations, with or without clinical care services;
- Training affiliations, with or without clinical care services;
- Administrative or management services affiliations;
- Joint ventures, mergers and acquisitions, and other significant participations; and
- Insurance contracts that cover UC employees and retirees and support health care access.

Most UC Health clinical care services affiliations involve UC personnel providing services for other health care providers often at non-UC Health locations. For academic medical centers, affiliations with different health care systems often:

- Involve subspecialty care not normally offered in the community;
- Consolidate different categories of care in the most appropriate site (UC or non-UC) to improve access and enhance outcomes;
- Provide additional training sites for students and residents;
- Facilitate coordination of care and population health management;
- Provide more opportunities for community engagement in research and clinical trials;

[4] AAMC. *Advancing the Academic Health System for the Future*. 2014

- Set conditions to refer patients back to their original community providers; and
- Set conditions to transfer lower acuity patients that do not require the expertise/technology of an academic medical center to a more appropriate site of care.

About half of California's doctors and many nurses, nurse practitioners, pharmacists, dentists, and physician assistants are trained by UC. The University works with other health systems to facilitate short-term trainee rotations for purposes of educational diversity and to accommodate the number of trainees enrolled in its training programs. These rotations typically range from a few weeks to a few months in length.

CURRENT UC HEALTH AFFILIATIONS INVOLVING NON-UC ENTITIES THAT PROHIBIT CERTAIN SERVICES FOR WOMEN AND LGBTQ+ PEOPLE

The WGCA acknowledged that no hospital provides every health care service. Most hospitals lack the resources and/or patient volume to provide all services, and UC Health's expertise in services that are not commonly available in community hospitals attracts their interest in affiliating with UC Health. The WGCA was not concerned with affiliations with community hospitals that fail to provide certain services due to factors such as resources and geography. The WGCA was concerned, however, when a non-UC affiliate has *non-evidenced-based policy restrictions on care*, that is, a formal organizational decision that certain services should be prohibited, not because the hospital lacks resources to provide the services or that the services lack evidentiary validation in the clinical setting, but because the services are seen as inconsistent with the values or mission of the organization.

The WGCA considered the fact that – nationally and internationally – many organizations with which the University may wish to affiliate will have non-evidence-based policy restrictions on care that disproportionately impact women and LGBTQ+ people. However, most UC Health affiliations are with health care organizations that operate in the state of California, and our experiences to date with those that have policy-based restrictions on care have mostly been affiliated with the Catholic Church.

In March, UC received California Public Records Act (CPRA) requests for all affiliation agreements exclusively with Catholic and Catholic-affiliated health care organizations. A review of these contracts identified two common types of agreements where patient access to care is limited due to policy restrictions: (1) clinical training agreements that require compliance with the Ethical and Religious Directives for Catholic Health Care Services (ERDs) or the Statement of Common Values (SCV) while receiving training at the host facility, and (2) clinical services agreements that require compliance with the ERDs or SCV when providing clinical services at the host facility.

The ERDs were written by the United States Conference of Catholic Bishops (see Appendix B) to ensure that care at all facilities in its purview align with the teachings and beliefs of the Catholic Church. The ERDs prohibit Catholic facilities from providing certain services and procedures that they deem "intrinsically immoral" and prohibit their employees from engaging in "material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide and direct sterilization" [Directive 70]. In considering affiliations with non-Catholic entities, the ERDS require a Catholic health care institution to ensure that "neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures" [Directive 73].

The following services are prohibited at Catholic facilities based on the ERDs: all medical and surgical methods of contraception; in vitro fertilization; use of egg or sperm donor outside of a heterosexual married couple; use of a gestational surrogate; abortion (even in cases of sexual assault); and participation in activities under the End of Life Option Act.

The ERDs have also been interpreted to prohibit the provision of medical or surgical gender-affirming services for transgender people, such as hysterectomy or mastectomy for transgender men. This prohibition on gender-affirming care comes from the writings of the U.S. Conference of Catholic Bishops on this matter in which they reject the possibility of a person having a gender that differs from their sex assigned at birth. For instance, in 2015, writing to the U.S. Department of Health and Human Services, the U.S. Conference of Catholic Bishops states, "We believe … that medical and surgical interventions that attempt to alter one's sex are, in fact, detrimental to patients. Such interventions are not properly viewed as health care because they do not cure or prevent disease or illness. Rather they reject a person's nature at birth as male or female."[5]

In hospitals which adhere to ERDs, non-physician lay leaders and/or Catholic priests or bishops sometimes become involved in individual patient care decisions. This reportedly has resulted in demeaning experiences for patients, as well as delays or disapprovals of standard of care services that can worsen health and even threaten the life of patients. For instance, a woman in a Catholic hospital admitted for care of severe lung disease who is found to be six weeks pregnant may request pregnancy termination to improve her pulmonary status. This request will likely need to be reviewed by the hospital ethics board and/or the local bishop; she can be denied this procedure after review by these non-physician decision makers.

The ERDs also review how to consider patient decision-making in the context of Catholic health care. They state that the "free and informed health care decision of the person… is to be followed so long as it does not contradict Catholic principles."

The Statement of Common Values (SCV) (see Appendix C) is used in approximately 10 percent of Dignity Health hospitals which are Catholic-affiliated, not Catholic. Like the ERDs, the SCV is a religious document that prohibits standard of care services. However, fewer services are prohibited under the SCV than at hospitals governed by ERDs; for example, Dignity's St. Francis Memorial Hospital in San Francisco offers a gender affirmation program. At facilities subject to the SCV, the following services are prohibited: abortion, in vitro fertilization and participation in the End of Life Option Act.

The WGCA was informed that UC Health is working with UC's six academic health systems and 18 health professional schools to identify relationships with health systems that have policy restrictions on care. Members were provided access to the contracts with Catholic-affiliated health care organizations that were produced pursuant to a March 2019 California Public Records Act request (approximately 160 at the time this report was written, many of which may have expired). It was also notified that UC issued interim guidelines and is using new, standard language to eliminate language that might be construed as obligating the University to adhere to or otherwise enforce religious doctrine. However, the WGCA did not deliberate on the content of the interim guidelines or contract language.

[5] USCCB. *Nondiscrimination in Health Programs and Activities*. RIN 0945-AA02. November 2015.

In addition to our academic health systems' direct affiliations with Catholic-affiliated health care organizations, these organizations are part of the provider networks for our UC employee health benefit plans. In some locations (e.g., Mercy Hospital in Merced and Dominican Hospital in Santa Cruz), Catholic-affiliated institutions are the only nearby provider for UC employees. Moreover, the Kaiser Permanente Health Plan requires employees enrolled in the plan to seek certain services from Dignity Health facilities where Kaiser Permanente services are unavailable (e.g., Kaiser Permanente cardiac surgery patients in Sacramento receive care from Mercy General, a Dignity Health facility).

CONCERNS/ISSUES RELATING TO AFFILIATIONS WITH NON-UC ENTITIES THAT PROHIBIT CERTAIN SERVICES FOR WOMEN AND LGBTQ+ PEOPLE

The WGCA also reviewed a range of concerns about UC Health affiliations with entities that have institutional policies that prohibit the use of contraception, abortion, assisted reproductive technology (e.g., egg or sperm donors, in-vitro fertilization, gestational surrogacy), and gender-affirming care for transgender people (e.g., hysterectomy for transgender men).

These restrictions have a differential impact on patients based on sex, gender, gender identity, religion, and sexual orientation which was discussed by the WGCA as basis for concluding these policies are not consistent with UC policies against discrimination. The UC Academic Senate Non-Discrimination in Healthcare Task Force outlined in detail how women and LGBTQ+ patients receiving care at institutions which adhere to the ERDs or other restrictive policies face discrimination and how this discrimination can have a negative impact on their health and well-being. The Academic Senate Task Force believes that affiliations with institutions that adhere to the ERDs are "antithetical to the university's values to engage in any activity that will lift some, but discriminate against others, upon the bases of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, citizenship, or veteran status."[6]

While the prohibition on contraception applies to all patients, women are disproportionately impacted compared to men because the vast majority of contraception is developed for and provided to women, and women, not men, must carry a pregnancy that is undesired and unplanned if they are prohibited from receiving contraception. In addition, the prohibition on abortion only applies to people who are pregnant, differentially impacting women compared with men. Similarly, while the prohibition on use of assisted reproductive technology applies to all patients, these prohibitions disproportionately impact LGBTQ+ patients because, by definition, one or more of these methods is needed to create biological children (e.g., a sperm donor for a lesbian couple). Therefore, this prohibition effectively eliminates the ability of lesbians and gay men to have access in facilities governed by the ERDs or SCV to procedures that would enable them to have biological children.

The WGCA also reviewed ways in which the ERDs and SCV may increase morbidity and possibly mortality for UC patients cared for in Catholic facilities. Twelve major professional medical societies in obstetrics and gynecology, including the American College of Obstetricians and Gynecologists, have affirmed the importance of providing comprehensive reproductive health services to prevent adverse health outcomes in women.[7] UC patients cared for in UC facilities are not prohibited from undergoing any

[6] UC Academic Senate. *Final Report of the Non-Discrimination in Healthcare Task Force*. July 2019.
[7] The American College of Obstetricians and Gynecologists. *Restrictions to Comprehensive Reproductive Health Care: Position Statement*. April 2016.

services related to contraception, abortion, assisted reproductive technology or gender-affirming care. But UC patients cared for in facilities with these policy restrictions, could negatively impact their care, sometime in ways that may be life-threatening.

Several examples were provided of worsened health outcomes for patients cared for facilities goverened by ERDs, including: (a) a patient with a nonviable six-week pregnancy experiencing hemorrhage during a miscarriage whose doctor is prohibited from safely ending the pregnancy in order to stop the hemorrhage at the facility; (b) a patient undergoing a Cesarean section who is denied a simultaneous tubal ligation and must seek out tubal ligation at another hospital sometime after birth (requiring a second surgery with associated risks); (c) a patient admitted to the hospital for a kidney infection who requests but is denied a Depo-Provera contraceptive injection, thus significantly increasing her risk of unintended and undesired pregnancy; and (d) a patient who is seven weeks pregnant with a severe heart condition in which pregnancy can worsen her cardiac status and is denied an abortion after review by an ethics board and a Catholic bishop who determine that the patient's life is not sufficiently in danger.[8] These restrictions on care may have more severe consequences for underserved patients because they may not have resources to obtain contraception and/or abortion at other facilities and/or provide associated out-of-pocket payments.

The WGCA was also informed of the risk of emotional and psychological harms to UC patients cared for in Catholic facilities. Patients who are denied services based on their sex, gender or gender identity may experience a demeaning interaction with their care provider and/or health system that can have significant adverse consequences to their health and well-being. This experience of discrimination may be particularly damaging in groups which already face significant discrimination such as transgender people.

Some members of the WGCA suggested that the harms described above for UC patients' care could be mitigated by transfer or referral of UC patients back to a UC facility to perform a service prohibited at Catholic or Catholic-affiliated hospitals. However, other members suggested that these transfers or referrals could result in unnecessary and unwarranted delays in treatment that may lead to increased morbidity and possibly mortality. In addition, these delays can cause emotional harm by denying care during stressful clinical scenarios (e.g., miscarriage), and/or to vulnerable patient populations.

The WGCA considered the extent to which reproductive health care and gender-affirming care for transgender patients, which have restrictions outlined in the ERDs and to some extent in the SCV, intersect with other areas of health care. The WGCA was presented with a framework in which these services are the foundation for the care of all premenopausal women and transgender people and cannot be isolated only to affiliations related to obstetrics and gynecology. For instance, women seeking care for cancer, pulmonary/cardiac or complex diseases or organ transplant need access to contraception as a critical piece of their care.

[8] Freedman LR, Stulberg DB, Conflicts in Care for Obstetric Complications in Catholic Hospitals, AJOB Primary Research (2013) 4:1-10; Stulberg, Debra B., Yael Hoffman, Irma Hasham Dahlquist, and Lori R. Freedman, *Tubal Ligation in Catholic Hospitals: A Qualitative Study of OB-GYNs' Experiences. Contraception 90, no. 4.* 2014: 422-428; Guiiahi et.al., Changing depot medroxyprogesterone acetate access at a faith-based institution, Conception 84 (2011):280-284; Yuan Liu, Luciana E. Hebert, Lee A. Hasselbacher and Debra B. Stulberg, *"Am I Going to Be in Trouble for What I'm Doing?": Providing Contraceptive Care in Religious Health Care Systems, Perspectives on Sexual and Reproductive Health* (2019).

Some WGCA members also expressed concern that UC providers and trainees, including students, may feel distress while working at facilities with policy restrictions on care, or experience ethical conflicts when they are prevented from performing services that they and their patients would otherwise choose.[9] The WGCA also discussed the harm to public health that occurs when there is decreased availability of reproductive health services and care for LGBTQ patients. Some members feel that providing significant financial and reputational support to organizations that prohibit contraception, abortion, and gender-affirming care is antithetical to our public health mission and perpetuates a decline in access to critical health services.

Some WGCA members also argued that engagement with organizations governed by the ERDs or SCV would be tantamount to an endorsement of discriminatory policies, which directly oppose fundamental UC values and in particular are inconsistent with the UC mission to reduce barriers in access to care. The Regents have heard from individuals that the Dignity Health affiliation would be harmful to members of the University community (e.g., transgender people) whose rights and identities are not recognized by institutional value statements embedded in ERD restrictions. The Academic Senate and others advised UC to limit clinical affiliations to those that conform to UC values in order to protect UC's reputation and advance its values.

ARGUMENTS FOR AFFILIATING WITH NON-UC ENTITIES THAT PROHIBIT CERTAIN SERVICES FOR WOMEN AND LGBTQ+ PEOPLE

The WGCA also reviewed a range of arguments for why, if governed by appropriate principles and guidelines, affiliations with non-UC entities the prohibit certain services for women and LGBTQ+ should be permitted. In particular, some members argued that if agreements expressly provide that UC personnel working or training at any clinical site will make clinical decisions consistent with the standard of care and their independent professional judgment, inform patients of all of their health care options, prescribe any interventions that are medically necessary and appropriate, and transfer or refer patients to other facilities when the care they need is not available where they are being seen, then the benefits of engaging with such organizations are sufficient to support affiliations.

All WGCA members acknowledge the significant body of research that documents the negative impact of non-evidence-based policy restrictions on care, but some members emphasize that no patient of an organization that has adopted such restrictions is better off if UC chooses not to engage with them. Some members discussed how UC's presence in these settings, under appropriate policies and guidelines, will improve patient access to quality care by providing comprehensive advice and facilitating access to options for services elsewhere. These members argued that if the focus was always on doing what is best for every patient, then our presence will be better for all patients who are served in these settings, many of whom represent underserved populations. The California Hospital Association[10] and the California Medical Association[11] have opined that a prohibition on UC's partnerships with policy-restricted hospitals would hurt the state's most vulnerable patients. Some members expressed the view

[9] Stulberg DB, Dude AM, Dahlquist I, Curlin FA. *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies. Am J Obstet Gynecol.* 2012;207:73 e1-5.
[10] California Hospital Association, *ACLU Position Threatens Patient Care*. November 21, 2019.
[11] California Medical Association, CMA President Statement in Repsonse to University of California and Dignity Health Partnership. November 20, 2019.

that existing affiliations, some many decades old, support the inter-institutional goals of UC Health to serve all people living in California and to support health equity by reducing health disparities.

Some WGCA members expressed the view that delivery of health care in the United States is challenging and complex. There may be competing value in any medical scenario that must be balanced for the best outcomes for patients and the communities we serve. Some have opined that the moral core of medicine is the care of the patient in circumstances that may be uncertain and imperfect.[12] In order to guide practitioners, the American Medical Association drafted a code of medical ethics in 2001 in which they outline nine principles that are standards of conduct that define essential behavior for physicians, recognizes their responsibility to patients first and foremost and their responsibilities to society.[13] Some WGCA members believe that this bioethical framework underpins the environment in which UC Health strives to deliver care, and a clear articulation of our values will guide our decisions and our commitment to serve all people living in California.

There are several examples of existing services that would be disrupted if blanket prohibitions were enacted. UC San Diego Health provides primary care services at the St. Vincent de Paul clinic in a joint family medicine and psychiatry residency program. These clinical and training agreements allow UC San Diego to see thousands of patients, including uninsured, homeless and medically indigent patients, while training tomorrow's workforce to care for our most vulnerable.

UC Davis Health's family medicine department's support of the Mercy Merced family practice residency raises the quality of training of the only such training program in the entire area. Davis's placement of its pediatric hospitalists with telehealth advanced support in Adventist Lodi has allowed twice as many children to receive care locally, and made sure transfers to UC Davis have only occurred for the sickest patients requiring the specialty services that UC Davis provides.

In San Francisco, the only burn center in the city is at Dignity's St. Francis Memorial Hospital, making UCSF's ability to care for burn patients and train physicians in the care of these patients completely dependent upon UCSF's having an affiliation with Dignity. Similarly, the only adolescent inpatient behavioral health beds in San Francisco are at St. Mary's Medical Center, making the current UCSF / Dignity affiliation essential to UCSF's ability to care for these patients and to support UCSF's national-recognized psychiatric training programs. For lower acuity care, UCSF provides hospitalist services at St. Mary's in San Francisco, enabling UCSF to transfer up to five patients per day from its seriously overcrowded emergency department – patients who would otherwise suffer various degrees of harm waiting for care as more seriously ill patients receive medical attention.

In FY 2019, UCLA clinicians saw an estimated 12,000 individual patients in over 25,000 encounters as a result of its affiliations with Catholic-affiliated institutions, providing oncology, radiation oncology, cardiology, neurology, pathology and other specialty expertise to patients whose access to those services would be jeopardized if such affiliations were prohibited. Similarly, in FY 2019, UCSF clinicians provided specialty services for over 5000 unique patients at affiliate faith-based institutions.

Some working group members pointed out that termination of agreements to provide services like these have real consequences for patients. For example, a UC bilateral professional services agreement with a Dignity facility allowed a UC pediatric surgeon to mobilize emergently, drive to the Dignity facility,

[12] Derse, A., *Medical Training and Errors: Competence, Culture, Caring and Character*. AAMC. December 10, 2019.
[13] American Medical Association, *Code of Medical Ethics Overview.* 2001.

and save the life of an unexpected 1 lb 4 oz premature baby who would have died if such an agreement did not exist.

The WGCA also discussed how blanket prohibitions against any affiliations with these hospitals would burden our ability to train our clinical personnel and expand access to care. In some regions, these hospitals may be the only viable partners for training and/or clinical affiliations. For example, UC Riverside relies heavily on clinical training affiliations with hospitals operated by or affiliated with hospitals that have non-evidence-based limitations on care, and there are few substitute facilities within a reasonable distance. Several of UC schools of nursing rely on affiliations with organizations that have policy-based restrictions on care. For example, in the last year at UC Davis, 30% of nurse practitioner and physician assistant students completed clinical placements in Catholic affiliated clinics for rotations in primary care, behavioral health, emergency medicine, surgery, and cardiology.

The WGCA also discussed how prohibitions on affiliating with any entity that provides significant clinical care prevents UC from working to optimize the health options for patients that are in special need of our unique expertise. Virtually all UC hospitals are at capacity, and a prohibition against such affiliations would impact UC's ability to dedicate our own tertiary and quaternary facilities to those patients who most need them. An inability to create a set of affiliations that directs low- and high-acuity patients to the most appropriate location results in many high-need patients being unable to access the UC quality care that they most need, leading directly to increased risk of morbidity and mortality.

The WGCA heard that this demonstrates there are both direct and indirect harms to patients when affiliations are limited. An example of a direct harm would be not being able to transfer a critically ill heart patient initially seen at an affiliate to our catheterization lab at UC for lifesaving care. An example of indirect harm would be not having space at UC to transfer such a patient because lower acuity patients are being treated at that UC facility rather than at another affiliated facility that could have taken those patients.

Some WGCA members noted that it is not unusual for UC providers and trainees to be in non-UC clinical settings that have some form of institutional restriction on care, including insurance restrictions, and thus it is not possible to adopt a UC principle that requires all affiliations to allow all UC personnel to perform all services and procedures at any non-UC institution. There are many circumstances where UC providers in non-UC settings need to refer a patient to another facility, and relocating patients should not be considered an unusual or unacceptable feature of clinical care.

Some members of the WGCA also commented that it would be hypocritical to impose an absolute restriction on clinical affiliations with such organizations while allowing UC to affiliate with these same organizations in order to provide health benefit plans to UC employees who are then treated by these same providers. All of the existing UC health benefits options for employees and retirees include affiliations with facilities and providers that have policy-based restrictions on care. Even Kaiser Permanente, California's largest health system and UC's most significant health benefits partner, contracts with health care organizations that have policy restrictions on care. The only hospitals that directly serve Merced and Santa Cruz, where thousands of our employees work, are organizations that have adopted non-evidence-based restrictions on care.

The WGCA heard that the UCSF section of the Academic Senate twice approved moving ahead with the Dignity relationship, emphasizing that while policy restrictions on care exist in many facilities, the larger

purpose of serving the interests of all patients, especially including the underserved, should be valued at least as importantly in considering whether to affiliate.

Many members of the WGCA support UC advocacy at the the federal and state level for laws and regulations that support comprehensive, nondiscriminatory care and access for all patients, but some argued that, in the meantime, UC should not ban affiliations with any organization that is in full compliance with all federal and state laws and regulations—including laws prohibiting discrimination in the delivery of health care—and that national accreditation organizations have judged to be operating in compliance with accrediting standards.

Some WGCA members also expressed the view that affiliation with organizations that have non-evidence-based policy restrictions on care does not amount to an endorsement of those policies, and the University can reinforce this by adopting the recommended guidelines and principles as conditions on such affiliations.

UC POLICIES

A number of UC policies are directly relevant to the issue of UC Health affiliations with non-UC Health organizations.

The University of California, in accordance with applicable federal and state law and University policy, does not discriminate on the basis of race, color, national origin, religion, sex, gender identity, pregnancy,[14] disability, age, medical condition (cancer-related), ancestry, marital status, citizenship, sexual orientation, or status as a Vietnam-era veteran or special disabled veteran. The University also prohibits sexual harassment. This nondiscrimination policy covers admission, access and treatment in University programs and activities, and applies to UC employees, agents and contractors.[15]

Key Regental policies on nondiscrimination include:

- Regents Policy 1111: The Statement of Ethical Values and the Standards of Ethical Conduct
- Regents Policy 4400: The Policy on University of California Diversity Statement
- Regents Policy 4401: Policy on Future Admissions, Employment, and Contracting
- Regents Policy 4402: Policy on Nondiscrimination on Basis of Sexual Orientation
- Regents Policy 4403: Report of the Working Group: Statement of Principles Against Intolerance

The above policies, and others at the system and local level, regulate the activities of all UC Health providers and trainees, wherever they work or learn. For example, health system, medical staff and medical group bylaws and policies govern the delivery of professional services and oversight of professional competence and conduct, and UC Health has established system-wide quality and branding guidelines for affiliations.[16] The President also sets policies governing clinical care delivery, including the policy on UC Health Participation in Activities under the End of Life Option Act.

[14] Pregnancy includes pregnancy, childbirth and medical conditions related to pregnancy or childbirth.
[15] University of California. *Nondiscrimination Statement*.
[16] System-wide quality and branding guidelines for UC Health affiliations were presented to the UC Board of Regents Health Services Committee on August 16, 2017

Policies that regulate review and approval of UC Health affiliations include the Charter of the Health Services Committee and a series of Presidential Delegations of Authority to the chancellors and the Executive Vice President for UC Health.

While not a formal policy, the UC Office of the President, which includes the UC Health Division, also recently drafted a set of seven Core Values: (1) Accountability, (2) Collaboration, (3) Diversity and Inclusion, (4) Excellence, (5) Innovation, (6) Integrity, and (7) Mission Driven, to ensure alignment with the University's commitment to education, research, and public service. The commitment to public service takes many forms across UC Health including education and training of future health professionals, research that improves health and cures diseases, and the provision of clinical care across the state, particularly for the most vulnerable.

UC Health, with representation from all of our Academic Health Campuses, have also collectively developed a set of cross-institutional goals, which describe our aspiration to serve the public by:

a) improving the health of all people who live in California now and in the future;
b) promoting health equity through the elimination of health disparities; and
c) reducing barriers to access to our clinical, educational, and research, academic programs.

WGCA RECOMMENDATIONS

THE UNRESOLVED ISSUE

After extensively reviewing all relevant UC policies, types of affiliations, concerns about affiliations with organizations that have certain non-evidence-based policy restrictions on care, and arguments in favor of maintaining such affiliations, the WGCA was unable to agree on the basic question of whether UC should affiliate with any organization that has institutional policies that (a) prohibit the use of contraception, abortion, assisted reproductive technology, gender-affirming care for transgender people, and the full range of end-of-life options and (b) permit non-clinicians to make clinical decisions affecting the health and safety of individual patients irrespective of the professional judgment of health care providers and/or the informed decisions of patients.

There was widespread agreement that the language used in many current and recently expired contracts with Catholic and Catholic-affiliated health care organizations, which appeared to require UC personnel to adhere to ERDs or the SCV, would not be appropriate in future affiliation agreements. There was agreement that UC should provide the highest levels of evidence-based care, improve access and quality, mitigate health disparities, and ensure that UC Health personnel advance UC values and policies wherever they practice. There was agreement that UC could not itself adopt such non-evidence-based restrictions on care without violating UC policies against discrimination and California constitutional obligations to remain free from sectarian influence in the administration of our affairs. However, some WGCA members believe fulfilling these obligations can only be accomplished by prohibiting certain affiliations, while others believed UC can act in a manner that is consistent with these obligations by adopting a new set of principles and guidelines governing such affiliations.

This is an issue of great importance, and increasingly, a matter that is being scrutinized by the courts. As it currently stands, the law is unsettled. In September 2019 a three-judge panel of the state Court of Appeal in San Francisco allowed a lawsuit to proceed against the Catholic health system Dignity Health

for barring a hysterectomy for a transgender patient (*Minton v. Dignity Health*).[17] Dignity Health has claimed — and continues to claim — that they had a right not to provide services based on their religious principles, and that within those restrictions their services were available to everyone without discrimination. The Court of Appeal allowed the lawsuit to continue so that a trial court could determine whether Dignity Health's actions violated California's Unruh Civil Rights Act. The outcome of this litigation is uncertain.

There is no publicly available evidence that any California regulator, federal regulator or The Joint Commission (the accrediting organization for most hospitals in the U.S.) currently considers ERD or SCV restrictions to violate antidiscrimination laws or hospital accreditation or licensing requirements. It is, of course, a separate matter whether it is legal under California law for UC, which is shielded under the California Constitution from "sectarian influence" in the administration of its affairs, to affiliate with entities that impose religious-based restrictions on clinical care (the current law is not clear). Moreover, federal law expressly prohibits discrimination against health care organizations that, for example, ban abortions based on their religious affiliation.

Recent decisions by the U.S. Supreme Court held that it violates the First Amendment's Free Exercise Clause for state entities to make grants available to non-religious groups but exclude religious groups, which may imply a federal constitutional principle prohibiting the University from excluding affiliations with religious organizations; and that governmental decisions protecting against discrimination are suspect if premised on religious animus.[18] Then again, no member of the WGCA is advocating a prohibition against all religious affiliations, since there are many religious-based health partners that UC Health affiliates with, such as Adventist Health (see Adventist Health letter to UC Davis Health at Appendix E), Hoag Memorial Hospital Presbyterian, and Jewish Family Services which do not have institutional policies that are broadly restrictive in ways that were the focus of the WGCA's discussions.

Assessment of the issues is complicated by the current state of California law, which does not treat organizations acting under ERD or SCV restrictions as providing substandard care or violating state antidiscrimination laws. The issues we face would be much easier to resolve if state policy and UC policy on patient options and antidiscrimination were aligned. It is because they are not that UC must consider whether to adopt more restrictive approaches to affiliations than are currently adopted by state or federal agencies or accreditation organizations such as The Joint Commission.

TWO OPTIONS

Given this lack of consensus on this basic question, members of the WGCA prepared two sets of values statements and principles/guidelines governing UC Heath affiliations with non-UC organizations. The WGCA chair recommends adoption either of one of these two options or some best combination of the two, understanding that the first option is designed to allow affiliations with organizations that have non-evidence-based policy restrictions on care if governed by appropriate policies and guidelines and that the second option is designed to impose a prohibition on such affiliations.

[17] Court of Appeal of the State of California, *Minton v. Dignity Health*, A153662, City and County of San Francisco, April 2019.
[18] Trinity Lutheran Church of Columbia, Inc. v. Comer, 137 S. Ct. 2012 (2017),

The advocates for each set of policies and guidelines agree that their recommended policies and guidelines must ensure UC compliance with University policies, values and guiding principles. They must also respond to the President's charge to the WGCA, namely, to provide recommendations that "ensure patients under the care of UC personnel at non-UC facilities have access to a full range of health care services," "preserve physician autonomy and allow patients to evaluate and choose from all appropriate care options," and "protect patient access to comprehensive care."

Each set of options also includes a set of recommendations designed to ensure compliance with the associated principles and guidelines governing affiliations, whereby UC Health locations (a) engage in a set of prerequisites before affiliations are entered into and (b) adopt effective monitoring mechanisms to ensure ongoing compliance with the principles and guidelines.

The chair emphasizes that, despite a disagreement on the unresolved issue, there is widespread agreement on many other core values and principles. Readers of these options will see extensive overlap in the language presented. In some cases the differences are expressed in just a few different words on individual items. There are also different approaches taken as to how extensive a statement of values should be, with one group believing it should be relatively shorter (allowing principles and guidelines to provide more detail) and another desiring a longer statement.

Option One is presented first, and it reflects the views of WGCA members who seek to remedy the defects of earlier affiliation agreements while still providing an opportunity for new affiliations to occur. It is followed by Option Two which includes language that, in practice, would preclude such affiliations. A comparison of the language in both options is available in Appendix F. As chair I do not offer a line-by-line analysis of the implications of this different language, but believe that the practical effect of adopting one option or the other is as described.

OPTION 1: ALLOW AFFILIATIONS WITH NON-UC ENTITIES THAT PROHIBIT CERTAIN SERVICES FOR WOMEN AND LGBTQ+ PEOPLE

PROPOSED STATEMENT OF UC HEALTH'S VALUES GOVERNING AFFILIATIONS WITH OTHER HEALTH SYSTEMS

> *UC Health aspires to serve the public by improving health and health care for all people living in California now and in the future, by promoting health equity through the elimination of health disparities, and by reducing barriers to access clinical, educational, and research programs.*
>
> *UC Health and all of our providers, faculty, staff, and trainees are expected to act in accordance with UC's core values of accountability, collaboration, diversity and inclusion, excellence, innovation, integrity, and a mission-driven dedication to align our work with the University's commitment to education, research, and public service.*
>
> *UC Health providers are committed to advancing UC policies in all settings in which they operate and will perform their duties in ways that expand access, respect diversity, and practice inclusion.*

PROPOSED UC HEALTH AFFILIATION PRINCIPLES AND GUIDELINES

Principle #1: Evidence-Based Care

UC Health, including all of our providers, trainees, and students, is committed to providing the highest levels of evidence-based care to all patients.

Guideline: Agreements will expressly provide that UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their health care options; (iii) prescribe any interventions that are medically necessary and appropriate; and (iv) transfer or refer patients to other facilities when the care they need is not available where they are being seen.

Principle #2: Constitutional Obligations

UC will abide by its California constitutional obligation to be entirely independent of political or sectarian influence in the administration of its affairs, and by all federal constitutional obligations including prohibitions against discriminating against individuals or organizations in protected classes.

Guideline: Agreements will require that affiliates understand and acknowledge UC's California constitutional obligations to be entirely independent of political or sectarian influence in the administration of its affairs. No provision in any institutional agreement will require UC or its personnel or trainees to enforce or abide by religious directives. The University's affiliation policies and practices will also be consistent with all federal constitutional obligations.

Principle #3: Nondiscrimination

UC personnel are bound by UC nondiscrimination policies wherever they work or train and UC will require all affiliates to have an express institutional policy prohibiting discrimination. We recognize and respect the diverse preferences and practices of our patients and personnel.

Guideline: Every UC Health affiliation agreement will describe UC's nondiscrimination policy, which prohibits UC personnel in any setting to engage in discrimination and harassment, and provides equal opportunities and care regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, status as a covered veteran, or any other basis prohibited by federal or state law.

UC Health will require that every affiliate agree to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination (these include SB 464, codified at Cal. HS&C 1262.6(a)(5), requiring every California hospital to provide each patient in writing information that includes their right to be free from discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language or immigration status as set forth in Section 51 of the Civil Code).

Principle #4: Expanding Access to Care

UC Health affiliations should aim to reduce barriers to access for all people living in California to UC Health, improve the ability of patients at partner institutions to access UC practices and services, and increase the availability of health care options to patients. As a government entity committed to serving the public under the rule of law, UC Health will not restrict access to any lawful care because certain procedures or medical options are considered controversial from a particular political or religious point of view. UC Health affirmatively supports a woman's right to receive comprehensive reproductive health care, including abortion and all forms of contraception and assisted reproductive technologies. UC Health affirms that LGBTQ+ people should not face discrimination in health care and that prohibiting services such as gender affirmation for transgender people and reproductive technologies that support the ability of LGBTQ+ people to have biological children is discriminatory. UC Health is also committed to providing the full range of options to patients at the end of life including legally-sanctioned aid in dying.

Guideline: Given UC's commitment to addressing health disparities and improving access for all people who live in California to quality health care, UC will evaluate potential affiliations in the context of UC's commitment to optimize access to comprehensive, nondiscriminatory, evidence-based health care options. To improve health for all people who live in California, UC Health will consider all aspects of an organization's care in an affiliation, including policy-based restrictions, service to the underserved, and the availability of other facilities within a geographic region. Where relevant to UC's role in an affiliation, we will ensure that access to services like abortion, contraception and assisted reproductive technologies, and gender-affirming care will be maintained or improved as a result of the affiliation.

Principle #5: Improving Quality of Care

UC Health is committed to affiliations that enhance the ability of UC and partner institutions to improve quality as defined by the Institute of Medicine — safe, timely, effective, efficient, patient-centric, equitable care.

Guideline: UC Health affiliations should be structured to enhance the quality of care provided at partner organizations and to enhance the range of high-quality services that patients in affiliated institutions can access. UC will work with partners to change or adapt policies and practices to improve quality. Performance and outcomes relevant to an affiliation should be documented and measured consistent with UC Health's existing system-wide quality guidelines for UC Health affiliations.

Principle #6: Academic Freedom

All affiliations must be consistent with UC's commitment to the protection of academic freedom.

Guideline: All affiliations must conform to the rights, responsibilities, and obligations of faculty and non-faculty academic appointees as specified by UC's Academic Freedom policies in APM-010, APM-011, and APM-015. This requires that teaching, research and scholarship be assessed

by reference to the professional standards that sustain the University's pursuit of knowledge, as set by the UC Academic Senate. These protections extend to teaching, research and scholarship conducted by UC academic appointees in non-UC locations when acting as agents of the University.

Principle #7: Preserving UC Values

All UC Health affiliations should be consistent with the fundamental mission and purpose of the University of California to serve society as a center of higher learning, providing long-term societal benefits through transmitting advanced knowledge, discovering new knowledge, and functioning as an active working repository of organized knowledge through teaching, research, and public service. Affiliations should also advance UC Health's core values of accountability, collaboration, diversity and Inclusion, excellence, innovation, integrity, and mission driven public service, including education and training of future health professionals, research that improves health and cures diseases, and the provision of clinical care across the state, particularly for the most vulnerable.

Guideline: UC Health affiliation agreements should expressly allow UC to terminate any affiliation agreement that, in our sole discretion, jeopardizes UC's core mission and values.

MONITORING AND ACCOUNTABILITY

The prerequisites or due diligence steps taken prior to entering into an affiliation should include the following:

- Document before final approval the importance of the transaction as it relates to UC's missions and values, the benefit to the broader patient community, and the consequences of not proceeding with the transaction;
- Ensure that contract language documents that UC's values, principles and guidelines govern the medical decisions made by UC employees;
- Verify that potential affiliates understand that they will be required to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination;
- Verify that access to options currently available to patients for comprehensive reproductive health care, gender-affirming services and end-of life care will be maintained or improved as a result of the affiliation;
- Develop a process to facilitate timely access to UC or other facilities for services that are not provided at an affiliate's facility;
- Communicate to our personnel voluntarily performing services or receiving training at other facilities our expectations that they adhere to the evidence-based standard of care and their professional judgment wherever they are providing services;

- Ensure that UC personnel have a point of contact at UC that they can reach out to if they believe that their professional judgment is being impeded in any way at the affiliate's facility;

- Ensure that a mechanism (e.g., call center, ombudsperson) has been established to collect and review patient feedback, concerns and complaints regarding care; and create a baseline measure of quality and outcomes performance against which improvements in quality can be measured consistent with system-wide quality guidelines for UC Health affiliations; and

- For joint ventures and/or investments, require non-UC affiliates to participate in the Human Rights Campaign's Healthcare Equality Index, a national LGBTQ+ benchmarking tool that evaluates health care facilities' equity and inclusion of their LGBTQ+ patients, visitors and employees.

After affiliations are entered into, UC health locations should:

- Monitor the quality of care provided at an affiliate's facility related to services provided by UC, consistent with systemwide quality guidelines for UC Health affiliations;

- Strengthen and supplement mechanisms as needed for UC personnel working at affiliate locations to report any incidents of their being impeded from adhering to the principles and guidelines governing affiliations; quickly report and resolve any grievances indicating a violation of affiliation guidelines;

- Strengthen and supplement mechanisms as needed for UC patients at non-UC facilities to share feedback, concerns and complaints regarding care; quickly report and resolve any grievances indicating a violation of affiliation guidelines; and

- Ensure the ability to terminate any affiliation agreement once entered into should circumstances change such that UC's core mission and values are jeopardized.

- For joint ventures and/or investments:
    - Assess and report on whether the affiliation is expanding access to UC quality care and reducing health disparities;
    - Monitor the affiliate's Health Equity Index Scores annually and report the results to leadership; and
    - Compile an annual report to the President and Board of Regents about the nature, rationale, and community impact of the affiliation.

OPTION 2: PROHIBIT AFFILIATIONS WITH NON-UC ENTITIES THAT PROHIBIT CERTAIN SERVICES FOR WOMEN AND LGBTQ+ PEOPLE

PROPOSED STATEMENT OF UC HEALTH'S VALUES GOVERNING AFFILIATIONS WITH OTHER HEALTH SYSTEMS

UC aspires to improve health and health care for UC patients and all people living in California by improving quality, eliminating health care disparities and reducing barriers to access to the educational, research, and service programs and initiatives operated in service of its public mission.

UC and its providers and trainees will provide the highest level of evidence-based care consistent with all of the rights and responsibilities of our patients and practitioners. Our clinicians will make clinical decisions, provide services, and perform procedures based on their independent professional judgment, will respect patient autonomy by carrying out patients' informed health care decisions, and are expected to act in accordance with UC's core values of integrity, excellence, accountability, respect and nondiscrimination. UC health providers are committed to following and advancing UC policies in all settings in which they operate, and will perform their duties in ways that expand access, respect diversity, practice inclusion.

As a government entity committed to serving the public under the rule of law, UC and its providers and trainees will not restrict access to any lawful care because certain procedures or medical options are considered controversial from a particular political or religious point of view. In particular, UC Health affirmatively supports a woman's right to receive comprehensive reproductive health care including abortion and all forms of contraception and assisted reproductive technologies and believes that prohibiting or restricting these services has adverse consequences for patient care and well-being. UC Health affirms that LGBTQ+ people should not face discrimination in health care and that prohibiting services such as gender affirmation for transgender people and reproductive technologies that support the ability of LGBTQ+ people to have biological children is discriminatory. UC Health is also committed to providing the full range of options to patients at the end of life including legally sanctioned aid in dying.

PROPOSED UC HEALTH AFFILIATION PRINCIPLES AND GUIDELINES

Principle #1: Standard of Care

UC Health clinicians are committed to following the highest levels of evidence-based care.

Guideline: Agreements will expressly provide that UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will make clinical decisions, provide services, and perform procedures consistent with the standard of care and their independent professional judgment, respecting patient autonomy by carrying out patients' informed health care decisions, considering the needs and wishes of each individual patient; inform patients of all of their health care options; and prescribe and perform any interventions that are medically necessary and appropriate.

Principle #2: Constitutional Obligations

UC will abide by its California constitutional obligation to be entirely independent of political or sectarian influence in the administration of its affairs, and by all federal constitutional obligations including prohibitions against discriminating against individuals or organizations in protected classes.

Guideline: Agreements will require that affiliates understand and acknowledge UC's California constitutional obligations to be entirely independent of political or sectarian influence in the administration of its affairs. Institutional agreements will expressly state that UC and its personnel and trainees will not enforce or abide by religious directives. The University's affiliation policies and practices will also be consistent with all federal constitutional obligations.

Principle #3: Nondiscrimination

UC personnel are bound by UC nondiscrimination policies wherever they work or train and UC will require all affiliates to have an express institutional policy prohibiting discrimination.

Guideline: Every UC Health affiliation agreement will describe UC's nondiscrimination policy, which prohibits UC personnel in any setting to engage in discrimination and harassment, and provides equal opportunities and care regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, status as a covered veteran, or any other basis prohibited by federal or state law. Agreements will describe that UC considers institutional policies that prohibit gender-affirming services for transgender people, abortion for pregnant people, or reproductive health services that disproportionately affect women and LGBT people, to violate their antidiscrimination policy because gender, pregnancy, sex, and sexual orientation are protected classes.

UC Health will require that every affiliate agree to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination (these include SB 464, codified at Cal. HS&C 1262.6(a)(5), requiring every California hospital to provide each patient in writing information that includes their right to be free from discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language or immigration status as set forth in Section 51 of the Civil Code).

Principle #4: Expanding Access to Care

UC Health affiliations should aim to reduce barriers to access to care for all people living in California, improve the ability of patients at partner institutions to access UC practices and services, and increase the availability of health care options to patients. Affiliations should not reduce access or the availability of services for existing UC patients including comprehensive reproductive health care, gender-affirming care for transgender people, and end of life care.

Guideline: UC will evaluate potential affiliations and take necessary action to promote, and not prohibit or limit, the use and delivery of comprehensive, nondiscriminatory, evidence-based

health care options to ensure that access to services including abortion, contraception, assisted reproductive technologies, and gender-affirming care for transgender people are maintained or improved as a result of the affiliation. UC will ensure that affiliations do not result in a decrease in the ability of UC patients to obtain these services in facilities where they receive care compared with access to these services prior to the affiliation.

Principle #5: Improving Quality of Care

UC Health is committed to affiliations that enhance the ability of UC and partner institutions to improve the quality of care for UC patients and other people living in California.

Guideline: UC Health affiliations should be structured to enhance the quality of care provided at partner organizations and UC will work with partners to change or adapt policies and practices to improve quality. Affiliations will not occur if potential partners are unwilling or unable to change or adapt policies to improve quality. Performance and outcomes relevant to an affiliation should be documented and measured consistent with UC Health's existing system-wide quality guidelines for UC Health affiliations.

Principle #6: Academic Freedom

All affiliations must be consistent with UC's commitment to the protection of academic freedom.

Guideline: All affiliations must conform to the rights, responsibilities, and obligations of faculty and non-faculty academic appointees as specified by UC's Academic Freedom policies in APM-010, APM-011, and APM-015. This requires that teaching, research and scholarship be assessed by reference to the professional standards that sustain the University's pursuit of knowledge, as set by the UC Academic Senate. These protections extend to teaching, research and scholarship conducted by UC academic appointees in non-UC locations when acting as agents of the University.

Principle #7: Preserving UC Values

All UC Health affiliations should be consistent with the fundamental mission and purpose of the University of California to serve society as a center of higher learning, providing long-term societal benefits through transmitting advanced knowledge, discovering new knowledge, and functioning as an active working repository of organized knowledge through teaching, research, and public service.

Guideline: UC will not enter into affiliations with entities that are fundamentally misaligned with our core mission and values. In addition, UC Health affiliation agreements should expressly allow UC to terminate any affiliation agreement that, in our sole discretion, jeopardizes UC's core mission and values.

MONITORING AND ACCOUNTABILITY

The prerequisites or due diligence steps taken prior to entering into an affiliation should include the following:

- Document before final approval the rationale and importance of the transaction as it relates to UC's missions and values, the benefit to UC patients, UC providers and trainees, and/or the broader non-UC patient community, review any potential harms in the affiliation for UC patients, providers, and trainees, and non-UC patients, provide alternative options to the transaction that could avoid harms, and the consequences of not proceeding with the transaction;

- Ensure that contract language documents that UC's values, principles and guidelines govern the medical decisions, services provided, and procedures performed by UC employees;

- Verify that potential affiliates understand that they will be required to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination, including UC's;

- Verify that the contract language expressly states that UC providers and trainees will not be required to enforce or adhere to religious directives in their decision making, delivery of services, or performance of procedures while working in the affiliate institution;

- Verify that access to options currently available to UC patients at their clinical site of care for contraception, abortion, assisted reproductive technology, gender-affirming services, and end-of life care will be not be decreased or diminished when UC patients receive care at the affiliate site, but rather that these services will be maintained or improved for UC patients as a result of the affiliation;

- Develop a process to facilitate timely access to UC or other facilities for services that are not provided at an affiliate's facility;

- Communicate to our personnel and trainees performing services or procedures or receiving training at other facilities our expectations that they adhere to the evidence-based standard of care and their professional judgment, respecting patient autonomy in decision-making wherever they are providing services;

- Ensure that UC patients cared for at the affiliate site will have full autonomy to make informed health care decisions within the standard of care and that these decisions will be followed and carried out, unrestricted by religious directives;

- Ensure that UC personnel and trainees have a point of contact at UC to which they can reach out confidentially if they believe that their ability to provide services or perform procedures based on their professional judgment is being impeded in any way at the affiliate's facility; and

- Ensure that a mechanism (e.g., call center, ombudsperson) has been established to collect and review patient feedback, concerns and complaints regarding care, and create a baseline measure of quality and outcomes performance against which improvements in quality can be

measured consistent with system-wide quality guidelines for UC Health affiliations.

After affiliations are entered into, UC health locations should:

- Monitor the quality of care provided at an affiliate's facility related to services provided by UC, consistent with systemwide quality guidelines for UC Health affiliations;
- Strengthen and supplement mechanisms as needed for UC personnel and trainees working at affiliate locations to confidentially report any incidents of their being impeded from adhering to the principles and guidelines governing affiliations, quickly report and resolve any grievances indicating a violation of affiliation guidelines, while protecting the privacy of any involved UC personnel;
- Strengthen and supplement mechanisms as needed for UC patients at non-UC facilities to share feedback, concerns and complaints regarding care; quickly report and resolve any grievances indicating a violation of affiliation guidelines; and
- Ensure the ability to terminate any affiliation agreement once entered into should circumstances change such that in UC's opinion, the University's core mission and values are jeopardized.

NEXT STEPS

In developing the two options for values, principles and guidelines, the chair emphasizes that the WGCA has not conducted a full analysis of all the implications, including financial implications, associated with these recommendations. It is possible that, *under either option*, some entities may choose not to enter into future affiliation arrangements with UC, and those with preexisting agreements may need to be terminated if these institutions do not agree to amend the agreements to conform with UC's approved principles and guidelines. Those who will act on this report should understand the limits of our analysis. Still, whatever the financial impact, the members of the WGCA believe that some version of these principles and guidelines is necessary to assure that UC Health will act in a manner consistent with relevant UC policies and values.

On the question of whether future modifications to UC policy may be warranted: at the present time the chair offers no suggestions, other than to reiterate the view expressed earlier that the existing legal environment in California is a complicating factor, and additional considerations of UC actions to engage with California lawmakers and regulators should be considered.

The various recommendations, while carefully and thoughtfully developed, should be one piece of a comprehensive review process that supports the deliberations and decisions of the President and Board of Regents on the principles and guidelines that should govern UC Health's affiliations with non-UC health services organizations.

I appreciate the opportunity to submit this report and urge the President to consider additional input from the University community, key external stakeholders and the broader public.

APPENDICES

A. INTERIM GUIDELINES FOR UC HEALTH AFFILIATIONS

INTERIM GUIDELINES FOR UC HEALTH AFFILIATIONS

8/14/19

Pending the deliberations of the President's Working Group on Comprehensive Access, below are interim contracting guidelines regarding the health centers' ability to enter into common types of health system agreements (new and renewals) where patient access to care might be limited due to policy restrictions on services provided. During this interim period:

(i) Contract terms should be no more than a year and include 90-day termination clauses.

(ii) There should be no requirement in the contract for the University or our personnel to adhere to or enforce religious directives (e.g. Statement of Common Values, Ethical and Religious Directives).

(iii) We should not enter into new or expanded joint ventures, "participations", management services arrangements, or investments.

Within the foregoing parameters, the following agreements are permissible:

- Training agreements (e.g., medical students, residents, nursing students)
- Professional services agreements (e.g., to provide call coverage, medical direction, clinical care)
- Lease agreements
- Administrative / consulting agreements (targeted, limited scope)

Any new agreement or extension, including permissible agreements, must be submitted to the EVP of UC Health for review prior to execution.

If there is a pressing need to renew or extend an existing agreement that does not adhere to the parameters above, the proposed agreement must be submitted to the EVP of UC Health, who will review and consult with the President and the Chair of the Health Services Committee to determine whether or not an exception to the guidelines should be granted.

B. ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES

Source: USCCB. *Ethical and Religious Directives for Catholic Health Care Services*. *Sixth Edition*. June 2018.

Ethical and Religious Directives for Catholic Health Care Services

Sixth Edition

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

This sixth edition of the *Ethical and Religious Directives for Catholic Health Care Services* was developed by the Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB) and approved by the USCCB at its June 2018 Plenary Assembly. This edition of the *Directives* replaces all previous editions, is recommended for implementation by the diocesan bishop, and is authorized for publication by the undersigned.

Msgr. J. Brian Bransfield, STD
General Secretary, USCCB

Digital Edition, June 2018

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Preamble

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are significant changes in religious orders and congregations, the increased involvement of lay men and women, a heightened awareness of the Church's social role in the world, and developments in moral theology since the Second Vatican Council. A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society.

Throughout the centuries, with the aid of other sciences, a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters and has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery. In response to today's challenges, these same moral principles of Catholic teaching provide the rationale and direction for this revision of the *Ethical and Religious Directives for Catholic Health Care Services*.

These Directives presuppose our statement *Health and Health Care* published in 1981.[1] There we presented the theological principles that guide the Church's vision of health care, called for all Catholics to share in the healing mission of the Church, expressed our full commitment to the health care ministry, and offered encouragement to all those who are involved in it. Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services.[2] The purpose of these *Ethical and Religious Directives* then is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today.

The *Ethical and Religious Directives* are concerned primarily with institutionally based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services. Since they express the Church's moral teaching, these Directives also will be helpful to Catholic professionals engaged in health care services in other settings. The moral teachings that we profess here flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.

The Directives have been refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians, and other health care providers. While providing standards and guidance, the Directives do not cover in detail all of the complex issues that confront Catholic health care today. Moreover, the Directives will be reviewed periodically by the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops), in the light of authoritative church teaching, in order to address new insights from theological and

medical research or new requirements of public policy.

The Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the six parts that follow is divided into two sections. The first section is in expository form; it serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form; the directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care.

General Introduction

The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing: he cleansed a man with leprosy (Mt 8:1-4; Mk 1:40-42); he gave sight to two people who were blind (Mt 20:29-34; Mk 10:46-52); he enabled one who was mute to speak (Lk 11:14); he cured a woman who was hemorrhaging (Mt 9:20-22; Mk 5:25-34); and he brought a young girl back to life (Mt 9:18, 23-25; Mk 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9:35). In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Mt 8:17; cf. Is 53:4).

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (Jn 6:35, 11:25-27). He "came so that they might have life and have it more abundantly" (Jn 10:10).

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.

For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St. Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor 4:10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away" (Rev 21:3-4).

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history. The zealous service of individuals and communities has provided shelter for the traveler; infirmaries for the sick; and homes for children, adults, and the elderly.[3] In the United States, the many religious communities as well as dioceses that sponsor and staff this country's Catholic health care institutions and services have established an effective Catholic presence in health care. Modeling their efforts on the gospel parable of the Good Samaritan, these communities of women and men have exemplified authentic neighborliness to those in need (Lk 10:25-37). The Church seeks to ensure that the service offered in the past will be continued into the future.

While many religious communities continue their commitment to the health care ministry, lay Catholics increasingly have stepped forward to collaborate in this ministry. Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a broader and more intense field of ministries than in the past.[4] By virtue of their Baptism, lay

faithful are called to participate actively in the Church's life and mission.[5] Their participation and leadership in the health care ministry, through new forms of sponsorship and governance of institutional Catholic health care, are essential for the Church to continue her ministry of healing and compassion. They are joined in the Church's health care mission by many men and women who are not Catholic.

Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick. These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention.

In a time of new medical discoveries, rapid technological developments, and social change, what is new can either be an opportunity for genuine advancement in human culture, or it can lead to policies and actions that are contrary to the true dignity and vocation of the human person. In consultation with medical professionals, church leaders review these developments, judge them according to the principles of right reason and the ultimate standard of revealed truth, and offer authoritative teaching and guidance about the moral and pastoral responsibilities entailed by the Christian faith.[6] While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.

Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work.

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care.

PART ONE
The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system. Today, this complex health care system confronts a range of economic, technological, social, and moral challenges. The response of Catholic health care institutions and services to these challenges is guided by normative principles that inform the Church's healing ministry.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.[7]

Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured.[8] Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.[9]

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.

Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.

Directives

1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.

2. Catholic health care should be marked by a spirit of mutual respect among caregivers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.

3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.
4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles.
5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.
6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.[10]
7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.
8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.
9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

PART TWO
The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: "I was ill and you cared for me" (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death.

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[11] Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace. It should be acknowledged, of course, that technological advances in medicine have reduced the length of hospital stays dramatically. It follows, therefore, that the pastoral care of patients, especially administration of the sacraments, will be provided more often than not at the parish level, both before and after one's hospitalization. For this reason, it is essential that there be very cordial and cooperative relationships between the personnel of pastoral care departments and the local clergy and ministers of care.

Priests, deacons, religious, and laity exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral caregivers to the particular needs of patients or residents, the following directives address only a limited number of specific pastoral activities.

Directives

10. A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—clergy, religious, and lay alike—should have appropriate professional preparation, including an understanding of these Directives.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy. Appropriate pastoral services and/or referrals should be available to all in keeping with their religious beliefs or affiliation.

12. For Catholic patients or residents, provision for the sacraments is an especially important part of Catholic health care ministry. Every effort should be made to have priests assigned to hospitals and health care institutions to celebrate the Eucharist and provide the sacraments to patients and staff.

13. Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of Penance.

14. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion, in accordance with canon law and the policies of the local diocese. They should assist pastoral care personnel—clergy, religious, and laity—by providing supportive visits, advising patients regarding the availability of priests for the sacrament of Penance, and distributing Holy Communion to the faithful who request it.

15. Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of Anointing of the Sick, recognizing that through this sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age. Normally, the sacrament is celebrated when the sick person is fully conscious. It may be conferred upon the sick who have lost consciousness or the use of reason, if there is reason to believe that they would have asked for the sacrament while in control of their faculties.

16. All Catholics who are capable of receiving Communion should receive Viaticum when they are in danger of death, while still in full possession of their faculties.[12]

17. Except in cases of emergency (i.e., danger of death), any request for Baptism made by adults or for infants should be referred to the chaplain of the institution. Newly born infants in danger of death, including those miscarried, should be baptized if this is possible.[13] In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.[14] In the case of emergency Baptism, the chaplain or the director of pastoral care is to be notified.

18. When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person.[15]

19. A record of the conferral of Baptism or Confirmation should be sent to the parish in which the institution is located and posted in its baptism/confirmation registers.

20. Catholic discipline generally reserves the reception of the sacraments to Catholics. In accord with canon 844, §3, Catholic ministers may administer the sacraments of Eucharist, Penance, and Anointing of the Sick to members of the oriental churches that do not have

full communion with the Catholic Church, or of other churches that in the judgment of the Holy See are in the same condition as the oriental churches, if such persons ask for the sacraments on their own and are properly disposed.

With regard to other Christians not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of canon 844, §4, also must be present, namely, they cannot approach a minister of their own community; they ask for the sacraments on their own; they manifest Catholic faith in these sacraments; and they are properly disposed. The diocesan bishop has the responsibility to oversee this pastoral practice.

21. The appointment of priests and deacons to the pastoral care staff of a Catholic institution must have the explicit approval or confirmation of the local bishop in collaboration with the administration of the institution. The appointment of the director of the pastoral care staff should be made in consultation with the diocesan bishop.

22. For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop.

PART THREE
The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.

Today, a patient often receives health care from a team of providers, especially in the setting of the modern acute-care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. The relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided. Diagnosis and care, therefore, entail a series of decisions with ethical as well as medical dimensions. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.

Directives

23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance

directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.[16] The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.[17]

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the

person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.[18]

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.

35. Health care professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[19]

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives.

PART FOUR
Issues in Care for the Beginning of Life

Introduction

The Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."[20] The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. The Second Vatican Council affirms:

> This love is an eminently human one. . . . It involves the good of the whole person. . . . The actions within marriage by which the couple are united intimately and chastely are noble and worthy ones. Expressed in a manner which is truly human, these actions signify and promote that mutual self-giving by which spouses enrich each other with a joyful and a thankful will.[21]
>
> Marriage and conjugal love are by their nature ordained toward the begetting and educating of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. . . . Parents should regard as their proper mission the task of transmitting human life and educating those to whom it has been transmitted. . . . They are thereby cooperators with the love of God the Creator, and are, so to speak, the interpreters of that love.[22]

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot approve contraceptive interventions that "either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible."[23] Such interventions violate "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[24]

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for

good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act. As Pope John XXIII observed:

> The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to all the holy laws of God: the immutable and inviolable laws which must be recognized and observed. For this reason, one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals.[25]

Because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their own spiritual destiny, can discover and cooperate in the plan of the Creator.[26]

Directives

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.[27]

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.[28]

41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).[29]

42. Because of the dignity of the child and of marriage, and because of the uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.[30]

43. A Catholic health care institution that provides treatment for infertility should offer not only technical assistance to infertile couples but also should help couples pursue other solutions (e.g., counseling, adoption).

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be

concerned about the danger of scandal in any association with abortion providers.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.[31]

49. For a proportionate reason, labor may be induced after the fetus is viable.

50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.[32]

51. Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent.[33]

52. 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.

53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.[34]

54. Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life.

PART FIVE
Issues in Care for the Seriously Ill and Dying

Introduction

Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.[35] The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life.[36]

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.[37]

The Church's teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[38] While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness,

accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.[39]

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.[40] Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."[41] For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.[42]

61. Patients should be kept as free of pain as possible so that they may die comfortably and

with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.[43]

PART SIX
Collaborative Arrangements with Other Health Care Organizations and Providers[44]

Introduction

In and through her compassionate care for the sick and suffering members of the human family, the Church extends Jesus' healing mission and serves the fundamental human dignity of every person made in God's image and likeness. Catholic health care, in serving the common good, has historically worked in collaboration with a variety of non-Catholic partners. Various factors in the current health care environment in the United States, however, have led to a multiplication of collaborative arrangements among health care institutions, between Catholic institutions as well as between Catholic and non-Catholic institutions.

Collaborative arrangements can be unique and vitally important opportunities for Catholic health care to further its mission of caring for the suffering and sick, in faithful imitation of Christ. For example, collaborative arrangements can provide opportunities for Catholic health care institutions to influence the healing profession through their witness to the Gospel of Jesus Christ. Moreover, they can be opportunities to realign the local delivery system to provide a continuum of health care to the community, to provide a model of a responsible stewardship of limited health care resources, to provide poor and vulnerable persons with more equitable access to basic care, and to provide access to medical technologies and expertise that greatly enhance the quality of care. Collaboration can even, in some instances, ensure the continued presence of a Catholic institution, or the presence of any health care facility at all, in a given area.

When considering a collaboration, Catholic health care administrators should seek first to establish arrangements with Catholic institutions or other institutions that operate in conformity with the Church's moral teaching. It is not uncommon, however, that arrangements with Catholic institutions are not practicable and that, in pursuit of the common good, the only available candidates for collaboration are institutions that do not operate in conformity with the Church's moral teaching.

Such collaborative arrangements can pose particular challenges if they would involve institutional connections with activities that conflict with the natural moral law, church teaching, or canon law. Immoral actions are always contrary to "the singular dignity of the human person, 'the only creature that God has wanted for its own sake.'"[45] It is precisely because Catholic health care services are called to respect the inherent dignity of every human being and to contribute to the common good that they should avoid, whenever possible, engaging in collaborative arrangements that would involve them in contributing to the wrongdoing of other providers.

The Catholic moral tradition provides principles for assessing cooperation with the wrongdoing of others to determine the conditions under which cooperation may or may not be

In sum, collaborative arrangements with entities that do not share our Catholic moral tradition present both opportunities and challenges. The opportunities to further the mission of Catholic health care can be significant. The challenges do not necessarily preclude all such arrangements on moral grounds, but they do make it imperative for Catholic leaders to undertake careful analyses to ensure that new collaborative arrangements—as well as those that already exist—abide by the principles governing cooperation, effectively address the risk of scandal, abide by canon law, and sustain the Church's witness to Christ and his saving message.

While the following Directives are offered to assist Catholic health care institutions in analyzing the moral considerations of collaborative arrangements, the ultimate responsibility for interpreting and applying of the Directives rests with the diocesan bishop.

Directives

67. Each diocesan bishop has the ultimate responsibility to assess whether collaborative arrangements involving Catholic health care providers operating in his local church involve wrongful cooperation, give scandal, or undermine the Church's witness. In fulfilling this responsibility, the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision.
68. When there is a possibility that a prospective collaborative arrangement may lead to serious adverse consequences for the identity or reputation of Catholic health care services or entail a risk of scandal, the diocesan bishop is to be consulted in a timely manner. In addition, the diocesan bishop's approval is required for collaborative arrangements involving institutions subject to his governing authority; when they involve institutions not subject to his governing authority but operating in his diocese, such as those involving a juridic person erected by the Holy See, the diocesan bishop's *nihil obstat* is to be obtained.
69. In cases involving health care systems that extend across multiple diocesan jurisdictions, it remains the responsibility of the diocesan bishop of each diocese in which the system's affiliated institutions are located to approve locally the prospective collaborative arrangement or to grant the requisite *nihil obstat*, as the situation may require. At the same time, with such a proposed arrangement, it is the duty of the diocesan bishop of the diocese in which the system's headquarters is located to initiate a collaboration with the diocesan bishops of the dioceses affected by the collaborative arrangement. The bishops involved in this collaboration should make every effort to reach a consensus.
70. Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.[48]
71. When considering opportunities for collaborative arrangements that entail material cooperation in wrongdoing, Catholic institutional leaders must assess whether scandal[49] might be given and whether the Church's witness might be undermined. In some cases, the risk of scandal can be appropriately mitigated or removed by an explanation of what is in fact being done by the health care organization under Catholic auspices. Nevertheless, a

collaborative arrangement that in all other respects is morally licit may need to be refused because of the scandal that might be caused or because the Church's witness might be undermined.

72. The Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law.
73. Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.
74. In any kind of collaboration, whatever comes under the control of the Catholic institution—whether by acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives.
75. It is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.
76. Representatives of Catholic health care institutions who serve as members of governing boards of non-Catholic health care organizations that do not adhere to the ethical principles regarding health care articulated by the Church should make their opposition to immoral procedures known and not give their consent to any decisions proximately connected with such procedures. Great care must be exercised to avoid giving scandal or adversely affecting the witness of the Church.
77. If it is discovered that a Catholic health care institution might be wrongly cooperating with immoral procedures, the local diocesan bishop should be informed immediately and the leaders of the institution should resolve the situation as soon as reasonably possible.

Conclusion

Sickness speaks to us of our limitations and human frailty. It can take the form of infirmity resulting from the simple passing of years or injury from the exuberance of youthful energy. It can be temporary or chronic, debilitating, and even terminal. Yet the follower of Jesus faces illness and the consequences of the human condition aware that our Lord always shows compassion toward the infirm.

Jesus not only taught his disciples to be compassionate, but he also told them who should be the special object of their compassion. The parable of the feast with its humble guests was preceded by the instruction: "When you hold a banquet, invite the poor, the crippled, the lame, the blind" (Lk 14:13). These were people whom Jesus healed and loved.

Catholic health care is a response to the challenge of Jesus to go and do likewise. Catholic health care services rejoice in the challenge to be Christ's healing compassion in the world and see their ministry not only as an effort to restore and preserve health but also as a spiritual service and a sign of that final healing that will one day bring about the new creation that is the ultimate fruit of Jesus' ministry and God's love for us.

Notes

1. United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops* (Washington, DC: United States Conference of Catholic Bishops, 1981).
2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, outpatient facilities, urgent care centers, hospices, nursing homes, and parishes). Depending on the context, these Directives will employ the terms "institution" and/or "services" in order to encompass the variety of settings in which Catholic health care is provided.
3. *Health and Health Care,* p. 5.
4. Second Vatican Ecumenical Council, *Decree on the Apostolate of the Laity* (*Apostolicam Actuositatem*) (1965), no. 1.
5. Pope John Paul II, Post-Synodal Apostolic Exhortation *On the Vocation and the Mission of the Lay Faithful in the Church and in the World* (*Christifideles Laici*) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 29.
6. As examples, see Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974); Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day* (*Donum Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1987).
7. Pope John XXIII, Encyclical Letter *Peace on Earth* (*Pacem in Terris*) (Washington, DC: United States Conference of Catholic Bishops, 1963), no. 11; *Health and Health Care,* pp. 5, 17-18; *Catechism of the Catholic Church,* 2nd ed. (Washington, DC: Libreria Editrice Vaticana–United States Conference of Catholic Bishops, 2000), no. 2211.
8. Pope John Paul II, *On Social Concern, Encyclical Letter on the Occasion of the Twentieth Anniversary of "Populorum Progressio"* (*Sollicitudo Rei Socialis*) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
9. United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (Washington, DC: United States Conference of Catholic Bishops, 1986), no. 80.
10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based health care services must be attentive to occasions when the policies and practices of other institutions are not compatible with the Church's authoritative moral teaching. At such times, Catholic health care institutions should determine whether or to what degree collaboration would be morally permissible. To make that judgment, the governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.
11. *Health and Health Care,* p. 12.
12. Cf. *Code of Canon Law,* cc. 921-923.
13. Cf. ibid., c. 867, § 2, and c. 871.
14. To confer Baptism in an emergency, one must have the proper intention (to do what the Church intends by Baptism) and pour water on the head of the person to be baptized, meanwhile pronouncing the words: "I baptize you in the name of the Father, and of the Son, and of the

Holy Spirit."

15. Cf. c. 883, 3°.
16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.
17. Cf. directive 53.
18. *Declaration on Euthanasia,* Part IV; cf. also directives 56-57.
19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810.
20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical Association," *Acta Apostolicae Sedis* 76 (1984): 390.
21. Second Vatican Ecumenical Council, *Pastoral Constitution on the Church in the Modern World (Gaudium et Spes)* (1965), no. 49.
22. Ibid., no. 50.
23. Pope Paul VI, Encyclical Letter *On the Regulation of Birth (Humanae Vitae)* (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 14.
24. Ibid., no. 12.
25. Pope John XXIII, Encyclical Letter *Mater et Magistra* (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae,* no. 4.
26. Pope John Paul II, Encyclical Letter *The Splendor of Truth (Veritatis Splendor)* (Washington, DC: United States Conference of Catholic Bishops, 1993), no. 50.
27. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose" (*Donum Vitae,* Part II, B, no. 6; cf. also Part I, nos. 1, 6).
28. Ibid., Part II, A, no. 2.
29. "Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes "the full sense of mutual self-giving and human procreation in the context of true love"' " (*Donum Vitae,* Part II, B, no. 6).
30. Ibid., Part II, A, no. 3.
31. Cf. directive 45.
32. *Donum Vitae,* Part I, no. 2.
33. Cf. ibid., no. 4. (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
34. Cf. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, *Origins* 24 (1994): 211-212.
35. Pope John Paul II, Apostolic Letter *On the Christian Meaning of Human Suffering (Salvifici Doloris)* (Washington, DC: United States Conference of Catholic Bishops, 1984), nos. 25-27.

36. United States Conference of Catholic Bishops, *Order of Christian Funerals* (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.

37. See *Declaration on Euthanasia.*

38. Ibid., Part II.

39. Ibid., Part IV; Pope John Paul II, Encyclical Letter *On the Value and Inviolability of Human Life* (*Evangelium Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1995), no. 65.

40. See Pope John Paul II, Address to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), no. 4, where he emphasized that "the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*." See also Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" (August 1, 2007).

41. Congregation for the Doctrine of the Faith, Commentary on "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration."

42. See *Declaration on Euthanasia*, Part IV.

43. *Donum Vitae,* Part I, no. 4.

44. See: Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with non-Catholic Entities in the Provision of Healthcare Services," published in *The National Catholic Bioethics Quarterly* (Summer 2014), 337-40.

45. Pope John Paul II, *Veritatis Splendor*, no. 13.

46. Pope John Paul II, *Evangelium Vitae*, no. 74.

47. *Catechism of the Catholic Church*, no. 2284.

48. While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization. See Pope John Paul II's Ad Limina Address to the bishops of Texas, Oklahoma, and Arkansas (Region X), in *Origins* 28 (1998): 283. See also "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (*Quaecumque Sterilizatio*), March 13, 1975, Origins 6 (1976): 33-35: "Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . is absolutely forbidden. For the official approbation of direct sterilization and, a fortiori, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil." This directive supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops on September 15, 1977, in *Origins* 7 (1977): 399-400.

49. See *Catechism of the Catholic Church*: "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (no. 2287).

C. STATEMENT OF COMMON VALUES

Source: Dignity Health. *Statement of Common Values*.

Statement of Common Values

In living our mission, we strive to deliver compassionate, high-quality, affordable health care; serve and advocate for those sisters and brothers who are poor and disenfranchised; and partner with others in the communities we serve to improve the quality of life. In carrying out our healing ministry, we embody the values of dignity, collaboration, justice, stewardship, and excellence.

Dignity

Holding the value of dignity means we show respect for persons, not for anything they do or any rank they hold, but because they reflect the face of God. Because persons are created in communities, respecting dignity also means working toward the common good within the communities we serve. The common good is realized when economic, political and social conditions protect and promote the basic rights of all persons and enable them to reach their common goals. We respect the dignity of all persons without regard to age, gender, sexual orientation, religion, culture, race, ethnicity, gender identity or economic, immigration or employment status. We believe that health care is a social good and a community service and that access to health care is a fundamental right of all persons.

For Dignity Health, respecting the dignity of persons requires reverence at every stage of life's journey from conception to natural death. Therefore, direct abortion is not performed. Reproductive technologies in which conception occurs outside a woman's body will not be part of Dignity Health's services. This includes in vitro fertilization.

In the context of a mutually respectful and healing relationship with the physician and the clinical team, patients have the right to make medical decisions, including accepting or rejecting treatment, and must give free and informed consent before any intervention. They also have a right to make an advance directive and to name a surrogate decision maker, and they or their surrogates must have access to medical and other information regarding their care. At the same time, patients have a right to privacy--of their persons and of their medical information—and must be able to trust that our record- keeping and information systems are reliable and safe. Patients' families are an integral part of their care, and patient advocates are welcome. There is no obligation to begin or continue treatment, even life-sustaining treatment, if from the patient's perspective it is an excessive burden or offers no reasonable hope of benefit. Death is a sacred part of life's journey; we will intentionally neither hasten nor delay it. For this reason, physician- assisted suicide is not part of Dignity Health's mission. Although pain management in all its forms is critical in allowing a person to die comfortably and with dignity, palliative care is consistent with all types of treatment and is not limited to those persons who are at the end of life.

We attend to all dimensions of the person and consider professional spiritual care essential to our service. Spiritual care encompasses the full range of spiritual services integrated with patient care, including skilled listening presence that assists people of all faiths and those of no faith to tap their own beliefs, values and spiritual practices as they experience illness, trauma, recovery and loss. Consistent with the spiritual foundation of our legacy, we extend this spiritual care to families and coworkers as well as patients.

Collaboration

We understand that the social fabric is woven in partnership with all who are called to serve the community. Our ability to realize our mission depends on our relationships and linkages with others: health care providers, community leaders, physician organizations, government agencies, employers, health plans and individuals.

Ours is a community of service and work—we recognize our complex responsibilities as health care providers to patients and their families, as employers, and as corporate citizens. Our commitment to collaboration fosters recognition of richness in diversity of culture and experience.

Dignity Health.

Statement of Common Values Continued

The provision of health care is characterized by necessary hierarchies and by many rules and regulations; however, collaboration marked by trust, transparency and commitment to continuous improvement means that our best work is accomplished by teams of moral equals, with respect for one another's personal and professional gifts. Collaboration among spiritual leaders and communities of faith extends our ability to support the religious preferences and spiritual needs of those we serve. Our commitment to advocate for reasonable and accessible care for all who need it requires us to engage actively in the development of health care networks and avenues that better ensure the health of populations.

Justice

The American ideal of blind justice is balanced at Dignity Health by a biblical sense of justice that is concerned with righting imbalances of power and that expresses a preferential option for the poor. We have a special responsibility for persons who are poor or vulnerable, helping them through direct service and acting as an advocate to change structures oppressive to them. We have a moral responsibility to participate in efforts to reform the national health care system that will result in a more equitable distribution of health care goods and a more rational use of common resources.

Dignity Health treats employees—the hands and heart of the ministry—justly and respectfully, recognizing that a meaningful and humanizing work environment gives people a voice in matters affecting their work; respects and promotes their personal health and professional growth; and provides a just wage. We strive to promote a just culture and workplace relationships that are fair, trusting, and accountable.

Stewardship

Stewardship is the protective care we give our treasures in order to pass them on to the next generation. Our treasures are our human and financial resources, our environment, our heritage, and the trust the public places in us. We guard the safety and integrity of these things carefully.

Health care resources belong to the community and as a health care system we are stewards of those resources with the responsibility to use them in a way that advances the health status of the community. In addition, we acknowledge our common duty to be stewards of the earth, and we recognize that we must use the earth's resources in ways that are equitable and ecologically sound. When resources are scarce, we have the responsibility to prioritize their use fairly and publicly.

Excellence

Motivated by compassion and professional integrity, we strive to provide the best care for every patient, at the right time, in the right setting, at an appropriate cost. We recognize that consistency in the way patients with similar conditions are treated is more likely to lead to better outcomes and, with humility and determination, we participate actively in opportunities to improve our service. We strive to implement evidence-based practices in order to promote safe, high-quality, efficient care that puts patients and their families at the center.

Resolution of Unforeseen Issues

Dignity Health's founders are women religious, for whom contemplation and action are linked in every decision. That tradition has come down to us in the way we go about making important, values-based decisions, specifically in the use of a discernment process that requires significant aspects of the decision be weighed in light of our core values. We try to be sure that stakeholders—people who are affected by the decision—can contribute appropriately to the decision. Options are considered in light of the core values, and after a period of reflection and respectful discussion, a decision is made that balances and honors the relevant values. This process is especially important when decisions are complex, or when the values involved may conflict. When issues that are unanticipated in this document arise between Dignity Health and its partners, we expect all to contribute to a decision that serves the common good.

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D. UC LEGAL GUIDANCE ON APPROVAL OF UC HEALTH TRANSACTIONS

UNIVERSITY OF CALIFORNIA

OFFICE OF THE GENERAL COUNSEL

Guidance: *Approval of UC Health Transactions*

April 10, 2019

Q. Who has the authority to approve a UC Health transaction?

A. The authority to approve depends on (i) the ***type of transaction*** and (ii) the ***value*** of the transaction.

Background

Types of Transactions. The President generally may enter into various contracts on behalf of the University, and has delegated much of this authority to the Executive Vice President for UC Health, the Chancellors, and other individuals. However, the following transactions require Board of Regents approval:

- University participation in corporations, companies, and partnerships
- Acquisition or disposition of a business
- Loans of University funds
- Affiliations with other institutions or hospitals involving financial obligations or commitments to programs not previously approved
- Agreements by which the University assumes liability for the conduct of persons other than University officers, agents, employees, students, invitees, and guests.

Delegations. For transactions that require Board approval, the Board has delegated its authority to approve ***UC Health business transactions*** to (i) the Health Services Committee (***Committee***) and (ii) the President (and, through delegation, the EVP-UC Health) and Chair or Vice Chair of the Committee, upon recommendation of the campus' Chancellor. The level at which approval must be obtained depends on the value of the transaction, as measured against the Medical Center's operating revenue for the prior fiscal year:

VALUE OF TRANSACTION		APPROVAL LEVEL
If the value is ***no more than*** the lesser of (i) ***1.5%*** of the Medical Center's operating revenue from the prior fiscal year or (ii) $25 million	→	Delegated Authority ("Local Level"). The transaction may be approved by action of the EVP-UC Health and Chair or Vice Chair of the Committee, upon recommendation of the Chancellor, subject to the annual cap described below.
If the value is ***greater than 1.5% and no more than 3%*** of the Medical Center's operating revenue from the prior fiscal year	→	Health Services Committee. The transaction may be approved by the Committee without further action by the Board, subject to the annual cap described below.
If the value is ***greater than 3%*** of the Medical Center's operating revenue from the prior fiscal year	→	Board of Regents. The Board as a whole must approve the transaction.

The thresholds for FY19 are set forth in Appendix 1.

Limits on Delegations. While the authority delegated with respect to UC Health transactions is broad, the foregoing delegations do not apply to ***capital projects***, transactions that are predominantly ***real estate*** transactions, or the ***issuance of debt***. Approval for such transactions continue to reside with the Finance and Capital Strategies Committee. However, the Health Services Committee may review and make recommendations on such transactions if they may affect UC Health clinical strategy. Examples of transactions that may be approved by the Committee or by delegated ("local") authority are listed in Appendix 2.

Further, the delegated ("local") and Health Services Committee authorities are subject to ***annual caps*** calculated each fiscal year based on the Medical Center's operating revenue for the prior fiscal year. Thus, even if the value of a specific transaction is less than 1.5% of the Medical Center's operating revenue or $25 million, approval by delegated ("local") authority is not sufficient if the value of the transaction, when combined with other transactions approved at that level for the Medical Center during the fiscal year, exceeds the annual cap. Similarly, even if the value of a specific transaction is less than 3% of the Medical Center's operating revenue, the Committee does not have authority to approve the transaction if its value, when combined with other transactions approved by the Committee for that Medical Center during the fiscal year, exceeds the annual cap. The annual caps for FY19 are set forth in Appendix 1.

Finally, any transaction involving ***more than one Medical Center*** is ineligible for approval by delegated ("local") authority.

How is the value of a transaction determined? The value of a transaction, which is defined in the Charter as amounts that a transaction "can reasonably be anticipated to commit or generate," depends on whether the University is acquiring an asset, or disposing of an asset.

- In a ***purchase or acquisition***, the value of the transaction is determined by the cumulative value of the University's financial commitment, including payments, contributions, and debt assumed. This applies to the capitalization of a new entity or joint venture, the purchase of an interest in an entity, an equity investment into an entity, or the purchase of a physician practice, hospital, clinic, or other facility or business. The value takes into account the University's cash and non-cash payments and contributions, including knowledge transfer, brand/goodwill, and tangible and intangible assets. Revenue from the purchased or acquired asset is not taken into account.

- In a ***sale or disposition***, the value of the transaction is determined by the value of the asset sold or disposed of. This applies to the University's sale of a dialysis or rehabilitation unit, or other asset. The value takes into account all payments to the University, including cash, securities, and tangible and intangible assets.

A note on the prior fiscal year's operating revenue. As noted above, the Medical Center's operating revenue for the prior fiscal year is relevant in determining the level at which approval must be obtained. This number is as reflected in the audited financial statements for the most recent full fiscal year that have been approved by the Board. The audited financials for a fiscal year (ending June 30) normally are approved by the Board in the fall of the following fiscal year. Until the audited financial statements for a fiscal year are approved by the Board, the audited financials last approved by the Board will apply for purposes of approving UC Health transactions.

Links

Regents Bylaw 22.2
Charter of the Health Services Committee
Delegation of Authority 2594-Execution of Documents Pertaining to the Clinical Enterprise

More Information

Rowena Manlapaz, Principal Counsel – Rowena.Manlapaz@ucop.edu or (510) 987-0388

APPENDIX 1

APPROVAL THRESHOLDS AND ANNUAL CAPS

Approval Thresholds for Fiscal Year 2018-2019						
	% of Operating Revenue	UCD	UCI	UCLA	UCSD	UCSF
Total Operating Revenue 2017-2018	100%	$ 2,221,761,000	$ 1,177,504,000	$ 2,514,065,000	$ 1,938,229,000	$ 4,370,406,000
Per Transaction Thresholds						
Health Services Committee	3.0%	$ 66,652,830	$ 35,325,120	$ 75,421,950	$ 58,146,870	$ 131,112,180
Delegated ("Local") Authority - EVP-UC Health, Chair or Vice Chair of the Health Services Committee, and Chancellor	1.5%*	$ 25,000,000	$ 17,662,560	$ 25,000,000	$ 25,000,000	$ 25,000,000
Annual Caps						
Health Services Committee	5.0%	$ 111,088,050	$ 58,875,200	$ 125,703,250	$ 96,911,450	$ 218,520,300
Delegated ("Local") Authority - EVP-UC Health, Chair or Vice Chair of the Health Services Committee, and Chancellor	3.0%^	$ 50,000,000	$ 35,325,120	$ 50,000,000	$ 50,000,000	$ 50,000,000

* *1.5% or $25 million, whichever is lesser.*

^ *3.0% or $50 million, whichever is lesser.*

APPENDIX 2

TYPES OF TRANSACTIONS
ARISING FROM OR SERVING THE PROGRAMS OR SERVICES OF UC HEALTH

	EXAMPLES / COMMENTS	APPROVAL REQUIRED
UC ***participation*** in corporations, companies, and partnerships	▪ Capitalization of a joint venture or other entity, including corporations, partnerships, LLCs, or a nonprofit entity ▪ Formation of an entity ▪ Purchase of an interest in an entity ▪ Equity investment into an entity	Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
Acquisition or ***disposition of a business***	▪ Purchase of a physician practice ▪ Purchase of a hospital, clinic, or other facility ▪ Sale of an inpatient unit (e.g., rehab or dialysis)	Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
Real estate transactions	▪ Purchase or sale of real estate ▪ Leases ▪ Capital projects (e.g., construction)	Regents, Finance and Capital Strategies Committee, or as delegated.
Affiliations involving financial obligations or commitments to ***programs not previously approved***	It is rare for an affiliation to fall under this type of transaction, since in most instances, the Medical Center already has the program in place. For guidance regarding a specific transaction, please contact OGC.	Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
Affiliations involving financial obligations or commitments to ***programs previously approved by the Board***	Most affiliations will fall under this type of transaction: ▪ Agreements to affiliate with any other person or entity, if the program exists at the Medical Center (e.g., affiliation for certain service lines) ▪ Agreements for UC to provide services, including in the international context (e.g., medical director services, consulting services)	Chancellor, as delegated.
Agreements by which UC ***assumes liability*** for the conduct of persons other than UC officers, agents, employees, students, invitees, and guests	▪ Agreement to indemnify a third party, regardless of whether the injury or claim was caused by the University (e.g., a pre-existing condition; claim caused by a contractor).	Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
	▪ ***Guaranty*** of a third party's obligations.	Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
Loans of UC funds		Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
Borrowing funds	▪ External financing	Regents, Finance and Capital Strategies Committee, or as delegated.
	▪ Borrowing funds in the context of a joint venture or other UC Health transaction (e.g., advances to UC in the event of its failure to make a capital contribution, etc.)	Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.
Other transactions primarily arising from or serving the programs or services of UC Health		Regents, Health Services Committee, or delegated ("local") authority, depending on transaction value.

E. ADVENTIST HEALTH LETTER TO UC DAVIS HEALTH

Administration

ONE Adventist Health Way
Roseville, CA 95661
916-406-1368

AdventistHealth.org

November 29, 2019

David A. Lubarsky, MD, Vice Chancellor and CEO
UC Davis Health
4610 X street, Suite 3101
Sacramento, CA 95817

Dear Dr. Lubarsky:

I am writing to provide you with more background on the governance and clinical policies of Adventist Health.

Historic Background

Adventist Health (AH) is a faith-based system sponsored by the Seventh-day Adventist Church. Our mission emphasis is on whole person health, providing physical, mental, spiritual and social impact in our communities. AH operates in over 80 communities in California, Oregon and Hawaii through 20 hospitals, 14 home care agencies, a health plan and a network of over 1200+ providers held in a California medical foundation model. Over 80% of the system's patients are from government payor sources, making AH one of California's largest safety net health systems, including East LA and two of the poorest counties in California. We have a special purpose in caring for the Mexican-American farming community in Central California through a wide network of Rural Health Centers.

Non-Discrimination

Adventist Health provides an environment for patients that is free from discrimination and will not exclude or treat people differently because of their ability to pay, age, color, culture, disability, gender identity or expression, language, marital status, religion, sexual orientation, socioeconomic status, type of insurance, or veterans status when delivering care, treatment, services and benefits of inpatients and outpatients. Every individual, regardless of personal beliefs, is welcome in our facilities.

Governance

While Adventist Health is sponsored by the Church, it is not owned or governed by the Church. It operates as an independently governed California nonprofit corporation.

The board of Adventist Health consists of 15 members. Two are Adventist Health officers, and the rest are members carefully selected for their competencies in key areas of healthcare.

Adventist Health is responsible for developing its own policies and governance. While its policies are informed by its Church heritage of health principles, the Church and its leadership have no direct control over Adventist Health policies and governance. Adventist Health does not believe in nor does it have policies equivalent to Ethical and Religious Directives.

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Clinical Decisions and Policies
Adventist Health supports and does not interfere with the patient – physician relationship and their care option choices. Clinical policies are established based on clinical best practices developed by multidisciplinary clinical team members and directed by physicians. The Church does not direct clinical practice.

Points of Clarification:
Because Adventist Health is a faith-based system, we are sometimes asked questions about how our faith traditions might influence certain specific clinical issues. Below are points of clarification to these questions:

Abortion:

- Adventist Health's practice is not to perform elective abortions; however, our system does allow abortion in cases of rape or incest, or where the life of the mother is at risk.
- Physicians at Adventist Health facilities may provide counseling and referrals based on their medical judgment and their patient's wishes. Adventist Health does not interfere with or guide those referrals.
- Adventist Health does not direct family planning counseling. Physicians and other providers may discuss family planning issues with their patients. Adventist Health supports the use of contraception and invitro fertilization when requested.
- Adventist Health physicians can perform tubal ligations and hysterectomies in Adventist Health facilities based on their clinical judgment and mutual decision making with their patients.

Transgender Care:

- Adventist Health hospitals have policies in place to make sure that all members of the LGBT community are provided with compassionate medical care that is considerate and respectful. Adventist Health hospitals do not have the competencies necessary to offer the complex gender reassignment treatments and surgeries but will help coordinate referral and transfer to capable facilities when requested.

Let me know if there are any other questions I can answer.

Sincerely,

Scott Reiner
Chief Executive Officer

SR/ct
D-11.29.19

F. COMPARISON OF RECOMMENDED OPTION 1 AND OPTION 2

PROPOSED STATEMENT OF UC HEALTH'S VALUES GOVERNING AFFILIATIONS WITH OTHER HEALTH SYSTEMS

Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
UC Health aspires to serve the public by improving health and health care for all people living in California now and in the future, by promoting health equity through the elimination of health disparities, and by reducing barriers to access clinical, educational, and research programs.	*UC aspires to improve health and health care for UC patients and all people living in California by improving quality, eliminating health care disparities and reducing barriers to access to the educational, research, and service programs and initiatives operated in service of its public mission.*	*UC ~~Health~~ aspires to ~~serve the public by improving~~improve health and health care for UC patients and all people living in California ~~now and in the future, by promoting health equity through the elimination of health~~by improving quality, eliminating health care disparities~~,~~ and ~~by~~ reducing barriers to access ~~clinical,~~to the educational, ~~and~~ research, and service programs~~.~~ and initiatives operated in service of its public mission.*
UC Health and all of our providers, faculty, staff, and trainees are expected to act in accordance with UC's core values of accountability, collaboration, diversity and inclusion, excellence, innovation, integrity, and a mission-driven dedication to align our work with the University's commitment to education, research, and public service.	*UC and its providers and trainees will provide the highest level of evidence-based care consistent with all of the rights and responsibilities of our patients and practitioners. Our clinicians will make clinical decisions, provide services, and perform procedures based on their independent professional judgment, will respect patient autonomy by carrying out patients' informed health care decisions, and are expected to act in accordance with UC's core values of integrity, excellence, accountability, respect and nondiscrimination.*	*UC ~~Health~~ and ~~all of our~~its providers~~, faculty, staff,~~ and trainees will provide the highest level of evidence-based care consistent with all of the rights and responsibilities of our patients and practitioners. Our clinicians will make clinical decisions, provide services, and perform procedures based on their independent professional judgment, will respect patient autonomy by carrying out patients' informed health care decisions, and are expected to act in accordance with UC's core values of ~~accountability, collaboration, diversity and inclusion, excellence, innovation, integrity, and a mission-driven dedication to align our work with the University's commitment to education, research, and public service.~~integrity, excellence, accountability, respect and nondiscrimination.*
UC Health providers are committed to advancing UC policies in all settings in which they operate and will perform their duties in ways that expand access, respect diversity, and practice inclusion.	*UC health providers are committed to following and advancing UC policies in all settings in which they operate, and will perform their duties in ways that expand access, respect diversity, practice inclusion.*	*UC ~~Health~~health providers are committed to following and advancing UC policies in all settings in which they operate, and will perform their duties in ways that expand access, respect diversity, ~~and~~ practice inclusion.*
	As a government entity committed to serving the public under the rule of law, UC and its providers and trainees will not restrict access to any lawful care because certain procedures or medical options are	*As a government entity committed to serving the public under the rule of law, UC and its providers and trainees will not restrict access to any lawful care because certain procedures or medical options are*

Legend	Insertion	~~Deletion~~	Moved to	~~Moved from~~

Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
	considered controversial from a particular political or religious point of view. In particular, UC Health affirmatively supports a woman's right to receive comprehensive reproductive health care including abortion and all forms of contraception and assisted reproductive technologies and believes that prohibiting or restricting these services has adverse consequences for patient care and well-being. UC Health affirms that LGBTQ+ people should not face discrimination in health care and that prohibiting services such as gender affirmation for transgender people and reproductive technologies that support the ability of LGBTQ+ people to have biological children is discriminatory. UC Health is also committed to providing the full range of options to patients at the end of life including legally sanctioned aid in dying.	*considered controversial from a particular political or religious point of view. In particular, UC Health affirmatively supports a woman's right to receive comprehensive reproductive health care including abortion and all forms of contraception and assisted reproductive technologies and believes that prohibiting or restricting these services has adverse consequences for patient care and well-being. UC Health affirms that LGBTQ+ people should not face discrimination in health care and that prohibiting services such as gender affirmation for transgender people and reproductive technologies that support the ability of LGBTQ+ people to have biological children is discriminatory. UC Health is also committed to providing the full range of options to patients at the end of life including legally sanctioned aid in dying.*

Legend	Insertion	~~Deletion~~	Moved to	~~Moved from~~

PROPOSED UC HEALTH AFFILIATION PRINCIPLES AND GUIDELINES

Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
Principle #1: Evidence-Based Care *UC Health, including all of our providers, trainees, and students, is committed to providing the highest levels of evidence-based care to all patients.*	**Principle #1: Standard of Care** *UC Health clinicians are committed to following the highest levels of evidence-based care.*	**Principle #1: ~~Evidence-Based~~Standard of Care** *UC Health~~, including all of our providers, trainees, and students, is~~ clinicians are committed to ~~providing~~following the highest levels of evidence-based care ~~to all patients.~~ .*
Guideline: Agreements will expressly provide that UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their health care options; (iii) prescribe any interventions that are medically necessary and appropriate; and (iv) transfer or refer patients to other facilities when the care they need is not available where they are being seen.	**Guideline**: Agreements will expressly provide that UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will make clinical decisions, provide services, and perform procedures consistent with the standard of care and their independent professional judgment, respecting patient autonomy by carrying out patients' informed health care decisions, considering the needs and wishes of each individual patient; inform patients of all of their health care options; and prescribe and perform any interventions that are medically necessary and appropriate.	**Guideline**: Agreements will expressly provide that UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will ~~(i)~~ make clinical decisions, provide services, and perform procedures consistent with the standard of care and their independent professional judgment, respecting patient autonomy by carrying out patients' informed health care decisions, considering the needs and wishes of each individual patient; ~~(ii)~~ inform patients of all of their health care options; ~~(iii)~~and prescribe and perform any interventions that are medically necessary and appropriate~~; and (iv) transfer or refer patients to other facilities when the care they need is not available where they are being seen~~.
Principle #2: Constitutional Obligations *UC will abide by its California constitutional obligation to be entirely independent of political or sectarian influence in the administration of its affairs, and by all federal constitutional obligations including prohibitions against discriminating against individuals or organizations in protected classes.*	**Principle #2: Constitutional Obligations** *UC will abide by its California constitutional obligation to be entirely independent of political or sectarian influence in the administration of its affairs, and by all federal constitutional obligations including prohibitions against discriminating against individuals or organizations in protected classes.*	**Principle #2: Constitutional Obligations** *UC will abide by its California constitutional obligation to be entirely independent of political or sectarian influence in the administration of its affairs, and by all federal constitutional obligations including prohibitions against discriminating against individuals or organizations in protected classes.*
Guideline: Agreements will require that affiliates understand and acknowledge UC's California constitutional obligations to be entirely independent of political or sectarian influence in the administration of its affairs. No provision in any institutional agreement will require UC or its personnel or trainees to enforce or abide by religious directives. The University's affiliation policies and practices will also be consistent with all federal constitutional obligations.	**Guideline**: Agreements will require that affiliates understand and acknowledge UC's California constitutional obligations to be entirely independent of political or sectarian influence in the administration of its affairs. Institutional agreements will expressly state that UC and its personnel and trainees will not enforce or abide by religious directives. The University's affiliation policies and practices will also be consistent with all federal constitutional obligations.	**Guideline**: Agreements will require that affiliates understand and acknowledge UC's California constitutional obligations to be entirely independent of political or sectarian influence in the administration of its affairs. ~~No provision in any institutional agreement will require~~Institutional agreements will expressly state that UC ~~or~~and its personnel ~~or~~and trainees ~~to~~will not enforce or abide by religious directives. The University's affiliation policies and practices will also be consistent with all federal constitutional obligations.

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Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
Principle #3: Nondiscrimination *UC personnel are bound by UC nondiscrimination policies wherever they work or train and UC will require all affiliates to have an express institutional policy prohibiting discrimination. We recognize and respect the diverse preferences and practices of our patients and personnel.*	**Principle #3: Nondiscrimination** *UC personnel are bound by UC nondiscrimination policies wherever they work or train and UC will require all affiliates to have an express institutional policy prohibiting discrimination.*	**Principle #3: Nondiscrimination** *UC personnel are bound by UC nondiscrimination policies wherever they work or train and UC will require all affiliates to have an express institutional policy prohibiting discrimination.* ~~*We recognize and respect the diverse preferences and practices of our patients and personnel.*~~
Guideline: Every UC Health affiliation agreement will describe UC's nondiscrimination policy, which prohibits UC personnel in any setting to engage in discrimination and harassment, and provides equal opportunities and care regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, status as a covered veteran, or any other basis prohibited by federal or state law. UC Health will require that every affiliate agree to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination (these include SB 464, codified at Cal. HS&C 1262.6(a)(5), requiring every California hospital to provide each patient in writing information that includes their right to be free from discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language or immigration status as set forth in Section 51 of the Civil Code).	**Guideline**: Every UC Health affiliation agreement will describe UC's nondiscrimination policy, which prohibits UC personnel in any setting to engage in discrimination and harassment, and provides equal opportunities and care regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, status as a covered veteran, or any other basis prohibited by federal or state law. Agreements will describe that UC considers institutional policies that prohibit gender-affirming services for transgender people, abortion for pregnant people, or reproductive health services that disproportionately affect women and LGBT people, to violate their antidiscrimination policy because gender, pregnancy, sex, and sexual orientation are protected classes. UC Health will require that every affiliate agree to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination (these include SB 464, codified at Cal. HS&C 1262.6(a)(5), requiring every California hospital to provide each patient in writing information that includes their right to be free from discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language or immigration status as set forth in Section 51 of the Civil Code).	**Guideline**: Every UC Health affiliation agreement will describe UC's nondiscrimination policy, which prohibits UC personnel in any setting to engage in discrimination and harassment, and provides equal opportunities and care regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, status as a covered veteran, or any other basis prohibited by federal or state law. Agreements will describe that UC considers institutional policies that prohibit gender-affirming services for transgender people, abortion for pregnant people, or reproductive health services that disproportionately affect women and LGBT people, to violate their antidiscrimination policy because gender, pregnancy, sex, and sexual orientation are protected classes. UC Health will require that every affiliate agree to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination (these include SB 464, codified at Cal. HS&C 1262.6(a)(5), requiring every California hospital to provide each patient in writing information that includes their right to be free from discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language or immigration status as set forth in Section 51 of the Civil Code).

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Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
Principle #4: Expanding Access to Care *UC Health affiliations should aim to reduce barriers to access for all people living in California to UC Health, improve the ability of patients at partner institutions to access UC practices and services, and increase the availability of health care options to patients. As a government entity committed to serving the public under the rule of law, UC Health will not restrict access to any lawful care because certain procedures or medical options are considered controversial from a particular political or religious point of view. UC Health affirmatively supports a woman's right to receive comprehensive reproductive health care, including abortion and all forms of contraception and assisted reproductive technologies. UC Health affirms that LGBTQ+ people should not face discrimination in health care and that prohibiting services such as gender affirmation for transgender people and reproductive technologies that support the ability of LGBTQ+ people to have biological children is discriminatory. UC Health is also committed to providing the full range of options to patients at the end of life including legally-sanctioned aid in dying.*	**Principle #4: Expanding Access to Care** *UC Health affiliations should aim to reduce barriers to access to care for all people living in California, improve the ability of patients at partner institutions to access UC practices and services, and increase the availability of health care options to patients. Affiliations should not reduce access or the availability of services for existing UC patients including comprehensive reproductive health care, gender-affirming care for transgender people, and end of life care.*	**Principle #4: Expanding Access to Care** *UC Health affiliations should aim to reduce barriers to access to care for all people living in California ~~to UC Health~~, improve the ability of patients at partner institutions to access UC practices and services, and increase the availability of health care options to patients. ~~As a government entity committed to serving the public under the rule of law, UC Health will not restrict access to any lawful care because certain procedures or medical options are considered controversial from a particular political or religious point of view. UC Health affirmatively supports a woman's right to receive~~ Affiliations should not reduce access or the availability of services for existing UC patients including comprehensive reproductive health care, ~~including abortion and all forms of contraception and assisted reproductive technologies. UC Health affirms that LGBTQ+ people should not face discrimination in health care and that prohibiting services such as gender affirmation~~ gender-affirming care for transgender people, and ~~reproductive technologies that support the ability of LGBTQ+ people to have biological children is discriminatory. UC Health is also committed to providing the full range of options to patients at the end of life including legally-sanctioned aid in dying~~ end of life care.*
Guideline: Given UC's commitment to addressing health disparities and improving access for all people who live in California to quality health care, UC will evaluate potential affiliations in the context of UC's commitment to optimize access to comprehensive, nondiscriminatory, evidence-based health care options. To improve health for all people who live in California, UC Health will consider all aspects of an organization's care in an affiliation, including policy-based restrictions, service to the underserved, and the availability of other facilities within a geographic region. Where relevant to	**Guideline**: UC will evaluate potential affiliations and take necessary action to promote, and not prohibit or limit, the use and delivery of comprehensive, nondiscriminatory, evidence-based health care options to ensure that access to services including abortion, contraception, assisted reproductive technologies, and gender-affirming care for transgender people are maintained or improved as a result of the affiliation. UC will ensure that affiliations do not result in a decrease in the ability of UC patients to obtain these services in facilities where they receive care compared with	**Guideline**: ~~Given UC's commitment to addressing health disparities and improving access for all people who live in California to quality health care,~~ UC will evaluate potential affiliations ~~in the context of UC's commitment to optimize access to~~ and take necessary action to promote, and not prohibit or limit, the use and delivery of comprehensive, nondiscriminatory, evidence-based health care options~~. To improve health for all people who live in California, UC Health will consider all aspects of an organization's care in an affiliation, including policy-based restrictions, service to the underserved, and the~~

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Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
UC's role in an affiliation, we will ensure that access to services like abortion, contraception and assisted reproductive technologies, and gender-affirming care will be maintained or improved as a result of the affiliation.	access to these services prior to the affiliation.	~~availability of other facilities within a geographic region. Where relevant to UC's role in an affiliation, we will~~ to ensure that access to services ~~like~~including abortion, contraception ~~and~~, assisted reproductive technologies, and gender-affirming care ~~will be~~for transgender people are maintained or improved as a result of the affiliation. UC will ensure that affiliations do not result in a decrease in the ability of UC patients to obtain these services in facilities where they receive care compared with access to these services prior to the affiliation.
Principle #5: Improving Quality of Care *UC Health is committed to affiliations that enhance the ability of UC and partner institutions to improve quality as defined by the Institute of Medicine — safe, timely, effective, efficient, patient-centric, equitable care.*	**Principle #5: Improving Quality of Care** *UC Health is committed to affiliations that enhance the ability of UC and partner institutions to improve the quality of care for UC patients and other people living in California.*	**Principle #5: Improving Quality of Care** *UC Health is committed to affiliations that enhance the ability of UC and partner institutions to improve the quality ~~as defined by the Institute of Medicine — safe, timely, effective, efficient, patient-centric, equitable care.~~of care for UC patients and other people living in California.*
Guideline: UC Health affiliations should be structured to enhance the quality of care provided at partner organizations and to enhance the range of high-quality services that patients in affiliated institutions can access. UC will work with partners to change or adapt policies and practices to improve quality. Performance and outcomes relevant to an affiliation should be documented and measured consistent with UC Health's existing system-wide quality guidelines for UC Health affiliations.	**Guideline**: UC Health affiliations should be structured to enhance the quality of care provided at partner organizations and UC will work with partners to change or adapt policies and practices to improve quality. Affiliations will not occur if potential partners are unwilling or unable to change or adapt policies to improve quality. Performance and outcomes relevant to an affiliation should be documented and measured consistent with UC Health's existing system-wide quality guidelines for UC Health affiliations.	**Guideline**: UC Health affiliations should be structured to enhance the quality of care provided at partner organizations and ~~to enhance the range of high-quality services that patients in affiliated institutions can access.~~ UC will work with partners to change or adapt policies and practices to improve quality. Affiliations will not occur if potential partners are unwilling or unable to change or adapt policies to improve quality. Performance and outcomes relevant to an affiliation should be documented and measured consistent with UC Health's existing system-wide quality guidelines for UC Health affiliations.
Principle #6: Academic Freedom *All affiliations must be consistent with UC's commitment to the protection of academic freedom.*	**Principle #6: Academic Freedom** *All affiliations must be consistent with UC's commitment to the protection of academic freedom.*	**Principle #6: Academic Freedom** *All affiliations must be consistent with UC's commitment to the protection of academic freedom.*
Guideline: All affiliations must conform to the rights, responsibilities, and obligations of faculty and non-faculty academic appointees as specified by UC's	**Guideline**: All affiliations must conform to the rights, responsibilities, and obligations of faculty and non-faculty academic appointees as specified by UC's	**Guideline**: All affiliations must conform to the rights, responsibilities, and obligations of faculty and non-faculty academic appointees as specified by UC's

Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
Academic Freedom policies in APM-010, APM-011, and APM-015. This requires that teaching, research and scholarship be assessed by reference to the professional standards that sustain the University's pursuit of knowledge, as set by the UC Academic Senate. These protections extend to teaching, research and scholarship conducted by UC academic appointees in non-UC locations when acting as agents of the University.	Academic Freedom policies in APM-010, APM-011, and APM-015. This requires that teaching, research and scholarship be assessed by reference to the professional standards that sustain the University's pursuit of knowledge, as set by the UC Academic Senate. These protections extend to teaching, research and scholarship conducted by UC academic appointees in non-UC locations when acting as agents of the University.	Academic Freedom policies in APM-010, APM-011, and APM-015. This requires that teaching, research and scholarship be assessed by reference to the professional standards that sustain the University's pursuit of knowledge, as set by the UC Academic Senate. These protections extend to teaching, research and scholarship conducted by UC academic appointees in non-UC locations when acting as agents of the University.
Principle #7: Preserving UC Values *All UC Health affiliations should be consistent with the fundamental mission and purpose of the University of California to serve society as a center of higher learning, providing long-term societal benefits through transmitting advanced knowledge, discovering new knowledge, and functioning as an active working repository of organized knowledge through teaching, research, and public service. Affiliations should also advance UC Health's core values of accountability, collaboration, diversity and Inclusion, excellence, innovation, integrity, and mission driven public service, including education and training of future health professionals, research that improves health and cures diseases, and the provision of clinical care across the state, particularly for the most vulnerable*.	**Principle #7: Preserving UC Values** *All UC Health affiliations should be consistent with the fundamental mission and purpose of the University of California to serve society as a center of higher learning, providing long-term societal benefits through transmitting advanced knowledge, discovering new knowledge, and functioning as an active working repository of organized knowledge through teaching, research, and public service.*	**Principle #7: Preserving UC Values** *All UC Health affiliations should be consistent with the fundamental mission and purpose of the University of California to serve society as a center of higher learning, providing long-term societal benefits through transmitting advanced knowledge, discovering new knowledge, and functioning as an active working repository of organized knowledge through teaching, research, and public service.* ~~*Affiliations should also advance UC Health's core values of accountability, collaboration, diversity and Inclusion, excellence, innovation, integrity, and mission driven public service, including education and training of future health professionals, research that improves health and cures diseases, and the provision of clinical care across the state, particularly for the most vulnerable.*~~
Guideline: UC Health affiliation agreements should expressly allow UC to terminate any affiliation agreement that, in our sole discretion, jeopardizes UC's core mission and values.	**Guideline**: UC will not enter into affiliations with entities that are fundamentally misaligned with our core mission and values. In addition, UC Health affiliation agreements should expressly allow UC to terminate any affiliation agreement that, in our sole discretion, jeopardizes UC's core mission and values.	**Guideline**: UC will not enter into affiliations with entities that are fundamentally misaligned with our core mission and values. In addition, UC Health affiliation agreements should expressly allow UC to terminate any affiliation agreement that, in our sole discretion, jeopardizes UC's core mission and values.

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MONITORING AND ACCOUNTABILITY

Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
The prerequisites or due diligence steps taken prior to entering into an affiliation should include the following: • Document before final approval the importance of the transaction as it relates to UC's missions and values, the benefit to the broader patient community, and the consequences of not proceeding with the transaction;	The prerequisites or due diligence steps taken prior to entering into an affiliation should include the following: • Document before final approval the rationale and importance of the transaction as it relates to UC's missions and values, the benefit to UC patients, UC providers and trainees, and/or the broader non-UC patient community, review any potential harms in the affiliation for UC patients, providers, and trainees, and non-UC patients, provide alternative options to the transaction that could avoid harms, and the consequences of not proceeding with the transaction;	The prerequisites or due diligence steps taken prior to entering into an affiliation should include the following: • Document before final approval the rationale and importance of the transaction as it relates to UC's missions and values, the benefit to UC patients, UC providers and trainees, and/or the broader ~~patient community~~non-UC patient community, review any potential harms in the affiliation for UC patients, providers, and trainees, and non-UC patients, provide alternative options to the transaction that could avoid harms, and the consequences of not proceeding with the transaction;
• Ensure that contract language documents that UC's values, principles and guidelines govern the medical decisions made by UC employees;	• Ensure that contract language documents that UC's values, principles and guidelines govern the medical decisions, services provided, and procedures performed by UC employees;	• Ensure that contract language documents that UC's values, principles and guidelines govern the medical decisions ~~made~~, services provided, and procedures performed by UC employees;
• Verify that potential affiliates understand that they will be required to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination;	• Verify that potential affiliates understand that they will be required to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination, including UC's;	• Verify that potential affiliates understand that they will be required to adhere to all laws, rules, regulations and accrediting standards regarding nondiscrimination, including UC's;
	• Verify that the contract language expressly states that UC providers and trainees will not be required to enforce or adhere to religious directives in their decision making, delivery of services, or performance of procedures while working in the affiliate institution;	• Verify that the contract language expressly states that UC providers and trainees will not be required to enforce or adhere to religious directives in their decision making, delivery of services, or performance of procedures while working in the affiliate institution;

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Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
• Verify that access to options currently available to patients for comprehensive reproductive health care, gender-affirming services and end-of life care will be maintained or improved as a result of the affiliation;	• Verify that access to options currently available to UC patients at their clinical site of care for contraception, abortion, assisted reproductive technology, gender-affirming services, and end-of life care will be not be decreased or diminished when UC patients receive care at the affiliate site, but rather that these services will be maintained or improved for UC patients as a result of the affiliation;	• Verify that access to options currently available to UC patients ~~for comprehensive~~at their clinical site of care for contraception, abortion, assisted reproductive ~~health care~~technology, gender-affirming services, and end-of life care will be not be decreased or diminished when UC patients receive care at the affiliate site, but rather that these services will be maintained or improved for UC patients as a result of the affiliation;
• Develop a process to facilitate timely access to UC or other facilities for services that are not provided at an affiliate's facility;	• Develop a process to facilitate timely access to UC or other facilities for services that are not provided at an affiliate's facility;	• Develop a process to facilitate timely access to UC or other facilities for services that are not provided at an affiliate's facility;
• Communicate to our personnel voluntarily performing services or receiving training at other facilities our expectations that they adhere to the evidence-based standard of care and their professional judgment wherever they are providing services;	• Communicate to our personnel and trainees performing services or procedures or receiving training at other facilities our expectations that they adhere to the evidence-based standard of care and their professional judgment, respecting patient autonomy in decision-making wherever they are providing services;	• Communicate to our personnel ~~voluntarily~~and trainees performing services or procedures or receiving training at other facilities our expectations that they adhere to the evidence-based standard of care and their professional judgment, respecting patient autonomy in decision-making wherever they are providing services;
•	• Ensure that UC patients cared for at the affiliate site will have full autonomy to make informed health care decisions within the standard of care and that these decisions will be followed and carried out, unrestricted by religious directives;	• Ensure that UC patients cared for at the affiliate site will have full autonomy to make informed health care decisions within the standard of care and that these decisions will be followed and carried out, unrestricted by religious directives;
• Ensure that UC personnel have a point of contact at UC that they can reach out to if they believe that their professional judgment is being impeded in any way at the affiliate's facility;	• Ensure that UC personnel and trainees have a point of contact at UC to which they can reach out confidentially if they believe that their ability to provide services or perform procedures based on their	• Ensure that UC personnel and trainees have a point of contact at UC ~~that~~to which they can reach out ~~to~~ confidentially if they believe that their ability to provide services or perform procedures based on their

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Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
	professional judgment is being impeded in any way at the affiliate's facility; and	professional judgment is being impeded in any way at the affiliate's facility; and
• Ensure that a mechanism (e.g., call center, ombudsperson) has been established to collect and review patient feedback, concerns and complaints regarding care; and create a baseline measure of quality and outcomes performance against which improvements in quality can be measured consistent with system-wide quality guidelines for UC Health affiliations; and	• Ensure that a mechanism (e.g., call center, ombudsperson) has been established to collect and review patient feedback, concerns and complaints regarding care, and create a baseline measure of quality and outcomes performance against which improvements in quality can be measured consistent with system-wide quality guidelines for UC Health affiliations.	• Ensure that a mechanism (e.g., call center, ombudsperson) has been established to collect and review patient feedback, concerns and complaints regarding care~~;~~, and create a baseline measure of quality and outcomes performance against which improvements in quality can be measured consistent with system-wide quality guidelines for UC Health affiliations.
• For joint ventures and/or investments, require non-UC affiliates to participate in the Human Rights Campaign's Healthcare Equality Index, a national LGBTQ+ benchmarking tool that evaluates health care facilities' equity and inclusion of their LGBTQ+ patients, visitors and employees.		• ~~For joint ventures and/or investments, require non-UC affiliates to participate in the Human Rights Campaign's Healthcare Equality Index, a national LGBTQ+ benchmarking tool that evaluates health care facilities' equity and inclusion of their LGBTQ+ patients, visitors and employees.~~
After affiliations are entered into, UC health locations should: • Monitor the quality of care provided at an affiliate's facility related to services provided by UC, consistent with systemwide quality guidelines for UC Health affiliations;	After affiliations are entered into, UC health locations should: • Monitor the quality of care provided at an affiliate's facility related to services provided by UC, consistent with systemwide quality guidelines for UC Health affiliations;	After affiliations are entered into, UC health locations should: • Monitor the quality of care provided at an affiliate's facility related to services provided by UC, consistent with systemwide quality guidelines for UC Health affiliations;
• Strengthen and supplement mechanisms as needed for UC personnel working at affiliate locations to report any incidents of their being impeded from adhering to the principles and guidelines governing affiliations; quickly report and resolve any grievances indicating a violation of affiliation guidelines;	• Strengthen and supplement mechanisms as needed for UC personnel and trainees working at affiliate locations to confidentially report any incidents of their being impeded from adhering to the principles and guidelines governing affiliations, quickly report and resolve any grievances indicating a violation of affiliation guidelines, while	• Strengthen and supplement mechanisms as needed for UC personnel and trainees working at affiliate locations to confidentially report any incidents of their being impeded from adhering to the principles and guidelines governing affiliations~~;~~, quickly report and resolve any grievances indicating a violation of affiliation guidelines, while

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Option 1: Allow Affiliations with Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Option 2: Prohibit Affiliations With Non-UC Entities that Prohibit Certain Services for Women and LGBTQ+ People	Comparison of Option 1 to Option 2
	protecting the privacy of any involved UC personnel;	protecting the privacy of any involved UC personnel;
• Strengthen and supplement mechanisms as needed for UC patients at non-UC facilities to share feedback, concerns and complaints regarding care; quickly report and resolve any grievances indicating a violation of affiliation guidelines; and	• Strengthen and supplement mechanisms as needed for UC patients at non-UC facilities to share feedback, concerns and complaints regarding care; quickly report and resolve any grievances indicating a violation of affiliation guidelines; and	• Strengthen and supplement mechanisms as needed for UC patients at non-UC facilities to share feedback, concerns and complaints regarding care; quickly report and resolve any grievances indicating a violation of affiliation guidelines; and
• Ensure the ability to terminate any affiliation agreement once entered into should circumstances change such that UC's core mission and values are jeopardized.	• Ensure the ability to terminate any affiliation agreement once entered into should circumstances change such that in UC's opinion, the University's core mission and values are jeopardized.	• Ensure the ability to terminate any affiliation agreement once entered into should circumstances change such that ~~UC~~in UC's opinion, the University's core mission and values are jeopardized.

• For joint ventures and/or investments:
  • Assess and report on whether the affiliation is expanding access to UC quality care and reducing health disparities;
  • Monitor the affiliate's Health Equity Index Scores annually and report the results to leadership; and
  o Compile an annual report to the President and Board of Regents about the nature, rationale, and community impact of the affiliation.
		~~• For joint ventures and/or investments:~~
		  ~~• Assess and report on whether the affiliation is expanding access to UC quality care and reducing health disparities;~~
		  ~~• Monitor the affiliate's Health Equity Index Scores annually and report the results to leadership; and~~
		  o ~~Compile an annual report to the President and Board of Regents about the nature, rationale, and community impact of the affiliation.~~

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G. ADDITIONAL RESOURCES

A. AAMC. Advancing the Academic Health System for the Future. 2013. https://www.aamc.org/what-we-do/mission-areas/patient-care/advancing-future-academic-health-systems

B. CA Health and Human Services Agency. Hospital Annual Utilization Report and Pivot Tables. https://data.chhs.ca.gov/dataset/hospital-annual-utilization-report

C. Final Report of the UC Academic Senate UC Non-Discrimination in Healthcare Task Force. 2019. https://senate.universityofcalifornia.edu/_files/reports/rm-jn-final-report-non-discrimination-healthcare-taskforce.pdf

D. The Joint Commision. Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. 2011 https://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

E. State of CA SB-464. California Diginity in Pregnancy and Childbirth Act. Approved October 7, 2019. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB464

F. UCSF Academic Senate. Taskforce on Clinical Affiliate Agreements and Quality of Care. October 2016. https://senate.ucsf.edu/sites/default/files/2017-09/4-CAC-d-cac-2016-10-21-AffiliationsTaskForceReport.pdf

G. University of California Accountability Report. Chapter 11, UC Health. 2019. https://accountability.universityofcalifornia.edu/2019/chapters/chapter-11.html

H. University of California Board of Regents Policy 1111: Policy on Statement of Ethical Values and Standards of Ethical Conduct. Approved May 2005. Amended March 6, 2017. https://regents.universityofcalifornia.edu/governance/policies/1111.html

I. University of California Board of Regents Policy 4400: Policy on University of California Diversity Statement. September 16, 2010. https://regents.universityofcalifornia.edu/governance/policies/4400.html

J. University of California Board of Regents Policy 4401: Policy on Future Admissions, Employment, and Contracting. May 16, 2001. https://regents.universityofcalifornia.edu/governance/policies/4401.html

K. University of California Board of Regents Policy 4402: Policy on Nondiscrimination on Basis of Sexual Orientation. June 1983. https://regents.universityofcalifornia.edu/governance/policies/4402.html

L. University of California Board of Regents Policy 4403: Report of the Working Group: Statement of Principles against Intolerance. January 22, 2016. https://regents.universityofcalifornia.edu/policies/4403.pdf

M. University of California Board of Regents Health Services Committee. April 9, 2019. https://regents.universityofcalifornia.edu/meetings/videos/april2019/april19.html

N. University of California Nondiscrimination Statement. https://www.ucop.edu/operating-budget/fees-and-enrollments/policies-and-resources/nondiscrimination-statement.html

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SANTA BARBARA • SANTA CRUZ

December 24, 2019

President Janet Napolitano
University of California Regents
University of California Office of the President
1111 Franklin St
Oakland, CA 94607

Re: Dissent and Concern Regarding the Working Group on Comprehensive Access Report

Dear President Napolitano,

Thank you for inviting us to serve as members of the Working Group on Comprehensive Access (WGCA). Chancellor Gillman chaired the WGCA with great attention to the diverse perspectives of committee members. We are very appreciative of his significant efforts and commitment to the group.

As the three representatives of the UC Academic Senate on WGCA, we did not sign on to endorse the WGCA report. We are deeply concerned with the plan for UC Health to expand its affiliations with healthcare systems that use religious directives to prohibit key services for women and LGBT people. Our concerns are consistent with: 1) UCSF faculty who voted 2:1 to oppose affiliations with these entities, 2) the Academic Senate Non-Discrimination in Healthcare Task Force report, 3) 2,900 UC faculty, staff, students, and alumni who signed an opposition letter regarding the UCSF/Dignity affiliation, and 4) all major reproductive rights and LGBT advocacy groups in California (see attached list).

As written, the report implies that UC Health leadership has proposed new and revised policies to address the concerns raised by diverse stakeholders about affiliations with religious entities. We strongly disagree with this assessment; **there are no significant differences in what UC Health is currently proposing compared with their plans prior to the WGCA deliberations.** Rather, UC Health has reworked and nuanced the language used to present their recommendations with an aim to appease public scrutiny. Moreover, the report does not provide sufficient content or structure to consider this critical point. For instance, as presented, it is nearly impossible to discern and understand the subtle, but important differences between version 1 and 2 of the proposed guidelines. We have many concerns about the report, but will highlight several key issues:

1. Deceptive Language about UC Employees and Religious Directives: UC Health is providing the public with false reassurances, hiding the reality that UC personnel in Catholic hospitals need to follow religious directives.

A. Affiliation agreements with Catholic hospitals state that the facility is subject to the Ethical and Religious Directives for Catholic Healthcare (the ERDs) which prohibit all contraception (birth control), abortion, assisted reproductive technology (e.g IVF), and by association, gender affirming care for transgender people (e.g. hysterectomy for transgender men).

B. Simply put, the ERDs are the rules of the hospital in Catholic facilities and UC employees are expected to follow hospital rules in all settings that they practice, or risk significant negative consequences.

C. However, UC Health leadership asserts that "no agreement will require UC personnel or trainees to enforce or abide by religious directives" (version 1, principle 2). This appears to contradict the reality of clinical practice in which UC staff in Catholic hospitals must abide by religious directives because the hospital rules prohibit them from providing certain services and procedures.

D. To clarify expectations for UC personnel working in Catholic facilities, we suggested that agreements expressly state that "UC personnel or trainees will *not* need to abide by religious directives" (version 2, principle 2). Without this exemption, UC personnel will assume that they must follow religious directives in Catholic facilities because it is standard practice to comply with hospital rules and regulations. UC health leadership adamantly declined our suggested edit to assure personnel will not follow religious directives.

If UC personnel and trainees do not need to abide by religious directives, why does UC Health refuse to include this exemption in affiliation agreements?

2. Misleading Discussion of Prohibitions on Patient Care: UC health leadership asserts that UC personnel will "make clinical decisions consistent with…their independent professional judgment…respecting the wishes of each individual patient" and "prescribe any interventions that are medically necessary and appropriate" (version 1, principle 1).

A. While these statements may appear to indicate full autonomy to practice medicine, *the wording is specifically crafted to limit autonomy and patient care in order to align with religious directives.*

B. The proposed guideline refers to "making clinical decisions", but clinical decisions are only one aspect of patient care. A provider also needs the freedom to deliver services and perform procedures to meet the standard of care. For instance, if a doctor makes a clinical decision that IV antibiotics are needed to treat an infection in a hospitalized patient, the doctor must also be allowed to give the antibiotics (deliver a service) to provide appropriate care. Similarly, if a doctor makes a clinical decision to provide an IUD for birth control, but is then prohibited from placing the IUD (performing a procedure) due to religious directives, patient care is compromised.

C. Autonomy limited to "prescribing interventions" is inadequate in the care of women and LGBT people because standard treatments are not available by prescription. For instance, the most effective methods of birth control cannot be obtained with a prescription. Rather, they require a procedure be performed in a hospital or clinic (e.g. IUD, contraceptive implant or injection, tubal ligation surgery).

D. Under the ERDs, the wishes of patients cannot be followed unless they align with Catholic doctrine. The ERDs state "the free and informed health care decision of the person…is to be followed so long as it does not contradict Catholic Principles".

E. To assure that UC personnel will have autonomy to practice medicine and care for our patients, we proposed edits to principle 1 as follows: UC personnel will "make clinical

decisions, *provide services, and perform procedures*...consistent with their independent professional judgment" and they will "prescribe *and perform* any procedures that are medically necessary and appropriate" (version 2, principle 1). UC health leadership declined this edit.

If UC Health leadership believes that personnel should have autonomy to practice medicine unconstrained by religious directives, why did they refuse to include the full scope of patient care activities in the guideline on autonomy?

3. **Inappropriate Presentation of Scope and Consequences of Affiliations with Catholic Healthcare**: UC health leadership present a biased assessment of potential consequences if UC does not affiliate with entities that have religious restrictions on care. They report data as numerators, but omit key denominators, which prevents accurate interpretation.

A. For instance, they report 12,000 patients at UCLA were seen in Catholic-affiliated institutions in FY 2019, which appears to be a very high volume. However, according to the UCLA website, there are 600,000 patients seen per year; therefore, patients at Catholic-affiliated institutions are just 2% of the annual patient population. They also describe two UC residency training programs that are affiliated with Catholic facilities, but according to public websites, UC has at least 106 residency programs; the programs in the report represent <2% of overall residency training. From these examples, it appears that a very small proportion of current training and clinical care programs would be impacted by adopting a policy that prevents affiliations with entities that restrict care for women and LGBT people based on religious directives.

B. UC health leadership also assert that people in California will be significantly harmed if we do not affiliate with entities that have religious restrictions on care. They describe that without these affiliations, patients would not otherwise receive "life-saving and life-sustaining" services. We believe it is misleading and inappropriate to posit that patients cared for in Catholic hospitals cannot receive the care they need without a UC affiliation, particularly because most of these hospitals currently operate without a UC affiliation. Presumably, if UC declines to affiliate with hospitals under the ERDs, these facilities will continue their current practice of affiliating with non-UC entities to provide care and services for their patients.

C. The report puts forth a false narrative in which affiliating with Catholic healthcare is essential, perhaps inevitable, in order to maintain our clinical, teaching, and research programs. We categorically reject this notion and believe it undermines the very foundation of UC's success, our capacity to address challenges with creative and innovative solutions that do not compromise our core values.

D. Only 14% of hospitals in California are governed by religious directives from the Catholic Church. Yet, UC health leadership has declined to present any alternative solutions to address our clinical and teaching capacity needs besides partnerships with these hospitals that restrict care for women and LGBT people.

E. We are concerned that the failure of UC Health leadership to provide any alternatives may lead the Regents to presume that there are no viable paths forward that do not involve expanding affiliations with Catholic healthcare entities. We reject this notion on the premise that multiple strategies always exist to tackle major challenges in healthcare. For instance, could UC Health expand UC affiliations with non-Catholic health systems? Or with public and county hospitals that focus on care of the underserved? Or re-open or expand current UC facilities such as Mt Zion hospital at

UCSF? We wonder what other possibilities might exist to address the clinical and teaching capacity needs of UC Health.

Why won't UC Health leadership propose any alternatives to address our clinical, teaching, and public health missions that do not involve affiliations that restrict care for women and LGBT people?

4. Inaccurate Assessment of the Impact of Affiliations on Care of Women, LGBT people, and the Underserved: UC health leadership emphasizes that they aim to affirm a "woman's right to reproductive healthcare including abortion" and assure that "LGBT people should not face discrimination in healthcare" (version 1, principle 4). UC health leadership asserts that affiliating with Catholic healthcare will improve care for women, LGBT people, and the underserved.

A. We need to strongly correct this misguided viewpoint. **Policies that prohibit contraception, abortion, and assisted reproductive technology harm women and LGBT people in significant and meaningful ways, and these prohibitions have a disproportionately negative impact on the health of low-income and other underserved patients.**

B. Healthcare entities that prohibit gender affirming care for transgender people based on religious directives discriminate against transgender people and harm transgender people in significant and meaningful ways.

C. Unlike other non-UC entities that can partner with UC to improve care in their facility with an affiliation agreement, Catholic healthcare cannot break from the ERDs, even when UC providers are present in the facility or UC health leadership has joint governance in an affiliation.

If UC health leadership aims to advocate for women and LGBT people, why would they seek affiliations that are opposed by every major advocacy group for reproductive rights and LGBT people in California (see attached list)?

5. **Late Additions of Undiscussed Content**: The final draft of the report included several key items that were not previously discussed at WGCA.

A. The WGCA was not provided with information on Employee Health Benefits and did not debate issues related to this issue.

B. At the first meeting of the WGCA, UC Health leadership reviewed the definition of what UC considers an affiliation and employee benefit contracts were not even mentioned.

C. However, employee benefits are discussed multiple times in the report by UC Health leadership in an attempt to justify affiliations with Catholic healthcare.

We do not believe it is appropriate to include this undiscussed information in the report, nor do we feel it is appropriate to equate employee health benefits, in which employees can choose membership in a variety of plans, to the issues of restricting or prohibiting clinical care for patients under our direct care at UC.

6. Lack of Transparency and Breeches of Confidentiality: We have been deeply distressed by some key process measures during the WGCA deliberations.

A. Although UC Health WGCA members were aware that interim guidelines had been issued for affiliations with Catholic healthcare, we were not told that interim guidelines were in place until after this issue was referenced in a public email from Chancellor Hawgood to UCSF during late November 2019.

B. Similarly, we were not notified that UC Health was actively renegotiating contracts with Dignity Health to alter key contractual language related to the ERDs at the same time that the WGCA was actively debating how UC should proceed in contractual agreements. When we raised this issue at one of the final WGCA meetings, we were told that these negotiations on the ERDs were out of scope for WGCA discussions. After several requests, we were ultimately provided with a small section of the renegotiated contract with Dignity Health during the last WGCA meeting. This contract was highly relevant and could have provided additional insights into our WGCA discussions.

C. In addition, we were told on multiple occasions by the WGCA Chair that the membership should be kept confidential until the report was public, but UCSF leadership sent an email to the entire campus on 11.15.19 that named themselves as WGCA members and also said a member was a "faculty in Obstetrics, Gynecology, and Reproductive Sciences".

D. Finally, and most concerning, there are several sections of the confidential WGCA report that are identical in content, word for word, to both the recently renegotiated contract with Dignity Health, and the Chancellor Hawgood email to the UCSF community on 11.15.19. We have not been provided with an adequate explanation of how identical paragraphs from a confidential report could appear in contracts and campus communications, but we believe this warrants further investigation. **Either the WGCA report was, at least in part, sourced directly from the revised Dignity contract, or the confidential WGCA report was used to draft the revised Dignity contract. At best, the behavior is highly inappropriate.**

Why was key information withheld from some, but not all, members of the WGCA, and how did language from the confidential WGCA reports regarding the ERDs also appear in recently renegotiated Dignity Health contracts?

The WGCA convened at a critical time to consider policy that affects the health and well-being of women and LGBT people in California. Across the country, encroachments on access to contraception and abortion have grown exponentially and the Supreme Court may soon overturn Roe vs. Wade, significantly disrupting the fundamental rights of women to receive comprehensive reproductive healthcare. Recent changes in federal government policies have stripped transgender people of equal protection against discrimination in healthcare settings.

In this context, California remains a critical safe haven state for women's reproductive freedom and the dignity and rights of LGBT people. In particular, the University of California, which is constitutionally obligated to remain free of sectarian influences in the administration of its affairs, has consistently set policies and practice that aim to elevate and support women and LGBT people.

We sincerely hope that UC will remain true to its legacy of fighting discrimination and injustices, guided by our core values and mission. We challenge UC Health leadership to

present solutions to our healthcare challenges that do not involve partnerships with entities that prohibit critical services for women and LGBT people.

Sincerely,
Academic Senate Representatives to the Working Group on Comprehensive Access:

Kum-Kum Bhavnani
Distinguished Professor of Sociology
Chair, UC Systemwide Senate 2019 - 2020

Vanessa Jacoby, MD, MAS
Associate Professor of Obstetrics, Gynecology, and Reproductive Sciences
University of California, San Francisco

Robert May
Distinguished Professor of Philosophy and Linguistics
University of California, Davis
Chair, UC Systemwide Senate 2018-2019

Letters or Statements in Opposition to UCSF/Dignity Affiliation, 5.24.19

Politicians

- CA Lieutenant Governor Eleni Kounalakis Lt Gov Opposition UCSF/Dignity
- CA Senator Holly Mitchell, Chair of Senate Committee on Budget and Fiscal Review
- CA Assemblymember Jose Medina, Chair of Committee on Higher Education
- CA Assemblywoman Lorena Gonzalez, 80th Assembly District
- CA Democratic Legislative Women's Caucus
- CA Legislature LGBT Caucus

UCSF Faculty

- UCSF Faculty Association Opposition to UCSF/Dignity UCSF Faculty Association
- UCSF all Faculty Vote, 705 respondents: **63% opposed**, 27% support, 10% neutral

Medical Societies

- American College of Obstetricians and Gynecologists
- CA Academy of Family Physicians
- Gay and Lesbian Medical Association
- California Nurse-Midwives Association

LGBT Groups

- National Center for Lesbian Rights
- Equality California
- Lambda Legal Defense and Education Fund, Inc.
- San Francisco LGBT Center
- Los Angeles LGBT Center
- National Center for Transgender Equality
- National LGBTQ Task Force
- Bay Area Lawyers for Individual Freedom
- National Trans Bar Association
- Transgender Law Center
- UCLA Williams Institute

Reproductive Rights Organizations

- ACLU
- Planned Parenthood (CA Planned Parenthood Education Fund)
- NARAL Prochoice California
- National Organization for Women, California
- California Latinas for Reproductive Justice
- National Health Law Program
- California LGBT Health and Human Services Network
- Women's Foundation of California
- Positive Women's Network-USA

- Center of Reproductive Rights and Justice, Berkeley Law
- Essential Access Health
- If/When/How: Lawyering for Reproductive Justice
- LadyParts Justice League

UCSF Donors

- The BaSe Family Fund
- Don and Carole Chaiken Foundation
- Ray and Dagmar Dolby Family Fund
- Grove Foundation
- Michelle Mercer and Bruce Golden Foundation
- Mary Wohlford Foundation
- Lisa Lindelef
- Tara Health Foundation
- Todd Werby and Manola Greene Fund

Other

- Americans United for Separation of Church and State

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STEVEN W. HETTS, M.D.
PROFESSOR IN RESIDENCE OF RADIOLOGY AND BIOMEDICAL IMAGING
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SAN FRANCISCO, CALIFORNIA 94143

January 2, 2020

Janet Napolitano
President, University of California

Re: Working Group on Comprehensive Access

Dear President Napolitano:

As a member of the Working Group on Comprehensive Access and the current Academic Senate Representative to the Regents Health Services Committee, I would like to take this opportunity to provide you with a few of my thoughts regarding the WGCA report forwarded to you by Chancellor Howard Gillman as well as the underlying issues we tackled over three months late last year. These are my personal thoughts and are not meant to represent the views of all faculty members.

First, I think Chancellor Gillman has done a masterful job summarizing the positions held by the diverse members of the WGCA. Although these positions are disparate, there are significant areas of overlap with regard to underlying values espoused by members of the university, be they health sciences faculty, non-health sciences faculty, or health system administrators.

Second, I would like to highlight that the challenges, opportunities, and approaches to affiliations with faith-based health care organizations have been discussed for over three years at UCSF. Dating back to the affiliation between UCSF Benioff Children's Hospital and Providence St. Joseph Health in Santa Rosa in 2016, the UCSF division of the Academic Senate has been involved in multiple task forces with campus administration and UCSF Health leadership, culminating in the 2017 Joint Senate-Administrative Review Committee of the Campus Affiliation Policy. Throughout that period and subsequent to it, UCSF Health leadership has been in communication with and sought input from the divisional Academic Senate. Both the UCSF Senate Clinical Affairs Committee and the UCSF Senate Executive Committee endorsed the approach to affiliation with Dignity Health in 2018. I summarized this timeline in my remarks to the Regents HSC on April 9, 2019.

Third, as a clinician from a specialty that both provides emergency care for stroke patients as well as relies on a large population referral base for treatment of rare vascular malformations of the brain in children and adults, I am particularly aware of the importance of working with

health systems outside UC in order to fulfill our service mission of providing life-saving medical care to all people in California who need our expertise. UC providers are sometimes stationed in outlying facilities to provide basic care, perform triage, and facilitate urgent or emergent transfers of patients to UC facilities for higher levels of care. The public health implications of not being able to work with other health systems to prevent permanent disability and death of patients are significant and, for me personally, are decisive. I believe these sentiments are echoed in the position statements from the California Medical Association on November 20, 2019 and the California Hospital Association on November 21, 2019. I know that you, too, have had a productive working relationship with the head of Dignity Health, as you and Dr. Sandra Hernandez previously reported to the HSC regarding joint planning for the future health care work force of California. Being able to work productively with individuals and organizations that do not have identical values as UC in areas where our values and their values are aligned is essential to provide the greatest good to the greatest number of patients.

Finally, I would like to express my gratitude for your consideration of this difficult topic. Many stakeholders are opposed to affiliations with organizations that do not share all of UC's values and many other stakeholders are in favor of affiliations that are carefully circumscribed such that clinical care can be delivered in specialties and programs that do not raise ethical dilemmas. Regardless of the approach taken, I am sure this will be a long road ahead. I wish you a healthy 2020 and would be happy to discuss this issue with you at any time.

Sincerely,

Steven W. Hetts, MD
Professor In Residence of Radiology and Biomedical Imaging
Chief of Interventional Neuroradiology, UCSF Mission Bay Hospitals
Co-Director, UCSF Hereditary Hemorrhagic Telangiectasia Center of Excellence
Co-Director, Interventional Radiology Research Laboratory
Department of Radiology and Biomedical Imaging
University of California, San Francisco

Gabriel G. Haddad, M.D.
Distinguished Professor of Pediatrics and Neurosciences
Chair, Department of Pediatrics
Physician-in-Chief and Chief Scientific Officer
Rady Children's Hospital – San Diego

January 3, 2020

Dear President Napolitano:

I am writing this letter to you to give you my feedback about my lack of endorsement of the final WGCA report that was sent to you on 12/9/2019.

First, I would like to state that I was honored to be part of WGCA and to deliberate with the outstanding and very committed leaders in the UC of the various campuses. Furthermore, Chancellor Gilman was an extraordinary leader during the WG's discussions.

It was clear during our deliberations that there were divergent opinions and that we all respected these various opinions. Indeed, we were all proud of the diversity of ideas that we all encourage in our University.

The lack of my support of the final report is not related to the way the report was written or to what it represented since it portrayed accurately both sides of the debate with regard to the affiliation of UC Health with faith-based organizations. While I believe that we had a healthy and substantive debate during the past 90 days, I did not support the final report for two reasons:

A) In my view, the final report appeared to expose the two sides of the arguments, which is valuable, and not as much to attempt to find ways of compromise and find solutions to a major problem affecting the UC health system. It is possible that this was not our task but it felt as if we did not "finish" what we started with.
B) There are ways we could have helped further to find solutions. For example:
    1. We had no data about the frequency of events that put UC personnel in situations when they faced ethical dilemmas that were inconsistent with UC's obligations.
    2. We had no data about the frequency of events that ERD restrictions affected general health care and not only health care related to abortions or contraception if UC health campuses were affiliated with faith-based organizations.
    3. We had no bioethicists in the group, which could have helped in general bring parties further closer.

It is possible that none of these ideas and data would have mattered to bringing parties together. And it is possible that such debates are so difficult that we will always have two sides of the coin and that these may not be reconcilable. However, I would like to be optimistic and believe that leaders with all the good intentions will find solutions at the great University of California!

All the best for this holiday season!

Sincerely,

Gabriel G. Haddad, M.D.

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Mark R. Laret
President and
Chief Executive Officer

January 17, 2020

Janet Napolitano
President
University of California
1111 Franklin St.
Oakland, CA 94607-5200

Dear President Napolitano:

As a member of the Working Group on Comprehensive Access, I want to compliment Chancellor Howard Gilman for his remarkable job leading this group over the past several months.

I endorse the Chair's report, and am adding these further comments in the hope that they add a useful perspective for the many readers of the report. I also recommend a path forward for your consideration.

"Always do what is in the best interests of the patient."

This was the advice given me as a young UCLA hospital administrator over 30 years ago, as a guide for how to decide among the complex regulatory, business, academic, patient care and public health issues that I would face running a large healthcare institution. That statement has been my guiding light during my career that included 15 years at UCLA, five years as CEO of UCI Medical Center, and 20 years as CEO of UCSF Medical Center.

That guideline is applicable to helping find the right answer to the complex question of whether UC Health enterprises should be allowed to affiliate with Catholic healthcare institutions. Opponents of these relationships now want a total ban on UC affiliations with Catholic healthcare institutions.

I come to this debate humbly and thoughtfully as someone who has been at the frontline of working with a diversity of healthcare providers, including Catholic healthcare. It was UCSF's relationships with Providence over four years ago that spurred UCSF's Academic Senate to review in detail – and subsequently endorse -- these relationships, and it was UCSF's proposed expanded relationship with Dignity last year that led to these current system wide deliberations.

As well, I come to this debate with a profound respect for the principles that motivate the opponents of these affiliations. Those principles start with the belief that all patients should be able to access the very best evidence-based care every day, in every setting where healthcare is provided – and not have those services limited on the basis of religious tenet.

On its face, this is a worthy objective. But ironically, prohibiting UC relationships with Catholic healthcare institutions ***would in fact exacerbate*** many of the exact problems the opponents of these relationships are trying to mitigate. Let me explain.

The arguments against UC affiliations with Catholic healthcare are clear – Catholic healthcare ministries do not support all the evidence based, legally accepted practices in women's reproduction, LGBTQ and end of life care. These limitations create issues for many groups of patients – women, members of the LGBTQ community and more. UC does not support these limitations, and provides these services in our UC health facilities.

The primary, compelling argument for continuing UC/Catholic healthcare affiliations is that ending numerous, long-standing UC affiliations with Catholic healthcare institutions would hurt individual patients by reducing or eliminating their access to the very best evidence-based care, care for which there often no alternatives other than UC. The examples are numerous:

- Catholic healthcare patients would be precluded from receiving onsite or telecare from highly skilled UC physicians for vitally important services which UC provides in numerous Catholic facilities across the State. These services include neonatology, cardiology, orthopedics, neurology, hospital medicine, oncology, neurosurgery and more. Denying access to UC's provision of this care is not in the best interests of those patients.

- UC would be precluded from affiliating with a significant percentage of all hospitals throughout the state, including the only full-service hospitals serving UC campuses in Merced (Mercy) and Santa Cruz (Dominican). UC would be prohibited from directly or indirectly providing care to UC employees and dependents in those hospitals, or even in outpatient facilities in partnership with those hospitals. This would not be in the best interests of our UC employees who are patients in these facilities.

- UC would be precluded from providing onsite or telecare to the poorest, neediest patients in the state who disproportionately receive their care at Catholic healthcare facilities. Another core

Catholic value referenced in the Ethical and Religious Directives is a commitment to serve the poor and marginalized in society. In California, the Catholic affiliated Dignity Health system provides more care to Medi-Cal patients than any other healthcare system in California. Freezing UC out of these facilities is not in the best interests of UC's many training programs that value access to these patients; it is not in the best interests of UC's efforts to fulfill its public service mission to improve the health and wellbeing of ALL Californians; and clearly it is not in the best interests of the poor patients being served in these hospitals.

- UC training programs and patients would be precluded from accessing critically important services that are only provided by Catholic healthcare facilities. In San Francisco, the only burn center and the only adolescent behavioral health inpatient units operating in the city are located at Dignity hospitals. Prohibiting a UC relationship with these hospitals would not be in the best interests of UCSF patients and trainees.

UC can and always must clearly state our support for the rights of women and LGBTQ people, fight discrimination against these groups, and do everything we can to increase the access of these groups and others to needed services, especially in communities that are underserved. But to put the interests of each and every individual patient first, and in order to fulfill UC Health's public service mission, UC must also work with the diversity of healthcare providers that comprise California's healthcare ecosystem– for-profit and not for profit, private and public, faith-based and secular.

In short, a total ban on UC relationships with Catholic healthcare would result in the UC discriminating against an entire class of patients who happen to be cared for in a Catholic hospital, because of those patients' legitimate choices, or those patients' geography where the only available hospital is Catholic. This would be akin to UC saying to patients getting their care in those hospitals: "Sorry, because UC disagrees with certain Catholic values, UC will not provide you with the care you need."

UC Health cannot have an asterisk on its mission statement to improve the health and well-being of ALL Californians that says "except for those Californians being cared for in Catholic healthcare facilities." This would not be the public service oriented, non-discriminatory University of California I have known and loved, and the organization I have committed my entire career to. That is not the UC that always does what is in the best interests of the patient.

I humbly offer the following elements as a recommended path forward.

First, an endorsement from the Regents that UC Health, as an asset of ALL the people of the State of California, should focus on improving the health of ALL people across the state, and in particular, addressing the special needs of the poor, the marginalized and the underserved who currently lack access to the best evidence-based healthcare services.

Second, an explicit endorsement by the Regents of Option 1 in the report (pages 22-26). That option clearly articulates a statement of values, seven principles, and specific monitoring and accountability measures.

And third, encourage those legitimately concerned about the issues associated with Catholic healthcare to take this debate to where it appropriately belongs – the State Legislature and Federal agencies where licensing, accrediting and regulatory decisions are made.

President Napolitano, the healthcare system in which UC health operates, and the system in which you and I and all Californians receive our healthcare, has many positive characteristics, but it is also seriously flawed. There is severe overcrowding in emergency rooms; there is a lack of essential healthcare services in rural parts of California; racial, ethnic, sexual orientation and gender identity health disparities in California are rampant; important services like behavioral health are in critically short supply with families not knowing where to turn; there is a crisis with the epidemic of neurodegenerative diseases like Alzheimer's for which our system is ill-equipped to cope; encouraging new technologies to diagnose and treat disease are coming at often unaffordable high costs; and the system for paying for healthcare is daunting to all, especially those who are elderly and sick. This is only a partial list.

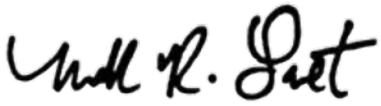
As one of the nation's largest and most important public enterprises fully engaged in medical research, training the next generation of caregivers and providing critically needed healthcare services, UC Health is challenged by all these issues. But more importantly, because of our capabilities, scale and public mission, UC Health has a unique opportunity, and I believe a special responsibility to work toward addressing every one of these issues.

To be successful in this effort, and to fulfill our mission to improve the health and wellbeing of ALL Californians, we must leverage ALL of UC's considerable research, education and clinical assets -- and we must leverage those assets across ALL elements of the existing healthcare system.

By definition, this means UC must work collaboratively with Catholic healthcare. Isolating UC from such a major component of the existing healthcare delivery system will never lead to success; only engagement will. And it is through that engagement where we will be able fulfill that guidance and sacred commitment: to always do what is in the best interests of the patient.

Thank you and the Regents for your leadership on this important issue.

Sincerely,



Mark R. Laret
President and CEO
UCSF Health

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January 20, 2020

President Janet Napolitano
University of California Regents
University of California Office of the President
1111 Franklin St
Oakland, CA 94607

Dear President Napolitano,

Thank you for the opportunity to comment on the report of the WGCA. I previously endorsed the compromise proposal from Chairman Gillman, as a member of the working group, despite many misgivings that it did not go far enough to guarantee protection of the patients we serve and whose lives we have in our hands. As the CEO of UC Davis Health and Vice Chancellor of Human Health Sciences I am responsible for making sure our organization provides first class education, research and patient care, and furthers the public service mission of UC to raise the level of healthcare for all Californians.

From the outset I will be short and direct; and note that additional supportive materials are available upon request. I write to explain how total disengagement from faith-based organizations is unethical, inhumane, and counter to UC principles. First, and perhaps most clear, disengagement violates the primary credo to which we all commit – primum non nocere – first do no harm. Patients must come first. Always.

The work group was charged to define principles under which we could work productively and ethically with other organizations, including those who had faith-based principles. In my opinion, despite Chairman Gillman's best efforts, the final product was unduly influenced by those who continue to try to turn this issue into a vote on abortion rights. That is not the issue. The issue is the right to healthcare for individual human beings who need and deserve our help, and how we help them will not be simple, as faith-based care will remain an option for patients in this state regardless of UC's decision.

Choosing the least injurious compromise, however, is not a difficult decision. With total disengagement, not one person will receive better health care. Not one person will have their reproductive rights enhanced. However, many patients will receive worse care, and innocents, including children, will die. Therefore, logically and philosophically, the case for engagement with our own set of principles is the only path ethically possible. In retrospect, bioethicists, not

single-issue faculty activists, should have been involved in guiding this process. I suggest we seek their input even now.

Our pediatricians and pre-term birth specialists serve a score of hospitals, supporting acute care in the ED's and NICU's (neonatal intensive care units) of those facilities. Most of these arrangements are with faith-based hospitals, and our relationship demonstrably improves the outcomes for patients who have chosen to seek care at these facilities. These supportive relationships require formal agreements that would be disallowed under disengagement. Most of the patients we see as transfers come to us because children, especially newborns, need a higher level of care than these faith-based hospitals can provide. We are the most immediate and qualified to provide such care. How many children, exactly, should suffer or die to make the point that UC doesn't support limitations on reproductive rights?

JAMA recently published a report that rural pediatric care is associated with worse outcomes, attributed to a lack of advanced care in those regions. UC is already addressing this issue proactively, building a virtual hospital with our superb pediatric (among other) sub-specialists providing real time support. We are also placing our providers in these rural hospitals, training the nursing staff who take care of complex patients such as pre-term babies in the NICU. Should we stop providing this care, adversely impacting young lives, to make a point?

Unfortunately, many rural patients do not have a choice for their hospital or health care provider, as religious organizations are the sole providers of hospital-based care in many counties in Northern California. This is because many of these locations are money-losing endeavors, and only organizations committed to losing money year after year will keep these facilities open. When confronted with these very real issues, the members of the committee who refused to endorse the report also refused to respond to this issue – perhaps because there is no acceptable answer. They simply stated faith-based organizations' patients could just "get care where they always did." Where they 'got care' was with us, or not at all. There is no alternative. The principles espoused by the vast majority of the WGCA (in the body of the report) address these complex issues, in an attempt to balance the support we all espouse for reproductive and gender rights with the needs of patients like these, the most vulnerable, across our region. There is no issue more important than the life of children. It is that simple. Developing children for their future success is the University's reason for existence.

I could refute equally well each and every other position espoused by those seeking disengagement. I will only touch on one more matter for the sake of brevity: Care at UC Merced. Disengagement would negatively impact the care of all students, faculty and staff at UC Merced. We are working with student health, UC Merced and UC Health to find a way to open a UC Davis staffed clinic, supported by telehealth, to bring UC level care to UC Merced and

its community. Right now, the only option for UC Merced beneficiaries is Kaiser Permanente, who then subcontracts their care to Mercy Merced (a Dignity Health facility), where all of these students, faculty and staff are then forced by Kaiser to receive care under ERD's - except for cancer. That is because, for 20 years, UC Davis and Mercy Merced have a joint venture to provide cancer care, including quality oversight, access to clinical trials, and a board-certified radiation oncologist from UC Davis who rotates there in order to provide a level of care not available in that community or remotely nearby. Were we to disengage, the only option for UC employees would be Mercy Merced under Kaiser, but without access to us! If UC were to open a clinic and seek to provide UC care in Merced, there would be nowhere to treat these patients if we were not allowed to utilize the only facility in town – a Dignity Health hospital. This was discussed at the WGCA and dismissed as 'a side issue' by those who support total disengagement. Again, I would ask how many of our employees should suffer or die without the benefit of our oversight of cancer services, just to make a point? This is antithetical to UC's four NCI Designated Comprehensive Cancer Centers which, by definition, broadly serve each region of the state.

UC Davis is the only academic medical center serving the inner city of Sacramento. We serve 33 counties across rural northern CA and the Central Valley, serving as patients' and hospitals' Level 1 Trauma Center – covering more than 50% of all of the state's counties. We serve as the referral center for all complex cases in this large swath of California in the rural north and underserved Central Valley. Almost all of the hospitals in these regions are faith-based. UC Davis has the only regional burn unit. We have the area's only Top 50 rated Children's Hospital. Every single patient in every single hospital in those 33 counties counts on us to be there when they need us. Last year we had 12,000 transfer requests, mostly from faith-based hospitals, as they are the only facilities serving these poor regions. The faith-based organizations include Dignity, Providence/St. Jospeh's – both Catholic with ERD's – and Adventist Health, which operates without ERD's. All, though, have policy restrictions against elective abortions in their facilities, and therefore all would fall under the absolutist position of disengagement.

UC Davis' clinical leadership has discussed this issue previously, following the discussion of this issue related to UCSF, and we categorically subscribe to principles-driven affiliation. We refuse to discriminate against patients because they happen to live in an area served only by a faith-based hospital, or because they are poor and were treated at faith-based hospitals that provide the only care close to their own community. Dignity Health is the largest provider of care to Medi-Cal beneficiaries in the state. Faith-based organizations are the largest provider to the underserved in our region. Disengagement is de facto discrimination against the poor, and especially against women and children of color, who disproportionately have Medi-Cal for their

health care. Disengagement actively harms them by denying them equivalent access to UC care.

We should not be choosing between harms as disengagement demands, but rather seeking to mitigate the issues in favor of the largest social good. Principled engagement is the only rational and humane way forward. Other options exist to address how ERD's can adversely impact care in California, but that needs to be addressed in statewide or national forums, and is not an issue UC can effectively address in a way that is beneficial for the people we serve. If we engage with the defined principles in the WGCA report, we will ensure ALL Californians have access to the highest level of health care possible, not just those who are well-off and fortunate enough to live near a UC Health campus.

Sincerely Yours,

David Lubarsky, MD, MBA
Vice Chancellor of Human Health Sciences, UC Davis
CEO, UC Davis Health

UC HEALTH

January 20, 2020

Janet Napolitano
President, University of California
University of California Office of the President
1111 Franklin St.
Oakland, CA 94607-5200

Dear President Napolitano,

Thank you for convening the Working Group on Comprehensive Access ("WGCA") and inviting us to serve as members. The issues discussed are of tremendous consequence to UC's academic health centers and to the patients we serve. We are grateful to our WGCA colleagues for the time and expertise they contributed. We particularly thank Chancellor Gillman for his thoughtfulness, skilled facilitation, and commitment to a fair and comprehensive debate.

As members of the WGCA representing stakeholders across the UC Health System, we are committed to UC's tripartite mission of education, research and public service. Consistent with that mission, we share the UC Health Values outlined in the WGCA Report, including an aspiration to improve health and health care for all people living in California now and in the future; to promote health equity through the elimination of health disparities; and to reduce barriers to access clinical, educational, and research programs. As part of UC Health, we are accountable to the people of California, our employees, retirees, students and our patients, and we are committed to providing the highest levels of evidence-based care to all patients.

Our affiliations – including those with institutions subject to policy-based restrictions on care – honor our mission and values by broadening our capacity and reach across the State. Affiliations allow us to provide more people with access to UC's high-quality care — care that does not vary because of personal characteristics or context. In considering the complex issues around affiliations, UC's ability to serve all patients, especially the underserved, should be paramount.

While UC Health continues to evaluate and address the issues raised during the course of the ongoing debate about affiliations, as members of the Working Group representing the leadership and faculty of UC's academic health systems, we are writing today to affirm our commitment to a new path forward for UC affiliations as outlined in Option 1 of the Chair's Report.

OUR MISSION, AND VALUES ARE THE BASIS OF OUR AFFILIATIONS TO PROVIDE ACCESS TO UC CARE FOR ALL PEOPLE LIVING IN CALIFORNIA

UC Health operates within an imperfect health care system where universal access and coverage are not yet a reality, federal and state funding continue to decline, and UC Health does not have the financial resources to build all of the facilities it would need to serve all of the patients who seek our services. Accordingly, UC must collaborate with others in executing our mission to serve all the people of California. A primary example is the need to partner with organizations that are willing to serve Medi-Cal patients in order to offer UC's unique expertise and services to more Medi-Cal patients, including those in rural areas, those who may be distant from existing UC facilities, or those who prefer to receive care in specific facilities. In California and across the nation, Catholic facilities governed by Ethical and Religious Directives ("ERDs") are often the most likely to provide care to medically underserved populations because of their commitment to serve the poor.

Every day 1 in 7 patients in the United States is cared for in a Catholic hospital.[1] Faith-based providers serve a disproportionate number of Medi-Cal patients in California, with Dignity Health providing more Medi-Cal inpatient hospital stays and outpatient hospital visits than any other provider in the State.[2] Affiliations with UC improve and expand the care available to the patients served by those institutions, including life-saving services such as cancer care. Both the California Medical Association and California Hospital Association have affirmed that a prohibition on UC's affiliating with policy-restricted hospitals would hurt the State's most vulnerable patients. As we look to the future with the goal of providing insurance coverage and high-quality care for all, UC Health's isolating itself from key participants in the California health care ecosystem would undermine the achievement of that goal.

AFFILIATIONS PROVIDE HIGHER QUALITY CARE TO WOMEN, THE LGBTQ+ POPULATION, AND THOSE SEEKING END-OF-LIFE CARE OPTIONS

We acknowledge and agree with concerns about the negative consequences for patients that can ensue from non-evidence-based policy restrictions on care such as those imposed by the ERDs or the involvement of individuals who are not health professionals such as religious leaders. No working group member sought to support or defend such restrictions. To the contrary, all of us are committed to supporting a woman's right to comprehensive reproductive health care; to assuring that all LGBTQ+ people have access to comprehensive services; and to providing the full range of options to patients at the end of life.

But we fundamentally disagree on the solution to issues raised by the divergence of our institutional values and the ERDs or other non-evidence based restrictions on care. Option 2 outlined in the Chair's report effectively bans affiliations with organizations that adhere to ERDs. Such a ban would result in immediate and direct harm to vulnerable patients across California by limiting their access to life-sustaining and life-saving care. Further, a ban on these affiliations would do nothing to advance access to critical services for women, those in the LGBTQ+ community, or individuals seeking access to end of

[1] Catholic Health Association, *Catholic Health Care in the United States*, January 2019.
[2] OSHPD Patient Discharge Data (based on 2017 data), *California Data Reporting Manual*

life services. Not one patient in the State of California would be better off as the result of a proposed ban on affiliations.

We believe the most ethical course is to focus on what is in the best interest of patients. We believe that UC cannot isolate itself and still meet our mission to improve the health of all people living in California. We advocate a change in practice that would allow UC's presence in facilities with policy-based restrictions on care provided that affiliations are subject to appropriate controls as outlined in Option 1 in the Chair's report. The presence of UC providers in these facilities improves the quality of care delivered, increases access to critical services, and presents patients with options and connections to services elsewhere in the UC Health System when the care they need is not available where they are being seen.

A NEW APPROACH TO ENSURE THAT UC'S VALUES ARE UPHELD IN AFFILATIONS WITH OTHER HEALTH CARE ORGANIZATIONS

As members of UC Health's leadership, our expectation has always been that UC personnel working or training at any clinical site will make clinical decisions consistent with the standard of care and their professional judgment considering the needs and preferences of their patients. As part of the ongoing debate on affiliations, UC Health has acknowledged, however, that many of our affiliation agreements have included language that may be read in a way that is inconsistent with these expectations, with our values, and with our understanding of how these agreements have been applied in practice.

We, as members of the WGCA, support all of the principles and guidelines outlined in Option 1 of the Report. These recommendations, if adopted, would set **new** system-wide rules governing both clinical and educational affiliations, as well as an oversight mechanism to ensure adherence. A key component of those guidelines is the following:

> ***UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their health care options; (iii) prescribe any interventions that are medically necessary and appropriate; and (iv) transfer or refer patients to other facilities when the care they need is not available where they are being seen.***[3]

The guidelines provide that UC Health must communicate this expectation to our personnel performing services or training at other facilities, and that UC Health will not enter into any agreement that would require UC or its personnel to enforce or abide by religious directives.

While it is true that personnel who agree, voluntarily, to work or train at a Catholic facility are subject to facility rules that do not permit the provision of certain services at that location, the approach reflected

[3] Language along these lines clarifying providers' ability to refer, counsel and prescribe was first proposed in the spring by UCSF in order to assuage concerns about the impact of ERDs in the context of debate about a proposed transaction with a Catholic organization.

in Option 1 of the report establishes that UC personnel will be held to UC standards wherever they work or learn. We note that to this day, we are not aware of a single instance where a UC provider was directed by an affiliate to provide care inconsistent with their professional judgment, nor of any instance where UC enforced or was asked to enforce the ERDs in a clinical setting. And if there were to be any issue in the future, the proposed guidelines in Option 1 also provide that UC Health can terminate any affiliation agreement where we have concluded that ongoing engagement jeopardizes our mission and values.

While we do not support policy-based restrictions on care, we also note that we are not aware of a single government agency, clinical or educational accreditation body, state licensing board, or medical specialty board that has declared that adherence to the ERDs is inconsistent with the standard of care or discriminatory. Catholic facilities are licensed by the State of California; accredited by The Joint Commission (the national organization charged with accrediting health care organizations nationwide) and the Accreditation Council on Graduate Medical Education (the national organization charged with accrediting medical residency programs); and deemed by the Centers for Medicare and Medicaid Services (CMS) to adhere to Medicare Conditions of Participation (a set of regulations setting health and safety standards for hospitals participating in Medicare). These facilities are also deemed to be appropriate sites for medical education by the Licensing Commission on Medical Education (LCME), the accrediting body for all undergraduate medical schools in the US and Canada. The State of California contracts with these facilities to provide health care services to Medi-Cal patients, and in fact several California public hospitals are operated by Catholic and other faith-based health care organizations.

Concerns about policy-based restrictions on care are best addressed through regulators and policymakers; a ban on UC affiliations with organizations that are operating in compliance with all applicable laws, regulations, and accreditation standards undermines UC's ability to carry out its mission to serve all the people of California.

PROPOSALS REQUIRING CONTRACTS TO SPECIFY THAT UC PERSONNEL MUST BE ABLE TO PEFORM ANY SERVICE IN ANY LOCATION ARE NOT VIABLE

Option 2 of the Chair's Report requires that UC Health affiliation agreements contain specific language stating that UC personnel or trainees will not abide by religious directives, and, that UC providers must be able to perform any medically necessary procedure in any facility at any time. This absolutist approach is not viable in facilities with or without ERDs. Requiring the unrestricted ability to perform any services any time in any location is inconsistent with the reality of how health care is delivered. Institutions must be licensed accredited and have the infrastructure necessary for the care they deliver and many have restrictions, irrespective of policy-based restrictions on care. It is common practice to arrange for services to be delivered to patients elsewhere when the facility where the patient is being seen doesn't have the accreditation, expertise, equipment, or infrastructure to do so. As outlined above, Option 1 in the Chair's report instead proposes to permit affiliations subject to conditions of engagement that document how UC personnel and trainees will operate in accordance with the UC standards within a facility governed by religious directives.

UC VALUES NEED TO APPLY CONSISTENTLY ACROSS THE ORGANIZATION

UC Health representatives to the Working Group first raised the issue of our health plans' affiliations at the Group's second meeting, and underscored then and repeatedly thereafter that UC values need to be applied consistently. The University must consider carefully the ramifications of proposed guidelines to uphold our values in various contexts. It would be hypocritical to ban clinical affiliations with organizations with policy-based restrictions on care while allowing the University's health benefits plan to contract with those same organizations.

A ban on affiliations with policy-restricted institutions in the context of UC's employee benefits plans would be disruptive for UC employees and retirees. As noted in the Chair's Report, many UC employees live in areas without direct access to UC providers; our health plans' networks therefore include a variety of providers and facilities so that our employees can access care locally. In Merced and Santa Cruz, the *only* hospitals available are organizations that adhere to religious directives. Without the ability to affiliate, UC employees and retirees living in these areas would have no in-network access to an acute care hospital. Likewise, a ban would also logically extend to UC's affiliation with Kaiser, which provides health insurance and care to approximately one-third of UC employees. Kaiser contracts with institutions governed by ERDs to provide to its members some services not available at Kaiser facilities.

THE INABILITY TO AFFILIATE WOULD PROFOUNDLY AND NEGATIVELY IMPACT OUR TRAINING PROGRAMS AND THE PATIENTS WE SERVE

One example of the disruption that a ban on affiliations would cause for our training programs is the medical school at UC Riverside. UC Riverside does not operate a UC hospital and the school relies heavily on affiliations with community-based institutions for training medical students and residents in order to fulfill its mission. If the School, which was founded to bring medical services to the underserved "Inland Empire" in Southern California, were not able to affiliate with health systems that adhere to policy-based restrictions on care, its clinical platform for training would be severely compromised., UCR would be at risk of losing approximately 1/3 of its training capacity and its only clinical training opportunity to provide care to the underserved Medi-Cal and uninsured populations of San Bernardino County.

Most importantly, termination of our affiliations with institutions that have policy-based restrictions on care would harm patients. In many instances UC provides specialty services to facilities in underserved areas that wouldn't otherwise have access. Our presence facilitates the transfer of complex patients requiring the resources of a UC facility. While the WGCA Chair's Report outlines extensively the negative impact of a ban, UC's Academic Health Centers are continuing to collect data to provide greater insight into the harm it would cause. Finally, the inability to affiliate also jeopardizes patients who might be served through affiliations that do not exist today. These include employees at campuses without UC health centers and vulnerable patients in under-served areas of the State such as the Inland Empire and the San Joaquin Valley. While the number of patients at issue may constitute only a portion of the total number of patients that UC serves, the lives and health of countless people are at stake.

UC HEALTH ALREADY ENGAGES WITH A VARIETY OF PARTNERS AND IS PURSUING SEVERAL WAYS TO FULFIL ITS MISSION OF SERVING ALL THE PEOPLE OF CALIFORNIA

Affiliations with other providers, including the Veterans' Administration, county hospitals, and private hospitals, are essential to the University's training and research programs, and UC's clinical enterprises operate as part of their regional health care ecosystems that are composed of private, public and faith-based institutions. As part of an integrated health system strategy, each of our health systems affiliates with a variety of types of partners in the community other than institutions with policy-based restrictions on care (e.g., UCLA with Cedars-Sinai, UCSF with John Muir, UCD and Sacramento County federally qualified health center, UCR with Tenet and HCA Healthcare). Both UCSF and UCLA already have significant affiliations with the public hospitals in their region (the former with San Francisco General Hospital and Marin General Hospital, and the latter with Martin Luther King Jr. Community Hospital and Harbor-UCLA Medical Center), and the remaining three of UC hospital systems (UCD, UCI, and UCSD) serve as the public hospital in the region. Several of our health systems (e.g., UCLA, UCSD, and UCSF) are actively planning to build new facilities to expand and improve access; while important, building new facilities requires significant capital, an extended period of time, and serves a limited geography.[4] None of these efforts obviates the need for affiliations with institutions that have policy-based restrictions on care, which play a key role in the State and the health care ecosystem in which UC Health institutions function.

UC HEALTH REPRESENTATIVES HAVE BEEN COMMITTED TO THE WGCA PROCESS

We attest that as WGCA members representing UC Health, we have acted with integrity during the deliberations of the WGCA, including adherence to the process outlined by the Chair and the President. As announced publicly several months ago,[5] in parallel to the efforts of the WGCA, UC Health leadership has been actively working to amend existing agreements to clarify expectations of UC trainees and health professionals when providing care at non-UC health facilities; in addition, the University established *interim* guidelines to govern affiliations deemed critical to UC's clinical and academic missions until a final policy decision is made. It is true that these were not discussed or vetted with the Working Group, whose charge was to consider what the University's policy should be going forward. No commitment had been made, nor would it have been feasible, to freeze all contracting activities pending a final policy decision.

[4] For example UCSF's planned new facility at the Parnassus site is estimated to cost over $3 billion and take 10 years to build.

[5] More information is available on the Working Group on Comprehensive Access website: https://www.universityofcalifornia.edu/current-issues/working-group-comprehensive-access.

A POLICY OF ISOLATION CAUSES HARM AND HELPS NO ONE

Our mission and values require us to advocate on behalf of all patients and to strive to offer access to UC's high-quality care to all the people of California. A policy of isolation undermines these efforts and, again, will not better serve a single patient. Consistent with UC's motto, "Fiat Lux" (let there be light), the presence of UC clinicians and trainees in in other institutions provides access to UC values and meaningful opportunities to improve care and expand options for all patients in those settings.

We respect the complexity of the issues you and the Regents now face, and greatly appreciate your commitment to addressing them. Thank you for your consideration.

Sincerely,

Gabriel Haddad
Chairman, Department of Pediatrics, UCSD
Physician-in-Chief and Chief Scientific Officer, Rady Children's Hospital

Sam Hawgood
Chancellor, UCSF

Steven Hetts
Advisor to UC Board of Regents Health Services Committee
Chief of Interventional Neuroradiology, UCSF

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January 6, 2020

Janet Napolitano, President
Office of the President
University of California
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Oakland, CA 94607
Via email

RE: WGCA REPORT; LEGAL CONCERNS REGARDING AFFILIATIONS

Dear President Napolitano,

I write to you as a member of the Working Group on Comprehensive Access (WGCA) in response to the final report. Chancellor Gillman, who chaired this very important endeavor with tremendous skill, shared a draft of the report with you, on Friday, December 20, 2019 and I understand that you will review it in more detail over the coming weeks. Given the importance and urgency of the matters under review by the WGCA, this letter serves to voice legal concerns regarding the University of California system (and its universities) engaging in medical contracts with religiously affiliated medical institutions that violate California constitutional law and legislative statutes.

I submit this letter as the only University of California law professor to serve on the WGCA and as the only bioethicist in the group. Moreover, my core areas of scholarship and teaching are health law, constitutional law, and tort law. In addition to my appointment as a Chancellor's Professor at the University of California, Irvine, I also direct the Center for Biotechnology and Global Health Policy. By further way of background, I am an elected member of the American Law Institute and the Hasting Center (an independent nonpartisan research institute, which was instrumental in establishing the field of bioethics). Finally, I began my law teaching career at a Catholic affiliated law school, where I also directed its health law programs, and graduated from a Catholic law school. I am deeply familiar with the church, its structure, values, and teachings.

Based on my understanding, after your close reading of the report submitted by Chancellor Gilman, you will publish the document online to seek input from additional stakeholders and the community at large. If you are publishing comments and responses to the report, I support this letter being entered into the record.

From the outset, I wish to make clear that University of California affiliations, which impede, restrict, or hinder the care that UC students, faculty, or staff receive based on religious doctrine violate state and federal constitutional law as well as specific California legislation that forbid the imposition of religious doctrine on UC students, faculty, or staff. State and federal constitutional law also prohibit the UC and its medical institutions from restricting, impeding, or denying care on the basis of religious doctrine. These actions are illegal and thus impermissible.

Specifically, the California Constitution states, "[t]he university shall be entirely independent of all political or sectarian influence and kept free therefrom in the appointment of its regents and in the administration of its affairs . . . ." Cal. Const., Article IX, Sec. 9(e). However, one need not scour the state's constitution to locate this important principle. It is prominently featured on the website of the University of California Regents.[1]

Of the many documents you may receive critiquing UC affiliations, this principle will stand out. Yet, I urge a deeper reading of the entire Article IX of the California Constitution from which this important principle emerges as it grounds not only that principle, but also places it in a larger context of "rights and liberties of the people" for the "promotion of intellectual, scientific, [and] moral…improvement." Cal. Const., Article IX, Sec. 1. Article. IX is entirely dedicated to education in our state and dates back to 1879.

For this reason a close reading of Article IX, Sec. 13(f) is also warranted as it specifies, "The university shall be entirely independent of all political or sectarian influence and kept free therefrom in the appointment of its regents and in the administration of its affairs…" Cal. Const., Article IX, Sec. 13(f).

California's constitutional framers were clear about the separation of religious doctrine from its educational affairs. Throughout Article IX it speaks to this: "nor shall any sectarian or denominational doctrine be taught, or instruction thereon permitted, directly or indirectly, in any of the common schools of this State." Cal. Const., Article IX, Sec. 8. The constitutional framers sought to protect religious minorities from discrimination, but were very clear that neither "common schools" nor our universities would be influenced by or dictated to by religious doctrine.

At stake and of concern in the present matter are contracts signed by UC executives that violate the important constitutional principles stated above. The contracts of concern, which I have had the opportunity to review, are primarily entered into with Catholic-affiliated medical providers. Here, I single out the Catholic affiliations, because they explicitly demand conditions of the UC that violate constitutional law and are thus impermissible (even though there are many organizations with which UC universities affiliate). And, while I understand that these contracts are being renegotiated at the present, the fact that they were entered into, obligating and binding UC students, faculty, and employees to follow religious doctrine is deeply disconcerting—and a violation of law.

To better understand what is at stake and why the perception that the affiliations will not compromise constitutional values (or UC commitments to nondiscrimination) is unfounded, I point you to the *Ethical and Religious Directives for Catholic Health Care Services.*[2] This document "was developed by the Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB) and approved by the USCCB" in 2018 at its Plenary Assembly. This document serves as "theological basis for the Catholic healthcare ministry" and defines terms and conditions under which Catholic healthcare institutions will enter into contracts.[3] The Ethical and Religious Directives, otherwise referred to as "ERDs" guide Catholic medical care.

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[1] University of California Board of Regents, *About The Regents*, https://regents.universityofcalifornia.edu/about/index.html.

[2] UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (2018, SIXTH EDS.)

[3] Id. at 5.

Simply put, the ERDs dictate all arrangements, collaborations, and contracts with affiliates such as the UC. The language is unequivocal, explicit, and hard to miss.[4] The Bishops write, "[t]he Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law."[5] The Catholic Church may dictate its own teachings and theological philosophies, but the University of California must not be ruled nor governed by them. Equally, the UC must not enforce Catholic teaching.

However, the ERDs leave little room for speculation or doubt that it is the Catholic Church's values, principles, and directives that will govern all contracts entered into. For example, the ERDs further state, "[b]efore affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carryout, assist in carrying out, make its facilities available fore, make referrals for, or benefit from the revenue generated by immoral procedures."[6]

The ERDs are abundantly clear that Catholic religious values will dictate all terms and all medical affiliations. That is, "[i]n any kind of collaboration, whatever comes under the control of the Catholic institution—whether acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives."[7]

Even though some medical executives in the UC might believe their informal communications with the Catholic hospitals "override" the contracts, they would be mistaken.

In the contracts that I reviewed during my time on the WGCA, they explicitly draw upon this type of language. In the contract with UC, Irvine, the affiliation agreement with St. Joseph's Hospital of Orange states:

> Patient Care, Pursuant to Section 70713 of Title 22, SCHOOL understands and agrees that Hospital, with its Medical Staff, retains professional and administrative responsibility for services rendered to Hospital patients. Further, SCHOOL shall conduct its activities in providing services hereunder consistent with…Hospital philosophy and values and the Ethical and Religious Directives for Catholic Health Services.[8]

Similarly, the 2015 contract between Dignity Health and the Regents of the University of California on behalf of the University of California, Davis demands "Students and Instructors shall comply…with the Statement of Common Values as adopted by Dignity Health, and, if Facility is Catholic-sponsored, with the *Ethical and Religious Directives for the Catholic Health Care Services*, as adopted by the United States Conference of Catholic Bishops."[9]

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[4] Each directive is numbered for ease of explanation and understanding for all those who affiliate with Catholic medical institutions.
[5] Id. at 26 (quoting ERD 72).
[6] Id. (quoting ERD 73).
[7] Id. (quoting ERD 74).
[8] *See*, AFFILIATION AGREEMENT BETWEEN REGENTS OF THE UNIVERSITY OF CALIFORNIA AND ST. JOSEPH HOSPITAL OF ORANGE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, 30, JUNE 1, 2016.
[9] *See* EDUCATIONAL TRAINING AGREEMENT FOR CLINICAL AND/OR NON-CLINICAL ROTATIONS AND EXPERIENCES, 6, SEPTEMBER 10, 2015.

Problematically, UC students were also made to sign such contracts, obligating them thusly:

> It is understood and agreed that Hospital as a Division of Dignity Health, operates as an extension of the religious works of Dignity Health's Religious Sponsors. Therefore it is understood and agreed that the policies and practices of Hospital shall conform to the principles inherent in the *Ethical and Religious Directives for Catholic Health Care Services* incorporated herein by reference.[10]

For students, they may feel pressured, coerced, or forced to sign such agreements, which conflict with their values. They might feel intimidated and perceive signing such contracts as a condition of their education. They might believe that they have no choice but to practice ERD-dictated medicine as part of their UC education.

Deeply of concern then are the terms to which UC faculty, students, and staff are held as patients or providers. For example, ERD 70 states, "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortions, euthanasia, assisted suicide, and direct sterilization."[11] This would also include important forms of contraception. Not only do such ERDs conflict with the fundamental principles and values of the California constitution, because they are rooted in religious doctrine, they also conflict with the California constitution, because a right to privacy is embedded in our state's constitution.

In California, the state protects privacy and autonomy in reproductive decision-making and end of life care. Moreover, it is understood that the gold standard of medical care after sexual assault and rape is to provide emergency contraception. However, emergency contraception is not provided at Catholic hospitals, because it is considered a "sin" by the United States Conference of Catholic Bishops to provide this type of medical care. Indeed, emergency contraception is not "counseled" or spoken about at Catholic hospitals. California is among more than a dozen states that require emergency care facilities to make available emergency contraception to patients that have experienced rape.[12] This standard, to which UC is held, is compromised and violated when it bends to religious directives.

Imagine training our students that after a girl or woman is raped that denying information is the proper form of treatment.

According to the UC Accountability Report, 53% of UC undergraduates are women and 43% of graduate academic students are women.[13] That report speaks to an "an ethos of respect and inclusion" in all facets of the UC educational experience, "in lecture halls and laboratories…in work cubicles…in

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[10] *See e.g.*, STUDENT TRAINING AGREEMENT FOR NURSE PRACTITIONER/PHYSICIAN ASSISTANT PROGRAM BY AND BETWEEN DIGNITY HEALTH D/B/A SEQUOIA HOSPITAL AND THE REGENTS OF THE UNIVERSITY OF CALIFORNIA, 7 AND 10, JULY 1, 2016.

[11] UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES, 25 (2018, SIXTH EDS.)

Id. at 25.

[12] Cal. Health and Safety Code § 13823.11 (2002)(providing all female victims of sexual assault the option of emergency contraception); *See also*, Cal. Insurance Code § 10604.1, Health & Safety Code § 1363.02 and Welfare & Institutions Code § 14016.8 (mandating that all Medi-Cal and insurer providing coverage, include information regarding emergency contraception).

[13] UNIVERSITY OF CALIFORNIA, ACCOUNTABILITY REPORT 2015, CHAPTER 7: DIVERSITY, https://accountability.universityofcalifornia.edu/2015/chapters/chapter-7.html

our hospitals and other outposts of community engagement."[14] Yet, it is a direct contradiction to an ethos of respect and inclusion when UC medical students must engage in a culture of care that conflicts with the law and denies dignity to women and transgender patients. As troubling, it is not consistent with an ethos of respect and inclusion or California constitutional law to subject UC patients to restricted healthcare services, which are labeled as "sins."

California lawmakers and citizens were deeply concerned about the potential for religious doctrine to dictate and influence its schools and universities. They understood that civil liberties and civil rights were at stake and could be compromised in the process. For this reason the California Constitution further provides that no California school or other entity, "shall ever make an appropriation, or pay from any public fund whatever, or grant anything to or in aid of any religious sect, church, creed, or sectarian purpose, or help to support or sustain any…hospital, or other institution controlled by any religious creed, church, or sectarian denomination whatever…"[15] It is worth emphasizing that this language was added to the California Constitution by popular vote.

Yet, it is not only the California Constitution that informs my letter to you. The Establishment Clause of the U.S. Constitution prohibits the entanglement of the state in religious activity.[16] The United States Supreme Court has made clear that even in instances where the activity may be for secular purposes, the Establishment Clause is violated if those activities favor or advance religion.[17] The Supreme Court has upheld this important constitutional principle for more than a century, explaining that professed religious beliefs cannot be "superior to the law of the land."[18] As Erwin Chemerinsky and I wrote in the *Georgetown Law Review*, "prior to 1990…challenges to laws based on free exercise of religion under the first Amendment rarely prevailed."[19]

The legal harms brought about by the affiliations are not abstract. State and federal law prohibit discrimination based on sex. Indeed, Article IX of the California Constitution, which speaks specifically to Education, articulates that discrimination based on sex is prohibited.

Time and again, California legislators have reiterated this important principle: in the California Unruh Act (Civil Code Section 51(b)) as well as the California Government Code. The latter states that no person shall be denied "full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency…"[20]

For reasons articulated herein, evaluating future paths regarding affiliations and comprehensive care require deep deliberation and thoughtful reflection. Those most likely at risk of experiencing

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[14] Id.
[15] Cal. Const., Article XVI, Sec. 5. (1879; Section 5 added Nov. 5, 1974).
[16] *Lemon v. Kurtzman*, 403 U.S. 602, 612 (1971)("sponsorship, financial support, and active involvement of the [state] in religious activity" violates the Establishment Clause of the U.S. Constitution).
[17] *Lemon v. Kurtzman*, 403 U.S. 602, 612-13 (1971).
[18] *See e.g., Reynolds v. United States*, 98 U.S. (8 Otto) 145 (1878)(Supreme Court rejecting a claim by a polygamist that a religious exemption should be permitted for a law banning polygamy); *Hernandez v. Commissioner*, 490 U.S. 680 (1989) (rejecting free exercise clause challenge to payment of income taxes alleged to make religious activities more difficult); *Braunfeld v. Brown*, 366 U.S. 599 (1961)(the Supreme Court rejected a free exercise clause challenge to Sunday closing laws).
[19] Erwin Chemerinsky and Michele Bratcher Goodwin, *Religion Is Not a Basis for Harming Others*, 104 *Geo. LJ.* 1111 (2016).
[20] California Government Code, Section 11135 (a).

restrictive care or the denial of care are women and LGBT persons. As well, these may be the communities least likely to be empowered to question or challenge the terms of the contracts—either as patients or providers.

Finally, I recognize the concerns expressed by UC medical executives. Some have articulated that the affiliations with Catholic medical institutions are necessary because those institutions serve the poor. Indeed, in some instances Catholic charities (and others) have stepped in when government has failed to provide for those most at need in our society. That type of charity should be applauded. The rising costs of healthcare is a serious issue that deserves attention. Yet, Catholic charities will be able to continue that important work even in the absence of UC affiliations, because their delivery of care is not contingent on UC.

Equally, proponents of UC affiliating with Catholic hospitals articulate that some of the best quality of care for adolescent sufferers of compromised mental health is taking place at Catholic hospitals. Interventions to aid in the care of youth are greatly important. Personally, I care deeply about these issues. However, those invaluable services to the youth are not contingent on UC affiliation. Moreover, a youth suffering from an unwanted pregnancy and experiencing the trauma associated with it, would be denied the medical care and counseling needed if it involved emergency contraception or abortion at a Catholic hospital.

I applaud Chancellor Gillman's earnestness, transparency, and deft leadership of the WGCA. These issues are challenging, but not based on the law or bioethics. The law and legal standards are clear as articulated above. In bioethics, the principles of patient autonomy, social justice, beneficence, and non-maleficence dictate the values of medicine. These obligations are patient-centered.

Our current UC challenges relate to limited resources. I take that quite seriously as we all should.

The UC is challenged by limited space and rising medical costs. Yet our constitutional values cannot be leveraged based on costs. For example, the UC would not risk affiliation with organizations that restrict care based on race, simply because an affiliate offered more beds and services or demonstrated a commitment to serving the poor. We understand the importance of dignity and equality in such matters. The standards are no less rigorous and clear as related to sex.

It has been my privilege to serve on the WGCA. I am at your service for any future iterations or work on these matters.

Sincerely,

Michele Goodwin

Michele Goodwin
Chancellor's Professor

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA
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Charles F. Robinson
VICE PRESIDENT AND GENERAL COUNSEL

January 23, 2020

Janet Napolitano, President
Office of the President
University of California
1111 Franklin Street, 12th Floor
Oakland, CA 94607

Re: WGCA Report; Response to Jan. 6, 2020, Letter from Prof. Michele Bratcher Goodwin

Dear President Napolitano:

This letter is in response to the January 6, 2020, letter you received from Professor Michele Bratcher Goodwin, Chancellor's Professor of Law at the Irvine campus, regarding the final WGCA Report. In her letter, Professor Goodwin asserts that it is illegal, under federal and state anti-establishment and anti-discrimination principles, for the University of California ("the University" or "UC") to contract with religiously affiliated medical institutions, because those institutions, out of adherence to religious precepts, limit the services those hospitals will provide.

Professor Goodwin is a preeminent legal scholar and a critically important voice in many fields including health policy, women's reproductive rights and justice, and civil rights more broadly. Nevertheless, I respectfully disagree with her legal analysis, which I believe both overstates the extent to which the University is constrained from collaborating on common goals with religiously affiliated institutions and understates the concerns that would be raised under the United States Constitution and statutes if the University were to exclude certain hospitals from potential affiliation because of their religious values. My goal in writing this letter is to provide a more balanced and comprehensive presentation of the legal issues at play in the debate on affiliations.

Contrary to Professor Goodwin's assertions, the University of California may, consistent with its constitutional and statutory obligations, enter into agreements with religiously affiliated health care organizations on terms that further their common goals of providing quality health care, especially to underserved populations, while also maintaining each organization's independence where their values and interests diverge. Neither federal nor state law establishes a categorical rule that requires or prohibits UC from entering into contractual relationships to provide medical care or training with facilities that restrict certain reproductive, gender-affirming, or end of life care on religious grounds. While there is a certain tension between the dictates of the Establishment and Free Exercise Clauses of the First Amendment to the United States Constitution, the U.S. Supreme Court has repeatedly "reaffirmed that 'there is room for play in the joints between' the . . . Clauses, allowing the government to accommodate religion beyond free exercise requirements, without offense to the Establishment Clause." *Cutter v. Wilkinson*, 544 U.S. 709, 713 (2005) (quoting *Locke*

v. Davey, 540 U.S. 712 (2004)). While some Supreme Court decisions from half a century ago (cited by Professor Goodwin) may have suggested fairly stringent limits on a state's ability to collaborate with religious institutions, more recent opinions (not cited by Professor Goodwin) either criticize or ignore that precedent. Instead, the Court has shown much greater concern to ensure that states not discriminate against religious institutions in violation of the Free Exercise Clause. Specifically, in *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012 (2017), the Supreme Court has stressed that a state's purported interest in avoiding "establishment" concerns (such as those articulated by Professor Goodwin) will not justify discrimination by the state against religious organizations.

That is not to say the University would be *required* to enter into an affiliation with a religious health care organization. Whether, and on what terms, an affiliation with a particular hospital or system will best further the University's secular goals and values, as compared to alternative programs or affiliations (or none at all), is a policy question, on which I express no view. But it is important that your and the Regents' consideration of this important issue be informed by a full and accurate understanding of the applicable legal framework. By considering potential affiliations on the basis of how the arrangement would advance the University's affirmative, secular values, rather than focusing on whether UC agrees with the religious values held by another institution, UC can navigate the path between the Establishment and Free Exercise Clauses.

I provide below a fuller analysis of the federal and state constitutional and statutory principles that might be implicated as the University considers these important questions regarding health care affiliations.

UC is Not Categorically Precluded Under the Federal Establishment Clause or Analogous State Provisions from Affiliating with a Hospital that Limits Care According to Religious Principles.

A. Federal Establishment Clause: There is no single clear standard for when a state's involvement with a religious entity violates the federal Establishment Clause. Professor Goodwin states that "prior to 1990" First Amendment "challenges to laws based on free exercise of religion . . . rarely prevailed" and notes that, in 1971, the Supreme Court articulated a seemingly broad test for determining whether a state's "entanglement" with or "advance[ment]" of religion violated the Establishment Clause. But those statements give, at best, an incomplete and outdated impression of the state of the U.S. Supreme Court's religion jurisprudence. Professor Goodwin's characterization of federal Establishment law relies primarily on *Lemon v. Kurtzman*, 403 U.S. 602 (1971), in which the Court set forth a test stating that the Establishment Clause prohibits "sponsorship, financial support, and active involvement of the [State] in religious activity," *id.* at 612, and that, even where the purpose of the government action is secular, the Establishment Clause is still violated where the principal or primary effect of the action advances religion, *id.* at 612-13. More recently, however, the Court has cast serious doubt on the validity of that articulation. Just last year, six members the Supreme Court either noted that the test has often been ignored or not applied, or expressly urged its overruling. *American Legion v. American Humanist Ass'n*, 139 S. Ct. 2067, 2080 (2019) (Alito, J., joined by Roberts, C.J., Breyer, J, and Kavanaugh, J.) (plurality) (citing eleven cases since 1993 not applying *Lemon*)[1]; (Thomas, J., concurring) (urging the test's express

[1] *America Legion*, 139 S. Ct. at 2080 (citing *Zobrest v. Catalina Foothills Sch. Dist.*, 509 U.S. 1 (1993); *Board of Ed. of Kiryas Joel Village Sch. Dist. v. Grumet*, 512 U.S. 687, (1994); *Rosenberger v. Rector and Visitors of Univ. of Va.*, 515 U.S. 819 (1995); *Capitol Square Review and Advisory Bd. v. Pinette*, 515 U.S. 753 (1995); *Good News Club v. Milford Cent.*

rejection); (Gorsuch, J., joined by Thomas, J., concurring) (characterizing *Lemon* as a "misadventure" and stating the Court has "shelved" the test).

Indeed, many cases demonstrate that a mere assertion of "entanglement" or "advancing" of religion will not necessarily doom even direct state involvement with religion and religious symbols, if an unbiased observer would understand the state's involvement as consistent with historical traditions of religious accommodation. Noting that the Court's "jurisprudence with respect to the constitutionality of direct aid programs has 'changed significantly' over the past two decades," the Court held that a school voucher program enacted for the secular purpose of providing educational assistance to low-income children in failing schools did not violate the Establishment Clause despite that most participating private schools were religiously affiliated. *Zelman v. Simmons-Harris*, 536 U.S. 639, 649 (2002) (quoting *Agostini v. Felton*, 521 U.S. 203, 236 (1997)). In *American Legion*, the Court rejected the argument that a state actor's support and maintenance of a large stone cross in the middle of a busy intersection was an impermissible establishment of religion, because the cross had been erected nearly a century before as a memorial to fallen soldiers, including non-Christians, using a traditional form to commemorate their sacrifice. 139 S. Ct. at 2089-90. Similarly, a governmental body's invitation to clergy to recite prayer at the opening of a session does not constitute impermissible "Establishment" of religion, in light of the long history of prayer on such occasions. *See Town of Greece v. Galloway*, 572 U.S. 565, 584-86 (2014) (plurality). The Court has also made clear that the government may provide funds for a deaf student's interpreter during classes at a Catholic high school (including religious topics), holding that the Establishment Clause is not offended "[w]hen the government offers a neutral service on the premises of a sectarian school as part of a general program that 'is in no way skewed towards religion.'" *Zobrest v. Catalina Foothills Sch. Dist.*, 509 U.S. 1, 10 (1993) (quoting *Witters v. Washington Dep't of Servs. for Blind*, 474 U.S. 481 (1986)).

Notably, a very strict exclusion of religious organizations from participation in government-sponsored programs would represent a stark break from many existing practices. Federal and state governments routinely provide direct and indirect funding to religious organizations in a variety of contexts, including many in the medical context. The federal government contracts with, and provides funds to, religious hospitals to provide covered care to qualified Medicare and Medicaid beneficiaries. Federal and state grants and vouchers for tuition are available to medical students who attend sectarian schools of medicine. And research grants are available for faculty at sectarian schools. Likewise, public employers, including UC, have contracts with religiously affiliated hospitals to provide healthcare to their employees. Thus, at the very least, any Establishment Clause analysis must be highly fact-specific.

In the case of UC's affiliations with religiously affiliated hospitals, a careful analysis would have to take into account the important and entirely secular purposes that underlie the University's decision to enter into affiliation agreements, the fact that in many instances religiously affiliated hospitals may be the best (or even only) candidates for affiliation in a particular location or that would further the University's goals of providing services to, and training regarding the care of, the most marginalized populations. The inquiry would also take into consideration the steps the

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Sch., 533 U.S. 98 (2001); *Zelman v. Simmons-Harris*, 536 U.S. 639 (2002); *Cutter*, 544 U.S. 709; *Van Orden v. Perry*, 545 U.S. 677 (2005); *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC*, 565 U.S. 171 (2012); *Town of Greece v. Galloway*, 572 U.S. 565 (2014); *Trump v. Hawaii*, 138 S. Ct. 2392 (2018)).

University has taken to ensure that its own faculty and students were free to provide scientifically based medical advice, prescriptions, and referrals, even when doing so might not be consistent with the affiliate's religious principles. These facts would demonstrate the independence of the University from the religious tenets of the affiliate and secular purposes of the University's program. Thus, it is not the case that the federal Establishment Clause categorically prohibits UC from affiliating with a non-secular entity to provide health care to underserved populations and medical training to its students.

B. California Constitution Religion Clauses: California has articulated what are arguably more strict limits on state entities' ability to be involved with religious organizations. The California Constitution specifically provides that "[t]he university shall be entirely independent of all political or sectarian influence and kept free therefrom in the appointment of its regents and in the administration of its affairs." Cal. Const. art. IX, § 9(f). In addition, the California Constitution's "no aid" clause prohibits any help or support by the State to, among other entities, any hospital controlled by a religious creed. Cal. Const. art. XVI, § 5. Properly understood, these provisions do not (and could not under the federal Constitution) categorically preclude religious hospitals from participation in UC affiliations.

The suggestion that any affiliation with a religiously affiliated hospital would constitute impermissible influence on the administration of UC's affairs, because it would require UC to adhere to religious-based limits on care, is unsupported as a factual matter, but also misunderstands the import of the constitutional provision. The "no influence" provision (which addresses both political and religious influence) is designed to prevent interference with UC's own internal affairs; it does not concern enforcement by a religious entity of its own policies over what occurs at its own facilities. California courts have construed the provision to protect the Regents' authority over UC's affairs from external influence; it has not been read to limit what UC may choose to do: "the power of the Regents to operate, control, and administer the University is virtually exclusive." *San Francisco Labor Council v. Regents of University of California*, 26 Cal.3d 785, 788 (1980) (citations omitted). Courts have specifically applied the provision to give UC *more*, rather than less, authority over how to accomplish its mission of medical instruction. *See California Medical Ass'n, Inc. v. Regents of University of California*, 79 Cal. App. 4th 542, 547 (2000) (holding that state law banning corporate exercise of medicine did not apply to UC).[2] This provision cannot, therefore, be read to provide a categorical bar to UC affiliating with a religious entity.

Existing contracts purporting to promise University adherence to or enforcement of religious principles have undergone or are in the process of renegotiation. To our knowledge, these provisions have never been enforced against the University or its personnel, and the University has never been asked to enforce them. Amended agreements clarify that UC medical students and faculty are required to adhere to the University's nondiscrimination policies in their provision of care, and remain free at all times to provide scientifically based medical advice and recommendations, including prescribing medications and referring to procedures that are not available in the particular facility. While certain procedures are not available at certain religiously affiliated hospitals, that is also true of secular hospitals.

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[2] Advocates supporting a public relations campaign against the University's continued affiliation with faith based organizations also appear to be engaging political levers aimed at pressuring University administrators and the Regents to ban such arrangements.

Professor Goodwin's reference to the California Constitution's "no aid" clause is also misplaced. She cites no case holding that the "no aid" clause precludes California public entities from paying religious entities for services provided, such as Medicaid payments to religiously affiliated hospitals for services to Medicaid enrollees, or public hospital district payments to religiously affiliated health systems for management or other services. Moreover, to the extent the "no aid" provision were construed to bar religious entities from participation in state programs on the same terms as non-religious entities, such exclusion would likely give rise to a challenge under the Free Exercise Clause, as discussed below.

Refusing to Enter Into Agreements with Hospitals on Account of Their Religiously Based Limits on Care Would Raise Concerns Under the Free Exercise Clause.

The U.S. Supreme Court recently held, in the context of the First Amendment's Free Exercise Clause, that a governmental actor such as UC may not categorically exclude entities with religious affiliations from participation in widely available state-sponsored programs, even if the stated basis for the exclusion is to avoid state entanglement with religion (purportedly to avoid violating anti-establishment principles). *See Trinity Lutheran*, 137 S. Ct. 2012. Specifically, in *Trinity Lutheran*, the Court held that it was impermissible for Missouri to exclude, on the basis of its state Constitution's "no aid" clause, religious schools from the state's otherwise generally available playground renovation program, simply because those schools are religious.[3] *Id.* According to the Court, the key legal analysis under the Free Exercise Clause is whether the policy "target[s] the religious for 'special disabilities' based on their 'religious status.'" *Id.* at 2019 (quoting *Church of Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520, 533, 542 (1993)). "To condition the availability of benefits . . . upon [a recipient's] willingness to . . . surrender[] his religiously impelled [status] effectively penalizes the free exercise of his constitutional liberties.'" *Id.* at 2022 (quoting *McDaniel v. Paty*, 435 U.S. 618, 626 (1978) (plurality)) (alterations in original).[4] Without addressing the significance of *Trinity Lutheran*, Professor Goodwin's characterization of the legal environment is incomplete.

Other U.S. Supreme Court cases since 1990, including other very recent ones, similarly reflect the Court's sensitivity to allegations of burdens on religious belief. In *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*, for example, the Court found that the State's refusal to accommodate a religious baker's objection to baking a cake for a same-sex marriage reflected an unconstitutional "hostility to a religion or religious viewpoint," when it did not explain why other

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[3] Several similar provisions in other state constitutions have been deemed invalid or called into question. *See, e.g., Colorado Christian Univ. v. Weaver*, 534 F.3d 1245, 1251 (10th Cir. 2008). The Supreme Court heard argument on another such case just yesterday. *Espinoza v. Montana Dep't of Rev.*, 435 P.3d 603 (Mont. 2018), *cert. granted*, (U.S. June 28, 2019) (No. 18-1195) (considering whether a law that creates tax credits to provide scholarships for families sending children to private schools, including religious schools, violates the state constitution's "no-aid provision" or the First Amendment).

[4] A plurality of the Justices in the *Trinity Lutheran* majority acknowledged in a footnote that the facts of the case involved school playgrounds and that the holding was therefore not addressing funding for "religious uses." 137 S. Ct. at 2024 n.3. Thus, there is some doubt about how far the Court will extend the rule in *Trinity Lutheran*, at least where the funding in question would go to support a religious use. Nonetheless, any analysis must grapple with the majority's rejection of putting a religious entity "to the choice between being a church and receiving a government benefit." *Id.* at 2024; *see also id.* at 2023 (distinguishing *Locke v. Davey*, where the Court upheld a state scholarship program that could not be used to pursue a degree in devotional theology, because the restriction did not "require students to choose between their religious beliefs and receiving a government benefit" (quoting *Locke*, 540 U.S. at 720-21)).

conscience objections were permitted and the Commission's comments at public hearings suggested animus toward religious beliefs. 138 S. Ct. 1719, 1731 (2018). In *Church of Lukumi Babalu Aye*, the Supreme Court unanimously held that a city ordinance forbidding the "unnecessar[y]" killing of "an animal in a public or private ritual or ceremony not for the primary purpose of food consumption" was unconstitutional under the Free Exercise Clause. 508 U.S. at 527, 547. And, in *National Institute of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018), the Court held that California could not compel a clinic to provide information to patients about abortion services, in light of their objection to providing such information. In light of these very recent examples of the Supreme Court's receptivity to claims involving religious objectors, Professor Goodwin's reliance on the relative infrequency of successful Free Exercise claims "prior to 1990" is not a helpful guide to the relevant constitutional principles that must inform the Regents' decisions today.

This does not mean that UC *must* affiliate with a religious entity to avoid violating the Free Exercise Clause. As the Supreme Court said in *Trinity Lutheran*, the Free Exercise Clause is not violated by "the denial of a grant" per se, "but rather the refusal to allow the Church—solely because it is a church—to compete with secular organizations for a grant." 137 S. Ct. at 2022; *see also Northeastern Fla. Chapter of Associated Gen. Contractors of America v. City of Jacksonville*, 508 U.S. 656, 666 (1993) ("[T]he 'injury in fact' is the inability to compete on an equal footing in the bidding process, not the loss of a contract"). It is for UC to decide whether a particular affiliation serves its legitimate, secular interests and mission. This decision should be focused on how the affiliate would meet UC's needs and goals, not on whether UC agrees or disagrees with the specifically religious grounds for any limitation in the services the affiliate offers at its locations. It may be possible for UC to cooperate with a religious entity to the extent of their common values and mutual objectives. Where UC concludes there is insufficient commonality of interest or other potential affiliations that do not so limit their services would better serve the University's goals, that determination would not run afoul of constitutional principles. The University would, of course, need to ensure that any such decision is made consistent with federal law protecting religious freedoms.

UC is Not Prohibited by Anti-Discrimination Principles from Affiliating with Organizations that Decline to Provide Certain Gender-Affirming Care or that Limit Reproductive Services.

Professor Goodwin's letter also suggests, without developing the point, that certain constitutional and statutory anti-discrimination provisions would preclude UC's affiliation with hospitals that limit the services available on religious grounds. Again, that characterization is incomplete and inaccurate.

The statutory legal framework is somewhat complicated and includes both state and federal laws. To the extent of a conflict, the federal law would prevail. State law both prohibits discrimination by UC against LGBTQ individuals and requires state government agencies to include in certain contracts an agreement that the contractor will not discriminate against LGBTQ individuals. *See, e.g.*, Unruh Civil Rights Act, Cal. Civ. Code § 51; Cal. Gov't Code §§ 11135, 12990. With respect to reproductive care, the California Constitution has been construed to protect a woman's right to make choices regarding her reproductive care and requires the state to maintain neutrality among the choices she might make. In contrast, however, to laws concerning LGBTQ discrimination, I am aware of no California law that contains any provision precluding entities contracting with the state from limiting reproductive health services, outside of the context of providing emergency care. *See* Cal. Gov't Code § 12990; Cal. Health & Saf. Code § 123466. This

difference may be attributable to a desire to accommodate religious objection, or to federal law mandating such accommodation. Many federal laws related to federally funded programs preclude making funding available to a state entity that discriminates against a health care facility on the ground that it does not provide (or provide references for) abortions.

The law is, at this point, uncertain as to whether a private institution's policy not to provide certain types of services, including services that would be part of medically appropriate gender-affirming care, constitutes prohibited discrimination against LGBTQ individuals. Nor is it resolved whether the federal Constitution would protect a religious institution's right to decline such services on Free Exercise grounds, even if state law prohibited it.[5] However those issues are ultimately resolved, it would not necessarily follow that the University could not affiliate with a hospital that sought to refrain from providing such services. If the hospital were legally obligated to provide those services, and had no First Amendment right not to do so, then the University would likewise be free to provide those services at that facility. If limiting services did not constitute discrimination by the affiliate, or the affiliate had a constitutional right to so limit its services, then it would not constitute discrimination on the part of the University to accommodate that limitation. As far as the University is concerned, the service would simply not be available at that facility, as is similarly true at other facilities with which the University affiliates.

While those opposed to such affiliations argue forcefully that it is impossible to provide ethical, medically appropriate care within the constraints adopted at certain religiously affiliated hospitals, that is not the prevailing view. Leading medical organizations have issued ethics opinions acknowledging that entities and physicians do not violate ethical standards of medical care by refusing to perform or teach certain procedures on the basis of religious principles. For example, the American College of Obstetricians and Gynecologists has explained that conscientious refusals to provide care can be permissible, provided another physician is made available to serve the patient. The Limits of Conscientious Refusal in Reproductive Medicine, ACOG Committee Opinion Number 385, Committee on Ethics (Nov. 2007, *reaffirmed* 2019), available at https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co385.pdf?dmc=1&ts =20200112T1711208952. Similarly, the American Medical Association has recognized that physicians can, at times, prioritize their conscience over ethical norms for the profession. Physician Exercise of Conscience, Code of Medical Ethics Opinion 1.1.7, AMA, available at https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience. Indeed, the fact that health care organizations that adhere to religious directives are able to obtain and retain licensure and accreditation is a strong indication that their provision of services, even as constrained by their religious principles, does not constitute a per se violation of federal or state anti-discrimination law.

I wish to reiterate that the ultimate decision whether to affiliate with a particular hospital or hospital system is a policy decision that can be based on an assessment of whether that prospective affiliation would serve the University's affirmative values and goals. Based on our analysis of the full constitutional and statutory context, it is permissible for UC to enter into an affiliation with a health care organization that adheres to religious principles without violating establishment or anti-

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[5] An intermediate appellate court in California recently held that there was a potential violation of California's Unruh Act when a religiously affiliated hospital refused to perform a hysterectomy on a transgender individual as part of gender-affirming care, when the hospital would perform hysterectomies in certain other circumstances. The court further held that the hospital was not entitled to an exception from the law's application under the First Amendment. *Minton v. Dignity Health*, 39 Cal. App. 5th 1155, 1164-65 (2019). That litigation is continuing.

discrimination provisions. It is also permissible for the University to conclude that, due to limits on the services the University would be able to provide, a particular affiliation would not serve the University's interests. However, the University should make any such determinations with an accurate understanding of the legal context, and based on the University's affirmative goals, not based on any disagreement with the religious tenets that underlie a potential affiliate's limitations on the services provided.

Sincerely,

Rachel Nosowsky, Esq.
Deputy General Counsel
Health Affairs & Technology Law

cc: Michele Bratcher Goodwin, Chancellor's Professor of Law
Howard Gillman, Chair, Working Group on Comprehensive Access