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June 3, 2019

**JANET NAPOLITANO, PRESIDENT**  
**UNIVERSITY OF CALIFORNIA**

**RE: Interim Report of the UC Academic Senate UC Non-Discrimination in Healthcare Task Force**

Dear Janet,

Earlier this year, the University Committee on Faculty Welfare Health Care Task Force (UCFW-HCTF) formed a Non-Discrimination in Healthcare Task Force, led by former Academic Council Chair Shane White, charged to explore the University's relationships with external healthcare providers that may potentially conflict with UC's values, public trust, mission, and/or policies on non-discrimination. At its May 22, 2019 meeting, the Academic Council unanimously endorsed the Task Force's attached Interim Report, which recommends that the University avoid affiliations with entities whose values conflict with UC's public mission and values.

As you know, the efforts of the Task Force took on increasing relevance this spring, in the context of a proposed affiliation between UCSF and Dignity Healthcare, which generated widespread opposition based on concerns about its alignment with the UC mission. Now, following UCSF's announcement that it will no longer pursue the affiliation, we stand ready to help the University identify a way forward that meets UCSF's need to increase access to quality healthcare and also comports with the UC mission and philosophy. We hope this report will help serve as a guide for those efforts.

Please do not hesitate to contact me if you have additional questions.

Sincerely,

Handwritten signature of Robert C. May.

Robert C. May, Chair  
Academic Council

Encl:

cc: Academic Council  
Senate Directors

## **Interim Report of the UC Academic Senate UC Non-Discrimination in Healthcare Task Force**

**April 2, 2019**

### **The UC Non-Discrimination in Healthcare Task Force**

In January 2019, due to serious concerns initially raised by UCSF faculty, the Academic Senate of the University constituted the UC Non-Discrimination in Healthcare Task Force. The Task Force was, in summary, charged with exploring potential conflicts arising between UC's public trust, mission and values, standards, and non-discrimination policies, on the one hand, and religiously-based practices and claims for accommodation or exemption on the other, in the context of health care. In this Interim Report, the Task Force notes that extant and proposed affiliation agreements between the university and external health care providers gives rise to conflict with the mission and values of the University. Such issues may affect teaching, research, and healthcare service activities. Faculty, other employees, students, and patients will bear the impacts.

### **UC's Place in the State of California**

Following the Organic Act of 1868, the California Constitution of 1879 affirmed that the University of California *shall constitute a public trust, and that it shall be entirely independent of all political or sectarian influence*. At that time, the University of California was granted autonomy in its affairs, in effect becoming a branch of state government. Such status conferred great responsibility upon the University for the educational, social and economic needs of the people of California. Subsequent legislation, such as the 1960 Donohue Act, gave the University jurisdiction and responsibility for public education in healthcare professions. The University mission is to provide: education, research, and service, including healthcare, for all the people of California.

### **Concerns and Conflicts**

The Task Force has made an initial appraisal of potential issues, and has identified at least five. One set of issues arises from affiliations between campus health divisions and private religious health care entities. A second area of concern is UC Care's network sufficiency given the prevalence of Catholic hospitals included as providers. A third set of issues arises when individual providers request exemptions from treating certain groups of patients. Issues also arise when students object to UC vaccination requirements. A potential fifth set of issues arises from providers who offer unsolicited prayer to patients or who seek accommodation to pray with patients. This Interim Report focuses primarily on the first set in the context of the UCSF-Dignity affiliations.

Concerns arise when external entities with whom UC enters into an affiliation with an entity governed by a private, sectarian organization bound by religious doctrine that requires limiting or denying care to particular groups of people and denying types of care which are standard practice of evidence-based medicine. Health care facilities with religious identities may and do provide health care shaped by religious belief. Catholic hospitals and health care systems are most likely to generate conflicts. Two factors account for this. One is prevalence. Catholic health systems constitutes the largest group of nonprofit health care providers in the United

States (Catholic Health Association of the United States <https://www.chausa.org/about/about/facts-statistics>). The second is that Catholic hospitals, including most Dignity hospitals follow the Ethical and Religious Directives for Catholic Health Care Services (ERDs) issued by the United States Conference of Catholic Bishops. A few Dignity Health hospitals follow a set of health care restrictions called the Statement of Common Values. Both the ERDs and the Statement of Common Values substantively constrain care and information provided to patients. They discriminate on the basis of gender identity. In particular, the ERDs prohibit highly-utilized, standard reproductive healthcare such as contraception, tubal-ligation, vasectomy, abortion in all cases, assisted reproductive technology use, and in the case of transgender care, hysterectomy. The ERDs also limit end-of-life care.

The restrictions in the ERDs and Common Values interfere with usual secular standards of care and patient outcomes. While international and domestic research repeatedly shows that evidence-based family planning methods are both widely embraced by women and critical to their family's health and wellbeing, they are largely prohibited by the Catholic policies. In a UC facility, a mother's contraceptive needs are addressed before returning home to take care of a newborn, a critical window of opportunity, especially if she desires sterilization. Whereas, 23% of women denied a sterilization after childbirth have an unintended pregnancy within one year (Flink-Bochacki, Flaum and Betstadt 2019).

Women having miscarriages who attend Catholic hospitals may face care restricted by doctrine. Catholic hospital doctors report they must wait for signs of infection if the fetus hasn't passed, in order for their ethics committee to allow them to treat. This may cause distress to both patient and doctor (Freedman, Landy and Steinauer 2008; Freedman and Stulberg 2013; Raghavan 2007). A national study found that 52% of ob-gyns who work in Catholic hospitals report conflict with their hospitals' religious policies for care, as compared with 17% for Christian hospitals and 9% for Jewish hospitals (Stulberg et al. 2012). Transgender care in Catholic hospitals is less well studied, but two cases under litigation in California indicate that denial can happen, consistent with statements that Catholic Bishops have made condemning transgender surgery. Some end-of-life care, most notably removing food and water per the patient's request and referrals for physician-aid-in-dying are not permitted.

Patients and UC providers may not have viable alternatives to seeking or providing care in UC affiliated facilities. Medical emergency, geography, or employment constrains health care access. A UC employee may have few options in their work assignments or in the providers covered by their benefits plan. A faculty member must not be denied the freedom to practice to the accepted standard of care, be forced to knowingly endanger a patient's welfare, to teach something inconsistent with the established standard of care, or be constrained in health promotion.

The ERDs and Statement of Common Values also constrain UC's educational mission. Students, trainees, and residents must not receive a lesser educational experience. Nor should UC employees be compelled to teach and students be compelled to receive instruction based on religious doctrine. In fact, Section 8 of the California Constitution prohibits instruction, directly

or indirectly, of “any sectarian or denominational doctrine . . . in any of the common schools of the State.”

Whereas UCSF leadership has proposed that a focus on transparency would help patients avoid being denied care, this is a formidable challenge that neither UC hospitals nor affiliated entities may be truly incentivized to take on. In fact, Catholic hospitals have exhibited an increasing trend toward opaque branding (Catholic Healthcare West became Dignity; The new system created by the Dignity-Catholic Health Initiatives merger is becoming CommonSpirit). Generally, patients (and many individual providers) do not expect a facility’s religious identity to affect the scope of services provided. Many are not even aware of their own hospital’s religious identity. In a recent national survey, 37% of women whose primary hospital is Catholic, did not know it was (Wascher et al. 2018). Likewise, the New York Times reported last year that it is quite difficult determine from a hospital’s website that it is Catholic (Hafner 2018). It is even less likely that women can anticipate the specific restrictions because few understand that care can be religiously restricted at all (Freedman et al. 2018). Women incorrectly believe that IVF, abortion for medical reasons, and sterilization among other prohibited services are actually available in Catholic hospitals (Guiahi, Sheeder and Teal 2014). Clearing up all these misperceptions would take considerable resources and perhaps a willingness for Catholic hospitals to affirmatively disclose the services they do not provide.

It is important to note key recommendations in the Report of the UCSF September 2017 Joint Senate-Administration committee of the campus affiliation Review policy have not yet been enacted. These included the creation of a Centralized Office to “*serve as a communications hub to the review committee,*” amongst other functions (page 11); policy revisions to “*include guidelines for the expansion of existing affiliations, which is separate than entering into new agreements*” (page 12); and that issues related to standards of care must be addressed (page 13). Of course, UCSF is not the only UC campus impacted by affiliations with religious healthcare entities; in fact, students, employees, faculty members, the families of UC employees availing of employer-provided health benefits, and non-associated members of the public may all be impacted.

The Task Force understands that UC’s schools, clinics and hospitals exist in a competitive marketplace which is undergoing consolidation and that success in our mission involves opportunity for teaching service and patient care. However, UC must avoid affiliation agreements with entities that constrain teaching, research, clinical care or other service, or that do not share UC’s key values, fail to advance our mission, and undermine UC’s public trust. Such affiliations may cause new gaps in care for UC patients. In addition, the inherently discriminatory and medically regressive model of care resulting from such affiliations will jeopardize UC’s reputation.

### **Recommendation**

The taskforce recommends that UC’s existing and potential affiliation agreements with entities whose values are in conflict with UC’s role as a public trust for the people of California be paused, scrutinized with increased rigor, and curtailed until any area of conflict with University mission and values have been resolved.

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