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Merger of Religious and Public Hospitals: Render Unto Ceaser

Arthur B. LaFrance

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Merger of Religious and Public Hospitals: Render Unto Caesar...

Arthur B. LaFrance¹

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I. INTRODUCTION

A. Preface

This article recounts the course and resolution of litigation in Newport, Oregon, from 1999 to 2002 that challenged the proposed merger of a Roman Catholic health system and a governmental, local hospital district.² Although the merger may simply be seen as one more instance of the pattern of mergers in the health care³ industry during the past decade,⁴ the issues raised in the Newport case are of considerable significance for several reasons.

First, the underlying agreement between a governmental hospital district, Pacific Communities Health District (the Health District), and a religious entity, the Providence Health System (Providence),⁵ raised constitutional questions as to whether and how a religiously affiliated health care system could merge with a public hospital district, exercising the latter's governmental prerogatives of taxation and governance.⁶ The issue was unavoidable because the terms of the agreement between the two hospitals committed the parties to respect Providence's "mission and values," a phrase that included the Ethical and Religious Directives on Health Care of the American Catholic Bishops Association (the Directives).⁷ The Newport case also raised serious questions as to the economic and service responsibilities of a public body, since the Health District would be

transferring twenty-five million dollars in assets and annual revenues without corresponding consideration.

Second, the exact nature of the religious issue in the case became difficult to identify. It might have been the simple fact of including religion in the agreement in post-merger services, or it might have been the nature of the corporation receiving the benefits from the agreement. That corporation, Providence, as a *religious* entity was a matter of dispute. Providence's buildings, services, and personnel are much like those of any large, effective health care system, sectarian or nonsectarian. However, its bylaws and corporate mission are different, as noted above, because they are subject to the Directives, although the significance of these to a patient is hardly self-evident. In addition, the impact on staff is equally unclear.⁸ Thus, much of the proof and advocacy related to *how* religion assumed importance in the case.

Third, the procedural aspects of the litigation, as well as its outcome, have considerable significance for similar litigation and mergers elsewhere. Although the Newport litigation might have been expected to reach a resolution on its pleadings or by summary judgment, it went through full discovery and a two-week trial. Thus, the Newport case provides one scenario for how such a trial might proceed.⁹

A few surprising aspects of the Newport litigation should be noted at the outset. There were extensive factual disputes concerning the effect of a merger with a religious hospital on services provided, the religious nature of the parties, and the fiscal need or wisdom of the agreement. Also, the arrangement in Newport, which entailed transferring assets and operations to a religious entity while keeping the governmental shell intact, meant that the agreement could be understood as tending to establish religion, either by preferential treatment of religion or by putting religion in charge of government, a distinction that made a difference in which case law was relied upon.¹⁰ Alternatively, the agreement could be seen as preferring one religion over others, thereby chilling the free exercise of religion and that,

again, would invoke a separate body of case law.¹¹ Another surprising aspect was that while the religious mission of Providence (“the healing ministry of Jesus”¹²) permeated the entire corporate entity and was openly espoused in its literature, there was testimony that Providence did not enforce the Directives.¹³ Finally, a continuing and obvious, but unappreciated, difficulty was proving a future status or consequence, i.e., that the merger agreement would ultimately lead to establishing religion or denying procreative rights. The difficulty here was that no witness could testify as to future consequences, yet these possibilities were central to the litigation.¹⁴

While these features of the case were noteworthy, the central task of all public interest litigation is to convert abstract constitutional principles into detailed proof, through live witnesses in an actual courtroom, talking about abstractions such as “entanglement,” “effect,” and “corporate culture” as though they were palpable facts. Such substance must turn on procedure: qualifying expert witnesses on public health, reproductive health services, and Church practices; offering photographs of hospital walls with crucifixes and hospital brochures with religious references; or presenting testimony concerning the impact of the Ethical and Religious Directives on the course of negotiations. In these ways, the abstractions of constitutional or public interest litigation take corporeal form to walk and speak in a specific courtroom in a given case.

The “separate but equal” doctrine in *Brown v. Board of Education*,¹⁵ the importance of counsel in *Miranda v. Arizona*,¹⁶ or the risk of advising husbands of intended abortions in *Planned Parenthood v. Casey*,¹⁷ are all matters of abstract constitutional theory. But they are also the stuff of human existence. Their presence in a case and their importance in the lives of litigants must be proven in a human, tangible way. Thus, this article will explore in some detail the way in which witness testimony unfolded in the Newport case because that process is essential to legal theory, and because the problems and resolutions are likely to recur elsewhere.

*B. An Overview of the Facts*¹⁸

Providence is a Roman Catholic enterprise and a major provider of health care through insurance, hospitals, and clinics in the Pacific Northwest. The Health District is a small governmental “special district,” like a school, water, or fire district, located in Newport, Oregon. The Health District operates a hospital and several clinics, with twenty-five million dollars in assets and an operating income of twenty-five million dollars; it is a relatively small provider of health care. In 1999, the two institutions developed an “affiliation agreement” that later went through several major amendments, providing for a transfer of facilities, personnel, and services to Providence, which would then operate the facilities through the Health District while continuing to tax the district’s citizens.

A group of citizens (the Ad Hoc Committee) became concerned that they would lose local governance of their health care institutions and that services would be curtailed in light of the religious principles of the Roman Catholic Church. The group held meetings, exchanged correspondence, and planned litigation.¹⁹ Ultimately, it was not the citizens but the two hospitals that filed a suit seeking to validate the agreement in the form of a declaratory proceeding. Settlement negotiations failed, and the case went to trial in December of 2000. Providence and the Health District both filed briefs with the court. The day before the Ad Hoc Committee’s brief was due, Providence and the Health District withdrew their suit. Granting their request, the court dismissed the case without prejudice, which led to an appeal that was later withdrawn.²⁰

This capsule summary provides the basis for the following account of the merger agreement, the issues raised, the development of the litigation and pleadings, the evidence offered at trial, and the post-trial proceedings. Throughout the litigation, the position of the merging hospitals was that they would provide good health care, the agreement was sound and necessary, and Catholic principles were not material. The Ad Hoc Committee took the opposite position on the latter two points, arguing that

the merger was not economically necessary or sound; that it would restrict existing or potential health care due to the governing Roman Catholic principles; and that the transfer of the Health District property and operations would tend to favor Catholics and discriminate against non-Catholics.

Central to the arguments of both sides was to what extent Providence's Roman Catholic principles would affect the Health District's delivery of health care services.

II. THE ETHICAL AND RELIGIOUS DIRECTIVES OF ROMAN CATHOLIC HEALTH CARE

A. The Directives as Governance

The Roman Catholic Bishops Association began developing policies for Roman Catholic health care in the mid-1970s, publishing a set of Ethical and Religious Directives for Catholic health care services in 1994 that were refined and further modified during the course of the Newport litigation.²¹ The Directives are a highly sophisticated, well-articulated, and coherent set of imperatives reflecting the application of Roman Catholic theology to Roman Catholic health care institutions. More importantly, they also represent a political attempt by the Catholic clerical hierarchy to assert its authority over the Catholic hospital hierarchy in the marketplace of health care. Because Catholic hospitals must compete in the competitive, secular business of health services, inevitably, from the perspective of the bishops, the values and the teachings of the Catholic Church may be compromised. The Directives are specifically designed to counter that problem and insulate Catholic hospitals, the billions of dollars in assets and income they represent, and the millions of patients they serve.

It was not clear at the beginning of the Newport case exactly what impact the Directives might have if the merger were to go forward. The teachings of Catholic theology are clear: abortions, assisted suicide, reproductive

surgery, and artificial reproductive techniques are forbidden; in addition, family counseling emphasizes natural methods of childbirth.²² All of this is understood, as a matter of Catholic theology. But the extent to which these dictates would operate within the hospital walls of the Health District was far from clear. The agreement formulated by the two hospitals required the Health District to accept “Providence’s values,” but it was not a self-evident reference to the Directives.²³ Even if it was, that reference did not necessarily mean that the Directives would actually control the staff and services in practice.

Discovery revealed an affirmative answer to these questions: the Directives are part of Providence’s articles of incorporation, and as such, they are binding on all staff throughout Providence, including the staff of the proposed merger. And even if existing services in Newport did not include services barred by the Directives, the existence of the Directives would prevent such services from being developed or offered in the future. For example, the French abortifacient, RU486, was becoming available in the United States as the litigation progressed. A fair question was whether it would be made available in Newport if the merger were effected. On deposition, the answer by Providence officials was a clear “no.” The Directives would certainly influence and restrict future health services in the district.

Thus, it is necessary to examine the Directives more closely. It should be noted that the Directives were being reviewed and toughened by the bishops as this litigation was underway. In fact, many of the concerns expressed by the Ad Hoc Committee were shared by the Catholic bishops, but for different reasons. Paradoxically, both were concerned with how Catholic teachings would come to play a role in Newport: the Ad Hoc Committee feared too much religious influence, and the bishops feared too little.

At the time of the litigation, the Directives contained separate “principles governing cooperation.”²⁴ These principles pertained directly to corporate mergers, as did the section titled “Forming New Partnerships with Health

Care Organizations and Providers.”²⁵ The essence of the concerns in that section had to do with what is referred to as “scandal” in arrangements like the one proposed in Newport. By “scandal,” the bishops and the Directives mean an organized compromise of the religious identity of hospitals and a lessened adherence to Church teachings and precepts.²⁶ The introductory comments to the “Forming New Partnerships” section reflected a sophisticated awareness of the interrelated nature of health care systems and the ways in which Catholic providers become enmeshed therein:

Until recently, most health care providers enjoyed a degree of independence from one another. In ever increasing ways, Catholic health care providers have become involved with other health care organizations and providers.

* * *

[N]ew partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles. The risk of scandal cannot be underestimated when partnerships are not built upon common values and moral principles. Partnership opportunities for some Catholic health care providers may even threaten the continued existence of other Catholic institutions and services, particularly when partnerships are driven by financial considerations alone. Because of the potential dangers involved in the new partnerships that are emerging, an increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships.²⁷

As these introductory observations indicate, the Catholic bishops had a legitimate and sophisticated concern that market forces and the imperatives of competition, as a necessity for survival, might cause Catholic health care institutions to compromise their theological principles or abandon their moral base.

The Directives themselves confirm the bishops' concerns and their effort to maintain a strong voice in the management and provision of health care services. One directive provides that "[d]ecisions that may lead to serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal, should be made in consultation with the diocesan bishop or his health care liaison."²⁸ Another requires a bishop's approval for any partnership that will affect the mission or religious identity of a Catholic provider.²⁹ Similarly, participation in such partnerships must be limited to what is "in accord with the moral principles governing cooperation."³⁰ Yet another directive is clear and categorical: 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.³¹

On one hand, these Directives are traditional religious imperatives meant to bind individuals; on the other hand, they are designed to apply to corporate, commercial, or institutional transactions. The Directives import a moral imperative and dynamic that would be difficult even for the most sophisticated corporate executive to implement. Further, they pose the very real danger of moral ambiguity by drawing distinctions between "formal" and "material" cooperation, as well as between "immediate" and "mediate" material cooperation, which constitute lines between right and wrong. The distinctions may be unclear; the consequence is not. Catholic institutions and executives in partnership with non-Catholic institutions, such as the merger proposed in Newport, risk moral error and condemnation.

The practices that might lead to this condemnation are delineated in the Directives. The bishops emphasize the "healing mission" of Jesus Christ, beginning with his acts of healing during his lifetime and proceeding through the teachings of St. Paul to extrapolate a mission for Catholic health care in the modern world, particularly in serving the poor and the family.³² The diocesan bishop, who exercises responsibilities that are rooted in his office as pastor, teacher, and priest, implements the mission.³³ By this

declaration, then, the church hierarchy and its representative, the local bishop, are placed squarely in the context and control of Catholic health care institutions throughout the country.

B. The Directives as Religion

The content of moral Catholic health care is spelled out in the Directives. The preamble speaks of addressing Catholic providers in institutional settings, starting with a general introduction that recaps the healing ministry of Jesus, addressing the imperatives of serving the poor, reaching the spirit as well as the body, and specifically involving both laity and the local bishop.³⁴ Part I of this article deals with the social responsibility of Catholic health care services; specifically, the first directive declares that Catholic institutions “must be animated by the Gospel of Jesus”;³⁵ another directive provides that “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.”³⁶

The Directives also deal with “The Professional-Patient Relationship.”³⁷ The introduction to that section reads as follows:

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the [C]hurch’s understanding of and witness to the dignity of the human person. The [C]hurch’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.³⁸

These policies are made operational in the directives that follow. For example, in Directive 24, the bishops declare that a Catholic health care institution “will not honor an advance directive that is contrary to Catholic teaching.”³⁹ Similarly, the Directives provide that a woman who has been

raped should be treated with medications to prevent ovulation or fertilization if there is no evidence that conception has occurred.⁴⁰ And further, it is not permissible “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.”⁴¹

The significance of Catholic religious teaching becomes perhaps clearest in Part IV, “Issues in Care for the Beginning of Life.” That section provides that the Church cannot approve contraceptive interventions that either purposefully or resultingly render procreation impossible.⁴² Similarly, “[r]eproductive technologies that substitute for the marriage act are not consistent with human dignity.”⁴³ Thus, artificial insemination, in vitro fertilization, and surrogacy are forbidden.⁴⁴ One directive states unequivocally, “Abortion . . . is never permitted.”⁴⁵ The concerns motivating the prohibition on abortion also motivate the directive that forbids promoting or condoning contraceptive practices,⁴⁶ including direct sterilization for men or women, as well as the directive that forbids prenatal diagnosis for the purpose of aborting children with birth defects.⁴⁷

Not surprisingly, in the section of the Directives titled “Issues in Care for the Dying,” Roman Catholic teaching is emphatically impressed upon Catholic health care institutions.⁴⁸ Catholic theology teaches eternal life, but also that life-prolonging procedures may be rejected if “insufficiently beneficial or excessively burdensome.”⁴⁹ However, the introduction to this section reads, “Suicide and euthanasia are never morally acceptable options.”⁵⁰ Directive 57 does recognize that a person may choose to “forgo extraordinary or disproportionate means of preserving life.”⁵¹ Moreover, the informed judgment of “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.”⁵² The Directives draw the line against euthanasia, defining it as “an action or omission that of itself or by intention causes death in order to alleviate

suffering.”⁵³ The bar is absolute: “Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way.”⁵⁴

By their very terms, the Directives are obligatory upon health care institutions, particularly those that might form new partnerships with non-Catholic institutions. It is easy and dangerous to ignore the profoundly revolutionary nature of the Directives. Moral and ethical teachings of the Church have long guided individual communicants of the Catholic faith, but the Directives transform those teachings and principles from matters of individual adherence to matters of corporate and community policy.

Health care institutions that are formed or operated in partnership with Roman Catholic health care providers do not cease to be community institutions simply by reason of their religious affiliation. They remain community institutions, receiving fire, police, zoning, and tax benefits, as well as Medicare and Medicaid funding from a community that is not solely Catholic, Protestant, Jewish, or Muslim but that is a pluralistic, political community in a secular nation.

Over the past thirty years, Catholic and all other health care institutions in this country have become major beneficiaries of public programs of tax policy and health finance, including Medicare and Medicaid. These programs do not come with religious tests or content. Catholic health care institutions, licensed and supported by the public, have a mission to serve in the public interest.

The Directives pose a direct challenge to this public responsibility. Clearly, religious groups may practice their faith and be guided by it. Additionally, if they accept no public benefit, they need accept no public burdens. But the very purpose of the Directives is to respond to a health care context that, over the past decades, has interwoven all providers into a complex health care tapestry. This entanglement poses the danger of “scandal”⁵⁵ precisely because there is no escape; all hospitals, including Catholic hospitals, are in a sense “public.”

The conflict resulting between the independence of religious institutions and the public responsibility of every hospital was at the heart of the Newport litigation. The central issue was how the Catholic principles would impact the Health District and its community through the merger agreement. While the language of the Directives is clear, if they are not implemented, nothing, arguably, is lost: no harm, no foul. Transferring assets and authority to a religious entity, such as Providence, violates the First Amendment only if it serves religious purposes or assists Providence's religious mission.

Thus, the nature of the Directives is important only in the consequences of those directives to the Health District and the services and people affected. The bishops' fears are real, given the nature of health care in the twenty-first century, but not every relationship involves scandal or sin. Competition and the ability to serve God turns at least partly, on the agreement effected between the Health District and Providence.

III. THE MERGER AGREEMENT

A. The Parties

On June 5, 2000, Pacific Communities Health District (the Health District), and Providence Health System, Oregon (Providence), an Oregon charitable, not-for-profit corporation, finalized an Operating Agreement.⁵⁶ The Health District is an Oregon municipal corporation.⁵⁷ It is a governmental unit created under state law with elected officials, the power of eminent domain, and taxing authority.

At the time of the agreement, the Health District was profitable. The Health District owns a general hospital, with forty-eight beds, as well as related health care facilities in Newport, Oregon.⁵⁸ It also operates outpatient clinics in Newport and in the neighboring towns of Walport, Depoe Bay, and Toledo.⁵⁹ While the Health District would be considered a small health care provider, it did offer a full range of services, with the

exception of abortions, which became significant later. However, in the realm of reproductive services, the hospital and the clinics did make available family planning and reproductive services, including laparoscopy.

Providence, in contrast, is a major provider of health care in the Pacific Northwest, with millions in assets and tens of thousands of employees.⁶⁰ The specific party to the agreement was Providence Health System, Oregon.⁶¹ The Oregon unit of Providence has a health plan insurance company, four hospitals, a number of treatment facilities, and several clinics mostly in western Oregon and chiefly in the Portland area.⁶² Also, by all accounts, its services are high quality. Significantly, Providence is a Roman Catholic organization and, by a specific provision in its articles of incorporation, its services are subject to the Directives of the Roman Catholic Church as summarized above.⁶³ Consequently, Providence did not offer a range of services that would otherwise have been offered by a general provider of health care.

It may be worth noting that the National Catholic Bishops Association was not itself a party to the Operating Agreement.⁶⁴ This is significant because the Bishops' Council, the group of Catholic bishops responsible for drafting the Directives, has interests that diverge from those of Catholic health care providers such as Providence. The providers function in a competitive marketplace. The Bishops' Council operates in a world of theology and church-based politics; it is suspicious of the motives and initiatives of Catholic health care systems. For instance, it became apparent through discovery and trial that the health care providers and the Bishops' Council were, in many respects, more at odds with one another than the litigants themselves.

The litigants included the parties to the Operating Agreement (the Health District and Providence) on one side and an Ad Hoc Committee of citizens on the other. The Ad Hoc Committee consisted of ten citizens from the Newport area, two of whom had served on the board of the Health District. The Ad Hoc Committee was diverse. One member had been the director of

social services for the county, another had set up reproductive counseling services for the state of Oregon, another was a nurse, another was a social worker, and another (the only male) was a businessman and real estate developer. The Ad Hoc Committee's concerns about the agreement included the following: the loss of local governance, the inadequate economic terms, the potential loss of services, and the merger of private religious and governmental interests contrary to the state and federal constitutions. The spectrum of concerns was quite broad, and the Ad Hoc Committee made it clear that they were not an abortion rights group.

Because Newport is a small, isolated, coastal community, the members of the Ad Hoc Committee were well acquainted with the executives, staff, and governing board of the Health District. Moreover, they came to know the administrators of Providence either through negotiating sessions or pretrial discovery proceedings. Inevitably, personalities bruised, nerves became frayed, and hostility was generated. In a small community, the proposed merger loomed large and exacerbated the pressure cooker quality of the litigation.

B. The Terms of the Agreement

The agreement provided that “[p]ursuant to ORS 440.360, the [Health] District is authorized to enter into business arrangements and relationships with public or private entities...”⁶⁵ There were further recitals to the effect that the Health District had decided that there were “clinical, economic and administrative synergies to be gained by affiliating with a major health care system,” and the Health District had decided that Providence qualified.⁶⁶

The Operating Agreement between the Health District and Providence had been called an “Affiliation Agreement” in an earlier iteration.⁶⁷ Counsel for the Ad Hoc Committee had sent, in February of 2000, a lengthy letter that critiqued the document.⁶⁸ In response, the Health District and Providence revised the document in significant ways, entitling it an “Operating Agreement” instead.⁶⁹ Significantly, the earlier Affiliation

Agreement had made specific references to Providence's adherence to the Roman Catholic Ethical and Religious Directives;⁷⁰ these references were deleted in the subsequent Operating Agreement.⁷¹

The final agreement, the one that was ultimately challenged at trial, was not styled as a merger agreement; rather, it was styled as an operating agreement. Indeed, the form of the agreement provided that Providence would simply be "operating" the health care services of the Health District on behalf of the Health District. Such a management agreement, if it had been genuine, might well have survived the challenge. A religious manager can serve just as well as a sectarian manager so long as the services are managed in a nonsectarian fashion. Under a true operating agreement, Providence would simply receive a fee, possibly a commission, for operating the Health District's services, property, and employees.

Instead of a simple transaction fee for a service, the Operating Agreement transferred far more than operating control to Providence. The Health District was substantially merged into Providence; Providence was granted not only all of the Health District's facilities, personnel, patients, operations and income, but also the Health District's taxing power. The governing board of the Health District would continue to exist but as a subunit of Providence. Governmental capabilities of the Health District, notably taxation power, were now subject to Providence's control. If it was an operating agreement, it was so only in the sense that Providence would operate the government.

1. Transfers to Providence

All Health District facilities, personnel, revenues, and services were to be transferred to Providence, whose consideration in return would be to operate them and to keep revenues. The agreement was to be a cooperative effort in which "Providence is responsible for providing local health care services at the Hospital and the [Health] District provides the facilities in which that can occur and monitors the performance by Providence of its

duties under this agreement.”⁷² The recitals went on to provide that Providence and the Health District would cooperate to provide support to each other, and that Providence was “committed to sustaining and enhancing the depth and breadth of those services now offered by the [Health] District.”⁷³ The recitals emphasized Providence’s goal to conduct local decision making for the governance and leadership of the hospital.⁷⁴

The agreement went on further to describe its terms. A lease for all of the Health District property was provided in the agreement. The name of the hospital was to be changed to “Providence Pacific Communities Hospital.”⁷⁵ The term of the agreement was to be from July 1, 2000, to December 31, 2029.⁷⁶ On the effective date of the agreement, the Health District was to transfer its current assets and liabilities to Providence, with certain exclusions provided later in the agreement.⁷⁷ The Health District was to retain all long-term assets, liabilities, and restricted funds, including title to and ownership of the leased property, the capital improvement and replacement funds, and liability for general obligation refunding bonds.⁷⁸

The agreement further provided that Providence would use and operate the leased property for the purposes of a general acute care hospital and outpatient clinics in the central coast service area.⁷⁹ Providence was forbidden from using the leased property or any working capital for any other purpose without prior written consent from the Health District.⁸⁰ Presumably, this requirement was written to forestall transfer of property or application of proceeds to some of Providence’s other hospitals or facilities elsewhere in the state.

2. The Parties’ Obligations

The transfers to Providence were substantial in value, scope, and quantity. In exchange for receiving all of the facilities and services of the Health District, Providence agreed to operate those facilities and services. This point bears restating: the consideration (i.e., payment) from Providence for the Health District’s transfer was that they would accept the transfer and

operate the facilities. The benefits of the agreement for Providence seemed to outweigh those for the Health District. While Providence undertook other ill-defined obligations, there was no *quid pro quo* for millions of dollars in value transferred by the Health District.

On the effective date of the agreement, Providence was to establish a board known as the Central Coast Service Area Community Council (the Community Council).⁸¹ Its function was to provide leadership and oversight of health care operations within the Health District.⁸² The agreement specifically provided that the Community Council was not a legal entity; rather, it was created to assist in the “governance and management” of Providence.⁸³ It is important to note that the agreement provided that the Community Council “shall operate in accordance with the policies, mission, and values of Providence.”⁸⁴ This statement appears to be an oblique reference to the Directives.

The functions of the Community Council were to provide oversight of the quality improvement programs, to provide a credential link between the Health District and Providence, to review and approve amendments to medical staff bylaws, and to [t]ake appropriate action with regard to other responsibilities as may be delegated by the Board of Providence from time to time.⁸⁵ The Community Council was also to provide “advice, counsel and direction” concerning community needs for health services, facility operations, financial performance, and strategic direction for the central coast area.⁸⁶ Significantly, the Community Council was to recruit for membership responsible persons who shared the mission and values of Providence,⁸⁷ which was another indirect reference to the Directives. The members of the Community Council were to be appointed by Providence in consultation with the Community Council.⁸⁸ The Council was to have at least eleven members with no more than two members appointed by the Health District.⁸⁹

During the lifetime of the agreement, the Health District’s board would continue to exist but in a subordinate role. The board would receive and

review reports and information concerning the delivery of health care services submitted by the Community Council or Providence.⁹⁰ The Health District's board would also monitor Providence's performance and submit any requested changes in goals, objectives, health care service delivery, or operations of the Health District to Providence and the Community Council.⁹¹ Additionally, the board would review and approve all master site development and facility plans or projects created by Providence involving total expenditures in excess of twenty-five thousand dollars.⁹²

Providence would determine the feasibility of extending its health plan and managed-care options to the central coast service area and would also seek to maintain an open physician panel in that region.⁹³ In order to make that determination, Providence would undertake several obligations. For example, Providence would establish and maintain a community cancer center, as feasible; it would determine the feasibility of radiation therapy services in the central coast service area between 2004 and 2009; and it would conduct periodic assessments of health services in the central coast service area by determining the feasibility of many of those services and assessing the need for medical office space.⁹⁴ Curiously, Providence would also seek to obtain the release of the Health District from its obligations under agreements with physicians and various departments including pathology, radiology, emergency medicine, and electrocardiography.⁹⁵

Providence's level of control is evidenced by the provision in the agreement that provided, "Providence shall be responsible for the total operation of the hospital."⁹⁶ Moreover, the agreement provided that Providence could adopt its own employment policies with respect to employees, and that "Providence shall offer employment, at Providence Pacific Communities Hospital, at their current level of compensation to all current employees of [the] District of the Effective Date, *in accordance with Providence's standard policies and procedures.*"⁹⁷

The recital of the Health District's responsibilities was brief in comparison to the recital of Providence's responsibilities. Significantly,

there were two provisions that later raised concern. First, the Health District was obligated to “[u]se its best efforts to maintain its operating tax levy on all taxable property within the jurisdictional boundaries of the District in order to provide the funds needed by the District to support the District’s operations and fund the provision of indigent care and other services by Providence....”⁹⁸ Second, the Health District was required to “[m]aintain primary responsibility for financing all master site development and capital construction and improvements....”⁹⁹ To this end, the Health District would use its best efforts to obtain voter approval of general obligation bonds, and it might request “financial assistance from Providence for master site development and capital construction and improvements.”¹⁰⁰

Two financial undertakings are significant. One was by Providence to invest not less than one million dollars in a mutually acceptable project for new diagnostic or therapeutic capabilities within twenty-four months.¹⁰¹ The investment was to be drawn from funds other than working capital or revenues generated in the central coast service area.¹⁰² The second undertaking involved the parties’ agreement to cooperate in an effort to maintain the district-operating tax levy. From that levy, \$450,000 would be allocated to reimburse Providence for charity care, uncompensated Medicaid and Medicare charges, community health programs, medical education, and residency training.¹⁰³ The total tax levy was estimated to be approximately \$560,000.¹⁰⁴

The agreement provided that while the Health District retained ownership of all facilities, properties, and equipment, it would “commit a portion of its Capital Improvement and Replacement Fund (the Reserve Fund) to implementation of master site development . . . and the construction of medical office space.”¹⁰⁵ The Reserve Fund totaled twelve million dollars in capital reserves, and the Health District had the right to maintain a balance in the Reserve Fund of only two million dollars.¹⁰⁶

3. Religious Directives

The agreement provided that “[e]ach party will perform its duties under the terms of this Agreement in a manner consistent with the party’s philosophy, mission, policies and values.”¹⁰⁷ Copies of these policy statements were appended to the Operating Agreement as Exhibit C.¹⁰⁸ While an earlier draft had made explicit reference to the Ethical and Religious Directives of the Catholic Church, the Operating Agreement and the appended Exhibit C carefully avoided such a reference. The incorporation of the Directives only became explicitly clear as a part of Providence’s articles of incorporation through discovery, deposition, and production.

At the end of the agreement there were provisions for termination.¹⁰⁹ Significantly, the agreement provided that “[i]f at any time...Providence is required to operate the Hospital in a manner that is not consistent with the philosophy, mission, policies and values of Providence,” Providence may terminate the agreement upon sixty days’ notice.¹¹⁰ If the operational management of the clinics placed Providence in a conflict with its philosophy, mission, policies, and values, the agreement provided that the “operation or management of the Clinics may revert to the operation or management of the [Health] District, if the parties mutually agree.”¹¹¹ The agreement then provided that “[t]he parties may also consider the option of transitioning employed physicians to private practice as a means of resolution without termination of this Agreement.”¹¹²

The agreement thus transferred all of the Health District’s facilities, personnel, services, and patients to Providence, where the principal consideration (other than creating a diagnostic center) given by Providence was to operate them. Those operations would have to be consistent with Providence’s mission and values. As noted, the importance of that consideration was reflected several times in the agreement. The importance was heightened in a relatively small community where the consideration included not only the operation of the hospital and clinic services but also

rental space for the Health District's medical offices for physicians and other professionals, who were required by the agreement to be members of the hospital's medical staff or other health professional staff. Thus, the agreement and the values it implemented would have a profound impact on health care services throughout the small city of Newport, the Lincoln County area around it, and a significant portion of the rural seacoast of Oregon.

C. Objections to the Merger Agreement

Both earlier and final versions of the Operating Agreement raised objections that were communicated to the Health District's board prior to the litigation in the Newport case. On December 23, 1999, counsel for the Ad Hoc Committee wrote to the Health District board members to communicate the committee's opposition to the earlier proposed Affiliation Agreement.¹¹³ The essence of the committee's objections would also apply to the subsequent revision, and the objections are conveyed in the following quotation from that initial letter:

In summary, the Committee's position is that the proposed agreement with Providence (a) unconstitutionally transfers management of a public institution to a religious group, subjecting public assets, services and taxing authority to religious policies and principles; (b) unconstitutionally provides support to that same religious group, by that same transfer and by a continuing obligation to use public taxing authority to fund future operations and construction on Providence's behalf, excessively entangling public authority with private, religious governance; (c) unconstitutionally curtails or burdens reproductive services and counseling by delegating public decision making to private, religious management; (d) contrary to Oregon statute, effects a merger and/or a partial liquidation of a public hospital district without required public process, review and approval and a delegation of District taxing authority to a private, religious group; [and] (e) contrary to Oregon court decisions, does so on terms so favorable to Providence as to constitute an abandonment of public,

fiduciary responsibility, beyond the authority of the officers of the District.¹¹⁴

Following this communication, there were exchanges between counsel for all parties as well as an effort to make a presentation to the Health District's board. Unfortunately, the board declined to extend more than a few minutes on their public agenda at their regular meetings. The preliminary draft of the Operating Agreement was reworked into the final, which was critiqued in a letter by counsel for the Ad Hoc Committee in similar terms to those stated above; the letter was sent to the chair of the Health District's board on February 17, 2000.¹¹⁵

Despite efforts at resolution, the positions of the parties did not shift, and litigation ensued. But it was not, as one might anticipate, initiated by the objecting citizens.

IV. THE LITIGATION: PRETRIAL

A. Pleadings

1. Choice of Forum

The issues posed by the merger between Providence and the Health District were fairly clear. Control and operation of a public entity by a religious entity raises First Amendment religion issues under the United States Constitution. These issues are independent of the possible effect on available services and operations. The Ad Hoc Committee argued that the availability of certain services would also be influenced, and this raised health care issues under the Fourteenth Amendment of the U.S. Constitution. These federal concerns could also be grounded on the Oregon Constitution¹¹⁶ and could be raised by title 42 of the United States Code, section 1983, in either state or federal court.¹¹⁷ In addition, there were state law questions as to whether a special public district, such as the Health District, could be operated by a private entity. There was also the question of whether the merger was a waste of public resources. These state law

questions could be raised pendent to the constitutional issues in either federal or state court.¹¹⁸

The possibility of filing in either federal or state court raises important issues involving choice of forum. As a general matter, civil rights and public interest attorneys prefer federal court.¹¹⁹ Federal court is generally a better forum for civil rights litigation because it offers a more rigorous selection process for judges; a more favorable docket in terms of volume and speed; a greater array of resources available to the judge; a greater familiarity with constitutional issues; and insulation from such political issues as those that were posed in the Newport case. In this case, the choice was between the Oregon Court of Appeals and the United States Court of Appeals for the Ninth Circuit. The Ninth Circuit was preferable for the reasons noted above and for its reputation as perhaps the most liberal bench in the federal judiciary.

Generalizations, however, are always subject to exceptions. A suit in federal court in the Newport litigation would have been assigned to the southern unit, which at that time also meant a conservative judge.¹²⁰ An appeal through the Oregon Court of Appeals to the Oregon Supreme Court would have involved one of the most highly regarded state supreme court benches in the country. A state court trial, however, would have been heard (as it ultimately was) by a trial judge inexperienced in complex constitutional issues, with a crowded docket, limited resources, and, not surprisingly, an equally limited patience and tolerance for the efforts of pro bono counsel.¹²¹ The best choice was federal court, and Portland in particular, which had a more favorable federal bench.

Instead, the Health District filed in state court in Newport, Oregon. The reason for this choice of forum may be surmised. The considerations favoring federal court disfavored the Health District and Providence. Perhaps counsel were more familiar with the state court processes, which is often true when counsel represents local governmental units in civil rights cases. Certainly another important consideration involved the logistics of

resources and travel. If the case had been brought and tried in federal court in Portland, then counsel, support services, and many of the expert witnesses would have been readily at hand, convenient to the court house. In contrast, filing in Newport meant a three-hour drive for conferences and court appearances. While this was a burden for both sides in the case, the financial resources of the corporations made the burden easier to bear. The same was not true for uncompensated, pro bono counsel and witnesses.

2. State Court Petition and Notice

As noted, the Ad Hoc Committee did not get to file its civil rights action in federal court. Instead, the Health District filed in state court, seeking a declaratory judgment by invoking a procedure ill-adapted for resolving issues. On March 15, 2000, the Health District filed a Petition for Judicial Examination and Judgment (the Petition),¹²² terming it a validation proceeding.¹²³ The Health District requested the local trial court to “enter a judgment that all actions taken and proceedings conducted by the [Health] District and the Board in connection with the [Operating] Agreement are in compliance with the provisions of applicable laws including, without limitation, all relevant constitutional provisions, statutes and regulations.”¹²⁴ The Health District further prayed that a judgment be entered that the agreement and the transactions were “valid and legal” under the provisions mentioned.¹²⁵

The only parties named as plaintiffs were the members of the board of the Health District, the first named being Gary Hoagland.¹²⁶ They sued “as the Board of Pacific Communities Health District.”¹²⁷ There were no defendants, and the members of the Ad Hoc Committee were not referred to anywhere in the body of the Petition.¹²⁸ Notice of the judicial proceeding was to be published, stating that a petition had been filed praying that the court approve proceedings of the board:

[U]ndertaken and proposed in connection with the District’s efforts to enter into an operating agreement with Providence Health

System—Oregon (“Providence”), under which the District has agreed to lease and transfer operation, but not ownership, of certain of its real and personal property to Providence, and to transfer certain current assets and liabilities to Providence, in exchange for which Providence has agreed to use and operate such property in a mutually agreed upon manner and in accordance with all applicable laws, in order to assure that quality health care services continue to be available to residents of the District.¹²⁹

The notice closed by telling any interested person that he or she could appear and contest by filing an answer.¹³⁰

The notice gave no hint of the magnitude of the proposed merger. Nothing was said about the millions of dollars of annual revenues and assets being transferred, or that these transfers were to continue for a term approaching thirty years. Nothing was said to convey the reality that Providence was giving little in return for these transfers, other than a commitment to make good faith studies and to possibly develop a diagnostic center. There was no hint in the notice that the governance of the Health District would be radically altered under Providence’s control. Most significantly, there was no suggestion that Providence operated under a set of religious Directives that might restrict or preclude services. If a reader of the notice had gone to the clerk’s office to read the Petition, there would have been little in the Petition itself to alert the reader. The Petition was vague, and a member of the public who ventured to read the whole Petition would not have been given proper notice of the significance of the issues or the parties to the Petition.

The Petition had two additional exhibits. Exhibit B was entitled “Principles of Affiliation” and consisted of the Health District’s generalities for setting criteria for selecting a merging partner, but it in no way provided a rigorous test for a partner or indicated whether that partner was restricted in religious terms.¹³¹ Exhibit C contained the Operating Agreement itself.¹³² A person who struggled through the almost seventy pages of the Operating Agreement might then come to another exhibit reciting the core

values of Providence to continue “the healing ministry of Jesus in the world of today.”¹³³ Among the core values listed were compassion, justice, respect for the dignity of persons, excellence, and stewardship.¹³⁴ There was no reference made to the Directives of the Catholic bishops.

This was a curious pleading and proceeding. The Health District believed, or asserted, that it was proceeding *in rem*, but *in rem* proceedings are generally directed toward physical objects, such as real property or boats when the title or disposition of the property are in controversy. In this case, a whole course of past negotiations and an entire course of an administration and corporate merger, yet to be undertaken, were the subject of the validation proceeding. The court was asked to pass judgment on the transfer of a complex business, involving millions of dollars in assets and proceeds, thousands of patients, and the merger of a governmental unit into a religious corporation. The state statutes invoked were actually intended, and previously used, only to resolve specific and limited municipal action such as the building of a public building or the imposition of a specific tax.¹³⁵ Clearly, the corporate merger proposed between the Health District and Providence was quite different. It presented an ongoing, flexible relationship of unclear scope, duration, and content, lasting for decades.

Most significantly, an *in rem* or declaratory procedure must be accompanied by the best notice possible and must be calculated to alert the greatest number of interested parties.¹³⁶ For the Newport case, this certainly would have included people in Newport as well as health care providers elsewhere in the state. But the notice published was opaque at best and deceptive in its suggestion that the proposed agreement and declaratory judgment were routine matters of little consequence. On the morning of the hearing challenging the notice, the defense counsel for the Ad Hoc Committee stopped for breakfast at the Embarcadero, a restaurant in Newport. When asked why he was in town, he explained the suit and notice and asked the waitress if she read the local newspaper. She replied,

“Regularly. But this is the first I’ve heard we were selling our hospital. Don’t let them get away with it.”

B. Responsive Pleadings

After the Health District filed its petition to validate the proposed merger, Providence filed a motion to intervene.¹³⁷ Plainly, the motion to intervene was appropriate. Indeed, an argument could be made that the Health District’s petition could be dismissed for failure to join indispensable parties had Providence not itself intervened.¹³⁸ The motion to intervene was granted as a routine matter.

The Ad Hoc Committee appeared, through Corrinne Williams, Barbara Davidson, and Norman Johnson, and moved to dismiss.¹³⁹ At this point the committee also became known as the “defendant.” Essentially, the grounds for the motion to dismiss were threefold: the notice had been constitutionally defective and failed to comply with U.S. Supreme Court case law under the due process clause; the Health District lacked statutory authority to effect an agreement that would transfer governance to a private party and transfer substantial assets without compensation; and the agreement would violate not only the establishment clause and the freedom of religion clause of the state and federal constitutions, but would also violate the provisions assuring rights of personal autonomy and reproductive choice.¹⁴⁰ The motion to dismiss also contended that the agreement would restrict services either presently provided or possibly desired in the future, because of the religious principles of Providence, as articulated in the Directives.¹⁴¹

The procedural challenge, particularly to the deficiencies in the notice, seemed well taken. For purposes of raising that challenge, the Ad Hoc Committee carefully filed a special appearance. The substantive challenges were well grounded, but it was possible that the judge believed that the facts needed to be developed by discovery and further arguments on motions for summary judgment. That is what ultimately happened, but a decision

granting the motion to dismiss seemed appropriate because on its face the Operating Agreement turns over not only assets but also the government itself to a religiously affiliated and governed body. The Operating Agreement and the case seemed well designed for a ruling on the face of the pleadings, dismissing the Health District's claim. However, the motion to dismiss was denied. No reasons were given.

On June 8, 2000, the Ad Hoc Committee filed an answer and counterclaim.¹⁴² The answer detailed the services that were presently available through the Health District as follows:

Presently, the [Health] District offers an array of in-patient, out-patient and clinic health care services, including surgery. It has, or could develop, the capability of providing facilities and services involving contraception, family planning, birth, reproductive [services], sex education, sterilization, abortion, end of life, withdrawing life support and physician assisted suicide and has, or could, develop community and professional education programs concerning these subjects. The [Health] District has public, fiduciary and statutory authority and responsibility in these matters for its residents, such as [the] defendant[.]. While these responsibilities may be shared with other agencies, they may not be abandoned or wholly delegated by the [Health] District under Oregon law.¹⁴³

The answer also made specific reference to the importance of the Directives to the Providence health system and to the proposed agreement, as follows:

The Agreement several times, by its express terms, requires that all operations under the Agreement shall be consistent with Providence's philosophy, mission, policy and values, which are thus made binding on the District, under the agreement. As a Roman Catholic Church sanctioned health care provider, Providence's mission, policies, philosophy and values are subject to the authority of the Roman Catholic Church and its American Bishops Conference's Ethical and Religious Directives. Though these are not fully presented in the Agreement, an earlier version

expressly referred to the Catholic Church's publication of the Ethical and Religious Directives (Exhibit A), developed by the American Bishops Conference, governing health care and detailed the full scope of their operational implications upon the District's health services.

Providence and the Sisters of Providence are required by Roman Catholic doctrine to limit and/or prohibit in significant ways the full range of medical or health care services they might offer under Oregon law. These limitations restrict and/or prohibit services and personnel in the areas delineated . . . above. These restrictions apply throughout the Providence system, including its managed care and contracted services, its leased facilities and those occupying them. Under the proposed Agreement, the District's facilities, services and personnel will become part of the Providence system, and therefore subject to the Ethical Directives. In addition to the restriction on services, the imposition of religious administrative authority will restrict religious freedom of Catholic employees and non-Catholic employees.¹⁴⁴

The answer then went on to allege the factual basis for the constitutional and statutory objections to the merger agreement, as follows:

Defendant[] believe[s] and allege[s] that the Agreement with Providence (A) transfers governmental assets to a religious group, making it a more viable entity; (B) visibly and symbolically identifies governmental authority, facilities and services as those of a religious group; (C) tends to establish religion and prefer one religion over another; (D) subjects government authority and state treasuries funds to a private religious group; (E) excessively entangles government and religion in the administration of services, personnel and facilities; (F) restricts present and future health care services and decision making along religious lines; (G) will deter people from seeking such services in the future, placing an undue burden on their rights to those services; and (H) divides the community politically along religious issues.

Defendant[] believe[s] and allege[s], under the Agreement, that those seeking services detailed . . . above will have to travel to seek them outside the [Health] District, at considerable expense, delay

and difficulty. They may ultimately be deterred from seeking those services, constituting an undue burden on those patients. Further, those services detailed . . . may become effectively unavailable anywhere in Oregon if the [Health] District completes its Agreement with the Sisters of Providence, as part of Providence's pattern and practice of aggressively acquiring other hospitals in Oregon and the Pacific Northwest. This process of acquisition now reaches previously independent medical groups in the Newport area, by sale or contract with the [Health] District.¹⁴⁵

Providence would operate the Health District's facilities subject to Roman Catholic limitations, and the Ad Hoc Committee had a direct interest in the matter, as taxpayers, residents, professionals in the fields of social services, health care and health care administration, and former members of the District Board of Directors.

The first claim for relief in the answer and counterclaim was that the Operating Agreement established religious entanglement by transferring governance to Providence, by transferring assets which would strengthen Providence financially, and by committing taxing and bonding authority to Providence.¹⁴⁶ The second claim was that the merger agreement was subject to Roman Catholic values, which would restrict, on religious grounds, the availability of health services and infringe on the freedom of religion while limiting constitutionally grounded rights to health care and reproductive freedom.¹⁴⁷ These limitations pertained to health care rights, both at the beginning and at end of life, and to the rights and interests not only of patients but also of hospital and clinic employees. A third claim alleged that the Health District Web site had maintained a public forum function but had excluded the Ad Hoc Committee from access and participation.¹⁴⁸

The Ad Hoc Committee concluded by seeking relief in the form of damages, injunctions, and attorney's fees, preventing the Health District and Providence from executing or carrying out the proposed agreement. In addition, the Ad Hoc Committee sought a constructive trust on the Health

District reserve fund, amounting to eight million dollars, to prevent it from being transferred to Providence. They requested a trial by jury on all of the claims for relief.¹⁴⁹ Appended to the Ad Hoc Committee's answer and counterclaim were the Directives.¹⁵⁰ These were incorporated by reference. They had not been included, or even mentioned, in the Petition or Providence's motion to intervene.

The District and Providence responded to the Ad Hoc Committee's answer and counterclaim. The responses primarily consisted of denials of recitations that the petitioners (the hospitals) lacked requisite knowledge or information sufficient to form a belief. Significantly, petitioners did admit that the Directives are part of the philosophy, mission and values of Providence Health Systems of Oregon, and that Providence would operate the Health District as part of its larger health care system. The petitioners also admitted that lawful abortions would not presently violate the terms of employment at the Health District hospital and that therapeutic abortions had been performed from time to time, but that after the effective date of the operating agreement, Providence would not perform direct¹⁵¹ abortions at the hospital or clinics.¹⁵²

The final phase of the pretrial pleadings involved cross-motions for summary judgment. These were preceded by extensive discovery in the form of production of documents and depositions of various individuals.

C. Discovery

In a sense, the merger agreement between Providence and the Health District posed no factual issues for discovery. The conduct of the plaintiffs was clear: they had effected an agreement, and the agreement spoke for itself, as did the articles of incorporation. Additionally, the Directives were clear and unambiguous on their face. All parties agreed that these operative documents comprised the sum total of the relationship between the Health District and Providence. The state and federal constitutional issues as to

religion and reproductive rights were clearly posed by the text of these documents.¹⁵³

Therefore, on its face, this case seemed to possess little need for discovery. The parties to the agreement maintained that they had legal authority to consummate the arrangement and that the agreement did not violate statutory or constitutional provisions of Oregon or the United States. The opponents of the agreement argued that the agreement constituted an establishment of religion and the preference of a religious group; further, the agreement would restrict health care services. These are legal issues that would not seem to require factual exploration, instead they would only need analysis under relevant constitutional principles. However, a number of factual issues became necessary to determine the final outcome of the case.

For instance, the nature of Providence as a religious entity was not self-evident. The agreement referred to Providence's principles, and the articles of incorporation referred to the Directives, which were self-evident religious principles. But, the extent to which those principles were implemented by Providence, or even influenced Providence in any significant way, needed to be established. Providence, surprisingly, maintained that any impact of the Directives on its operation of the Health District's services was *de minimis*.

Providence was an integrated health care system, including an insurance plan, a number of hospitals, a number of physician groups, and a number of clinics and free-standing service facilities. Providence operated in several states and employed well over ten thousand people. It did not, and could not by federal and state law, discriminate in terms of religion in its hiring or its services. Regardless of the Directives, from the perspective of a patient or a consumer, the service or treatment in most instances would seem the same as that provided by a for-profit and governmental, academic, Catholic, Jewish, Lutheran, Mormon, or Seventh-Day Adventist facility. Similarly, from the perspective of an employee, the terms and conditions of daily labor

were unlikely to be limited by or conditioned upon religious observance or even remotely influenced by the religious mission. An X-ray technician, a brain surgeon, a dietician, or a physical therapist at Providence would have an experience virtually indistinguishable from other institutions.¹⁵⁴

The significance of the religious mission of Providence was not so much in what it did as in *what it chose not to do*. The potentially discriminatory impact of the religious mission on staff or patients needed to be explored. More importantly, it was necessary to establish whether Providence's control of the Health District would mean an end to existing services or the preclusion of possible services, which residents could and would rightfully expect from their government.

The Ad Hoc Committee's position was that the agreement would turn management and governance over to a Roman Catholic institution that would, in turn, exclude important services that would otherwise be available. It was not clear, however, what those services were or whether they had previously been available or whether Providence would actually deny them. Obviously, the Directives expressed a restrictive view as to health care at the beginning of life and at the end of life, in addition to issues surrounding family planning, reproductive freedom, and counseling. Factually, it was unclear that the Health District had ever offered the services that the Catholic Church found repugnant such as abortion. If these services did not exist under the previous scheme, arguably, nothing would be changed under the new agreement. Thus, the ultimate question was the impact of Providence's governance within the Health District. Would the Church be running the government? Would the government be operating under religious principles? How would decision making and policy setting be conducted within the Health District and within Providence?

The ways in which the agreement merged the government into Providence's structure and yet kept the Health District and its taxing powers alive were important in two respects. The first important aspect was that religion was controlling government in ways that research suggested were

unique.¹⁵⁵ Another important element was that the relationship created an entanglement between governmental and religious institutions, forbidden by First Amendment case law.¹⁵⁶ But in both of these areas, matters of degree were important, and those turned upon facts, and that was a matter for discovery.

Another problematic area for factual development was the parties' intent regarding religious principles in the delivery of health care. Clearly, the parties *knew* that Providence was a Roman Catholic entity, but this did not necessarily mean that they *intended* to advance Roman Catholic values. Indeed, the publicly elected directors of the Health District might well have chosen Providence simply because, among an array of the other religious and secular institutions, Providence could provide the best health care. Similarly, the Providence executives, in effecting the arrangement with the Health District, might have intended to advance the delivery and distribution of health care services, as opposed to advancing the religious teachings of the Roman Catholic Church. Even if the *effect* of the agreement were to establish religion or prefer a religion but the *intent* of the parties was otherwise, then arguably the challenges to the agreement would fail.¹⁵⁷

An important subsidiary issue was the role of the local bishop, as he would be the Catholic functionary, if any, who would implement the Directives. But if he chose not to, or if Providence ignored him, then the Directives would be irrelevant. The Directives were clearly national in their scope and application, but whether this was true of their enforcement was not clear. It was also unclear who would be charged with enforcement, what sanctions would be employed, or which deviations would be tolerated. Indeed, prior to discovery, it was not even known whether agreements such as these required prior approval from the bishop and, if so, whether such approval had been obtained.¹⁵⁸

A final area for factual exploration surrounded the economic necessities and benefits of the agreement. If the agreement was not necessary, then the

Health District was simply conferring a benefit upon a religious group without justification. Similarly, if the benefits to the Health District from Providence were negligible or dubious, then there would be no public benefit to the Health District, but a benefit would be improperly conferred upon a religious entity.

The Health District argued that it needed the agreement with Providence for a number of purposes such as synergies in communications, as well as procurement, training, delivery of services, and economies of scale. Conversely, the Ad Hoc Committee maintained that the needs and benefits were negligible and insignificant. Such factual disputes require testimony on matters of constitutional facts—those considerations central to a constitutional concept or rule that may or may not be present in a particular case, or those relationships and consequences that trigger constitutional prohibitions or guarantees.¹⁵⁹ What seems to be an easy application of a written constitution to a written agreement instead becomes a difficult exercise in factual advocacy.

It is clear from this analysis that discovery had to examine three different sets of facts: (1) the impact that religious principles would have on services; (2) details of how the merged entities would operate; and (3) the economic merits of the agreement. The Ad Hoc Committee had to be prepared to argue that the effects would be unconstitutional and that *even if that were not so, the arrangement itself was unconstitutional*. The latter proposition also required factual exploration by discovery, prior to motions and arguments on summary judgment.

Discovery proceeded without incident. Production included a range of documents and financial statements. Depositions were addressed to eight individuals, including the CEO of Providence, John Lee; the ethicist for Providence, Father John Tuohey; the president of the Health District's board, Charles Perry; the executive director of the Health District, Michael Fraser; and three of the members of the Ad Hoc Committee, Corrinne Williams, Barbara Davidson, and Norman Johnson. The transcripts of these

depositions were attached to the defendant's motion in opposition to summary judgment, as well as the defendant's cross-motion for summary judgment.

The testimony at trial was largely consistent with and repetitive of the depositions and discovery. The depositions were offered in the argument of the motions for summary judgment in support of the Ad Hoc Committee's position: the Directives would control Providence, Providence would control the government, and the agreement was bad in both its content and its consequence.

D. Summary Judgment Proceedings

1. Cross-Motions

On October 13, 2000, Providence moved for summary judgment on the basis that there were no genuine issues of material fact concerning the issues raised in the motion.¹⁶⁰ It is worth reflecting briefly on this motion for summary judgment. The effect of such a motion is to cut off a citizen's right to an evidentiary hearing and right to a jury trial. Because it bypasses important proceedings and terminates important rights, a motion for summary judgment should be cautiously approached and reluctantly granted. Moreover, in order to find no material issue of fact, summary judgment must rest upon facts developed through the appropriate process, as by interrogatories or depositions.

Rather than relying on the discovery and depositions that had raised important issues of fact about which the parties disagreed, the motion that Providence submitted relied on an affidavit of Mark May, an executive who had never been deposed.¹⁶¹ In fact, May's affidavit had never been seen prior to its submission as part of Providence's motion. Indeed, May was unknown on the record until his appearance by affidavit; thus, there had been no cross-examination or any opportunity to rebut his claims. May was the Regional Director of Physician Services; had worked for Providence

since 1980; and was responsible for strategic primary care development, clinic leadership, and affiliation with other hospitals.¹⁶² May had been the primary contact with respect to the Operating Agreement with the Health District.¹⁶³ His affidavit recited that Providence owned a number of hospitals and that they had been recognized by various crediting agencies as offering excellent care.¹⁶⁴

The May affidavit went on to recite that a board of directors actually governed Providence, although the not-for-profit corporation's sole member was the "Sisters of Providence-Mother Joseph Province," whose Mother House is located in Montreal.¹⁶⁵ The majority of the board members and the current president of Providence were not Sisters.¹⁶⁶ (Indeed, it was asserted that the President was not even Catholic.)¹⁶⁷ Of the thirteen thousand Providence employees in Oregon, approximately ten were Sisters, and May estimated that "the proportion of Providence employees who are Catholic is about the same as the general population."¹⁶⁸ His affidavit alleged that no bishop or other Church official "holds any position in the governance or management of Providence."¹⁶⁹ May's affidavit further claimed that Providence was a Catholic health care system and recognized the Directives as containing "certain ethical principles that guide Catholic health care providers in the provision of health care services" and "certain restrictions on the reproductive and end-of-life health care services that may be performed."¹⁷⁰ The affidavit avowed that although Providence is sponsored by a religious community, "the health care services that Providence will provide under the terms of the Operating Agreement will not [be] religious in nature."¹⁷¹

May asserted that Providence was one of the largest providers of health care services in Oregon, offering a full range of health care services.¹⁷² The affidavit further stated that Providence "employs and provides health care services to persons of all different races, creeds, religious affiliations and economic means" and "has adopted a strict policy of respecting each person's autonomy."¹⁷³ May also discussed Providence's policy of focusing

on patients' spiritual needs and pointed out that many of the hospital chaplains are not Catholic.¹⁷⁴ May closed his affidavit by stating that as a provider of health care services in the Health District, Providence did not intend to promote any particular religious belief or practices.¹⁷⁵

Attached to May's affidavit were the Operating Agreement; the Articles of Incorporation of the Sisters of Providence, which stated as one of its purposes "[t]o do any and all other things in furtherance of . . . the teachings and laws of the Roman Catholic Church and the Ethical and Religious Directives for Catholic [h]ealth [c]are [f]acilities as promulgated by the local bishop";¹⁷⁶ the Directives; and a table published by the Oregon Health Care Division with data that in each of the years 1995, 1996, and 1997, between 130 and 150 residents of Lincoln County had obtained abortions in Benson, Lane, Marion, Multnomah, and Washington counties. Also attached were Providence Health System publications describing their core values as relating to the providence of God and the five core values of compassion, justice, respect, excellence, and stewardship.

May subsequently filed a supplemental affidavit on October 13, 2000, to which the Resolutions of the Board of Directors of Pacific Communities Health District was attached.¹⁷⁷ The resolution recited that because of rapid changes in health care services and because of an unstable financial environment, the Health District had solicited proposals from four health care systems—Providence, Samaritan, Legacy, and Peace Health.¹⁷⁸ After evaluating the proposals, the board decided to proceed with Providence.¹⁷⁹ May's affidavit constituted the total factual basis on which Providence sought summary judgment.

In response, the Ad Hoc Committee filed a cross-motion on summary judgment.¹⁸⁰ The cross-motion recited that it was supported by the Operating Agreement, the Directives, and the articles of incorporation, all of which were attached to the motion for summary judgment.¹⁸¹ More importantly, the defendant's cross-motion was supported by the depositions of a number of people examined prior to trial, numbering several hundred

pages of sworn testimony, given in the presence of opposing counsel, subject to cross-examination.¹⁸² The defendant also submitted the 1998 and 1999 Financial Statements of the Health District and its February 17, 2000, letter analyzing the Operating Agreement discussed above.¹⁸³ The defendant specifically reserved issues of material fact from the request for summary judgment; additionally, the committee opposed the petitioner's motion for summary judgment with respect to these issues:

(b) those portions of the First Claim for Relief which turn upon material factual issues, as to which there is a good faith dispute for which testimony may be required, including allegations...as to future church/state entanglement and governance issues and...as to future impact on services, consumers and providers in the community, issues which may be raised by implementation of the Operating Agreement; (c) those portions of the Second Claim for Relief concerning religious restriction of health services which turn upon material factual issues, as to which there is a good faith dispute for which testimony may be required, including allegations . . . as to the destructive impact throughout the [Health] District and . . . on future health policy and service, issues which may be raised by implementation of the Operating Agreement.¹⁸⁴

The defendant Ad Hoc Committee's summary judgment motion recited that it was based on the First and Fourteenth Amendments to the U.S. Constitution, as well as Article I of the Oregon Constitution and the state statutes governing special districts such as the Pacific Communities Health District.¹⁸⁵ The last paragraph of the motion specifically provided,

In addition to the federal constitutional grounds for judgment . . . [the Ad Hoc Committee] seek[s] summary judgment for the further reason that the Operating Agreement would violate Oregon statutes and the Oregon Constitution...by transferring business assets without sufficient need or adequate compensation, by failing to follow proper procedure in so doing, and by adopting policies on health care, particularly abortion and physician-assisted death, contrary to state law and policy.¹⁸⁶

The defendant's motion for summary judgment specifically incorporated by reference the analysis and state law authority contained in a separate memorandum that was submitted by the *amicus curiae* American Civil Liberties Union.¹⁸⁷

The Ad Hoc Committee's cross-motion on summary judgment was in sharp contrast to the motion submitted by Providence. It identified and specifically reserved from summary judgment issues as to which material factual dispute existed.¹⁸⁸ More importantly, it relied upon and specifically incorporated extensive factual material developed during discovery by production and deposition.¹⁸⁹ The significance of this cannot be overstated. The Mark May affidavit supporting Providence's motion had never been seen prior to its submission as a part of the motion. This meant there had been no cross-examination, nor any opportunity to rebut any of his claims. In contrast, the Ad Hoc Committee relied on the sworn testimony of known individuals who had been identified by the parties, examined and cross-examined in each other's presence. The nature of this evidence was clearly weightier than that submitted by Providence.¹⁹⁰

2. Briefs and Arguments

To defend its effort to obtain summary judgment, Providence submitted a brief relying on May's affidavit and the Health District's resolution. The brief then recited that under the relevant Oregon rule, summary judgment was appropriate if the pleadings, depositions, affidavits, and admissions on file show there is no genuine issue as to any material fact.¹⁹¹ Providence argued that it did not violate the Oregon statute prohibiting a district from denying abortion¹⁹² because the hospital would not be "operated" by the Health District under the Operating Agreement. Indeed, Providence would be operating the hospital and the Health District could permit this since its *purpose*—to assure quality health care—was secular. The primary effect

would also be secular, even though the agreement would aid a church-related entity.

As for the constitutional test regarding entanglement as violating the establishment clause,¹⁹³ Providence argued that the entanglement must be with religion, not simply with a religiously connected entity, in order to constitute a violation.¹⁹⁴ Providence argued further that even if certain forms of health care were lost, there was no right to have abortions offered by the Health District or its hospitals.¹⁹⁵ In any event, the loss of certain health care benefits would not be the result of discrimination against any religious group or a penalty for the exercise of religion.

The Ad Hoc Committee of citizens submitted a fifty-six page memorandum on summary judgment, arguing that this case was distinctive because the government was enabling a private, religious entity to take over not only a governmental function, but also a governmental entity.¹⁹⁶ In that sense, it resembled the facts involved in the United States Supreme Court cases *Board of Education of Kiryas Joel Village v. Grumet*¹⁹⁷ and *Larkin v. Grendel's Den*.¹⁹⁸ Moreover, because the Health District retained its identity as part of the agreement with Providence, it would be adopting religious symbols and endorsing religious teachings through the changes in its name and logo and through its endorsement of the Directives. Here, the Ad Hoc Committee was relying on *Santa Fe Independent School District v. Doe* and *Lee v. Weisman*.¹⁹⁹

The Ad Hoc Committee drew attention to the arguments about government control and symbolism: the agreement meant the Health District was endorsing the Directives—an endorsement of great symbolic significance quite apart from the practical consequences of the agreement itself—which limited services that might be available in the community. Thus, the effect of the merger on health care services was not controlling or dispositive; it was simply impermissible for a religiously grounded entity to control the government, or for the government to endorse or to adopt religious symbols or teachings. Just as a state supreme court could not post

the Ten Commandments in its entryway,²⁰⁰ so the Health District could not endorse, adopt, or enforce the Directives.

The citizens also argued that the agreement with Providence impermissibly entangled the affairs and operations of government with religion and favored one religion over another.²⁰¹ The Ad Hoc Committee argued that the Health District would have to monitor Providence's services and quality, which would entangle it with Providence.²⁰² Additionally, the Health District had turned over a number of important functions, including taxing authority and its earning revenue,²⁰³ the Operating Agreement provided that the Health District was subject to the missions, policies, and values of Providence, which would include the religious Directives.²⁰⁴ All of this created an excessive entanglement under relevant U.S. Supreme Court decisions as per the *Lemon v. Kurtzman* test.²⁰⁵

Apart from the entanglement argument, the Ad Hoc Committee also claimed that the government wrongly favored one religion by transferring the assets, cash flow, and patient base to Providence.²⁰⁶ In particular, the committee emphasized that the transfer of the Health District's operations included its employees, who would have to accept a contract imposing the Directives on their health care services if they wished to remain employed.²⁰⁷ The committee relied on the U.S. Supreme Court cases *Aboud v. Detroit Board of Education*²⁰⁸ and *Keller v. State Bar of California*²⁰⁹ for the proposition that forcing the Health District employees to accept these types of changes violated the First Amendment to the United States Constitution. The Ad Hoc Committee also argued that the agreement violated Article VI of the U.S. Constitution, which prohibits a religious test for any office or public trust in the U.S. government.²¹⁰

Finally, the committee argued that the proposed agreement between the Health District and Providence burdened their due process rights to health care services both at the beginning and at the end of life.²¹¹ They argued that the proposed arrangement with Providence would violate state laws that create an entitlement to health care, as well as federal law, which allowed

both the right to die and the right to an abortion.²¹² The Ad Hoc Committee relied on *Roe v. Wade*²¹³ and *Planned Parenthood v. Casey*²¹⁴ to support these arguments. Furthermore, the necessity for the merger agreement and the Health District's financial condition became relevant, because a burden on Fourteenth Amendment rights only becomes "undue" if it is unreasonable.²¹⁵ The Health District tried to justify the arrangement with Providence as reasonable because it was financially necessary. The citizens contended, however, that the Health District was actually in excellent economic condition and that the arrangement required so little of Providence that, economically, the arrangement was unjustifiable.

The Health District and Providence both filed responsive motions and briefs.²¹⁶ Providence's reply brief began by observing that it was "up to the voters, and the voters alone, to decide whether to have a hospital district in the first place."²¹⁷ The argument went on to state that "[t]he statutes don't *require* a district to provide any medical services at all . . . [but] the statutes *allow* a district to provide practically any medical services the people want—and are willing to pay for."²¹⁸

Providence's reply brief then turned to the arguments about religion. Providence maintained that it was not helpful to speak of "a threatened "merger"" because there would be none.²¹⁹ Rather, "both sides will retain their identity."²²⁰ Also the governance of the Health District would not be transferred and replaced by the court's "religious governance" of Providence, because the Health District's board would still "make law for the District."²²¹ Providence would not acquire any control over the board of directors.²²² Providence went on to argue as follows: "The opposition briefs betray deep confusion as to what is government and what is not. The Health District's hospital is not government. The hospital is property. It is a facility. . . ."²²³ The reply brief also contended that the Ad Hoc Committee engaged in "inflammatory rhetoric" when it suggested that the merger agreement would transfer a solvent, valuable system of health care with no return consideration.²²⁴ Providence then quoted from an affidavit

by the Health District hospital's chief administrator, stating that it had been operating at a loss to prove that the Health District was not solvent.²²⁵ Providence took issue with the cases cited by the committee and argued that it relied on cases in which two entities "often in difficult straits, have employed government to aid them with money, supplies, zoning restrictions and the like. . . . Providence did not initiate this transaction Providence did not seek out the [Health] District for assistance, let alone assist in pursuing any religious activity. It was rather the [Health] District that sought help."²²⁶

Providence reiterated its argument that religious purpose was missing in the merger agreement.²²⁷ It distinguished the committee's reliance on *Kiryas Joel* and *Grendel's Den* by contending these were cases in which religious criteria had been explicitly employed.²²⁸ As to entanglement under *Lemon v. Kurtzman*, Providence cited its earlier argument that the entanglement has to be in the religious activity of Providence, rather than in the general activities of a religious entity.²²⁹ Providence further argued that it would operate the hospital and "then operation of the hospital by the [Health] District necessarily ceases."²³⁰ Providence also contended that "[t]he Directives may then have some effect on Providence's operation of the hospital, but [it] can't and won't have any effect on anything that the [Health] District does, because the [Health] District will not be involved in the operation."²³¹ Therefore, Providence argued, the Health District would not be entangled with the Directives.²³²

As to the issues of reproductive services and end-of-life services under the Fourteenth Amendment, Providence argued that the Health District and Providence were not constitutionally obligated to offer all forms of health care.²³³ The fact that there might be a constitutional right to specific forms of health care did not mean that the Health District or any governmental unit must offer that health care.

3. Court Ruling

On November 22, 2000, the trial judge ruled on the motions for summary judgment.²³⁴ After a lengthy review of the pleadings and the arguments,²³⁵ the judge first ruled that the Operating Agreement would not violate Oregon's abortion statutes and then turned to the state constitutional law claims stating, "It is my judgment that the question of whether this court should follow the Oregon Constitution in analyzing the [Operating Agreement] is one of the most important aspects of this case."²³⁶ He concluded that under the Oregon statutes, if funds went to a religious organization as opposed to a religious *function*, this meant that the Oregon Constitution had not been violated.²³⁷ He therefore held that evidence should be taken on that question. As to the Directives, the judge agreed with Providence; similar to other private organizations that might provide the same health care services as Providence, any benefits flowing to Providence from the Health District would be used for providing health care services and not for proselytizing.²³⁸ Still, the judge stated that he believed evidence must be taken to answer the questions of whether under the Oregon Constitution money would be paid to a religious or theological institution and whether that money will be "paid for the benefit of" that institution.²³⁹

Turning to the U.S. Constitution and the First Amendment, the judge held that the *purpose* behind the Operating Agreement was secular and that its primary *effect* was one that neither advanced nor inhibited religion.²⁴⁰ However, he also stated that "the court should hear evidence as to *how, why and whether* the [Operating Agreement], during its implementation, would 'foster an *excessive government entanglement* with religion.'"²⁴¹ As to these issues, the court denied summary judgment, and it held that evidence would be taken at trial.²⁴² As to free exercise under the First Amendment, the judge could find nothing in the record to support a violation, but also remarked, "even so, discretion causes me to opt in favor of taking evidence on the subject."²⁴³

The judge then turned to the Fourteenth Amendment issues concerning a right to health care services at the beginning and at the end of life as a matter of due process.²⁴⁴ The committee's argument had been that the Operating Agreement, by implementing the Directives, would restrict services offered now or in the future. Moreover, the merger agreement's restrictions were unreasonable, and therefore unconstitutional, because the restrictions were not financially justifiable. The court simply ruled against these claims, granting summary judgment on the ground that "there is no federal constitutional obligation that a public hospital provide 'reproductive health care and that the failure to do so does not violate the equal protection or due process clauses.'"²⁴⁵ He added that it was the judgment of the court that "this hospital, operated by the [Health] District or by Providence, has the ability to provide that same service to the [Health] District residents but is not *required* to do so."²⁴⁶

The court then outlined the issues for trial. First, under the authority of the Oregon Constitution, the court thought that there was a genuine issue of material fact on the following questions: (i) whether the funding to Providence directed by the Operating Agreement "benefits" Providence as a religious institution; and (ii) whether the Operating Agreement, in operation, avoids excessive government entanglement with religion.²⁴⁷ Second, under the First Amendment of the U.S. Constitution, the court believed there was a genuine issue of material fact as to (i) whether the Operating Agreement, in operation, avoids excessive government entanglement with religion; and (ii) whether the hospital, post-Operating Agreement, is going to be operating as a "pervasively religious institution."²⁴⁸ Finally, as to the Fourteenth Amendment of the U.S. Constitution, the court determined the following: (i) the Operating Agreement does not cause the impairment or loss of rights that otherwise existed prior to its execution; (ii) there is no federal constitutional obligation that a public hospital provide reproductive health care, and the failure to do so does not violate either the equal protection or due process clauses of the

Fourteenth Amendment; and (iii) if it is determined at some future date that the court's ruling on this subject is incorrect, the court notes that Providence, a private institution, will be operating the hospital and is therefore not subject to the Fourteenth Amendment.²⁴⁹

It is not necessary to provide a thorough critique of the decision on summary judgment because the case proceeded fully to trial; however, a few points should be noted. The ruling on the First Amendment simply ignores the establishment issues raised by the enormous, unnecessary transfer of assets to Providence. Also, the requirement that the Ad Hoc Committee must prove the hospital would be "pervasively religious" is nowhere supported in case law.²⁵⁰

As to the Fourteenth Amendment, the judge's finding that there was no loss of rights was simply impossible to conclude without testimony, and the finding that there is no right to reproductive health care ignores the argument that such health care cannot be denied for religious reasons. As for the conclusion that Providence is "private" and the hospital would not be subject to the Fourteenth Amendment (i.e., no "state action"), the judge's ruling seems to fly in the face of the Operating Agreement's terms,²⁵¹ which provided that Providence would operate not only the hospital *but also the Health District*. Thus, the necessary state action is present in the governmental ownership and authority taken over and operated by Providence. The decision is also inconsistent: if there was state action for the purpose of the First Amendment, then there would be also be state action for the purposes of the Fourteenth Amendment.²⁵²

V. TRIAL AND DECISION

A. Trial Testimony

1. Plaintiffs

The litigation between the Health District and the Ad Hoc Committee went to trial in November of 2000.²⁵³ During a week and a half of trial, the

parties called as witnesses many of those who had previously been deposed. The Health District's witnesses included John Lee, CEO of Providence; Michael Fraser, CEO of the Health District; Doctors Long and Cely, president of the Health District's board and a staff practitioner, respectively; and Father John Tuohey, a Roman Catholic priest and staff ethicist for Providence.²⁵⁴ Additional witnesses for the plaintiffs were Dr. Albert Starr, a noted heart specialist, and Mary Jo Tully, the chancellor for the archdiocese of Portland.²⁵⁵

Although the CEO of Providence, John Lee, testified at great length, his testimony was essentially an overview of Providence's operations. Furthermore, he deferred to other witnesses for the details concerning the impact of the Directives on services within the Health District, as well as how the mechanics and management of the merger would be affected. However, Lee was clear that the Directives were a part of Providence's articles of incorporation and a continuing part of Providence's commitment to the healing ministry of Jesus.²⁵⁶ He also stated that the ministry and the Directives are a constant source of reference for all of Providence's operations and personnel.²⁵⁷ Finally, he testified that the tax revenues from the Health District were essential to making the arrangement economically feasible.²⁵⁸

Dr. Cely testified that he presently does tubal ligations at the Health District's Newport hospital subject only to medical justifications, and that he provides information for patients seeking abortions, vasectomies, or contraceptives.²⁵⁹ Tubal ligations are done at the hospital and are commonly sought after labor and delivery.²⁶⁰ He knew nothing about the Catholic Directives.²⁶¹ In addition, he cited no hospital policies banning abortion, family planning, or physician-assisted suicide.²⁶² Dr. Long, who had been extensively involved in negotiating the agreement with Providence, was similarly uninformed about the Directives, although he did testify they were a continuing source of concern.²⁶³ He also confirmed Dr. Cely's testimony about existing policies at the Health District facilities.²⁶⁴

Warranting somewhat greater summary was the testimony of Mary Jo Tully, the chancellor of the archdiocese of Portland. She testified that the Directives are reviewed by the Vatican and are a part of health care that must be complied with.²⁶⁵ The archdiocese would not allow contraception and tubal ligation.²⁶⁶ If the archbishop does not approve a hospital's medical practices, he can ultimately declare that the hospital is not Catholic.²⁶⁷ Even so, Tully went on to testify that the bishop will not insert himself into the physician-patient relationship and has no jurisdiction over the governance or operation of Providence.²⁶⁸ In fact, the bishop had not been consulted on the contract between the Health District and Providence.²⁶⁹

Michael Fraser's testimony was somewhat more detailed as to the agreement and operations. Fraser, the CEO of the Health District, described the clinics and the hospital as providing mostly primary care.²⁷⁰ In the process of deciding whether to affiliate the Health District with Providence, he testified that there were extensive committees and meetings, followed by an extensive selection-and-screening process.²⁷¹ Bids were solicited only from nonprofit hospitals—Providence, Legacy, Peace Health, and Samaritan—that were all religiously affiliated.²⁷² These hospitals are all sizable, good health care providers. No bid was deemed unacceptable, and Samaritan had recently begun an affiliation with North Lincoln Hospital nearby.²⁷³ Fraser also testified that the Directives would apply to all physicians having medical staff privileges at the hospital or renting space in the newly proposed medical office building.²⁷⁴ Furthermore, the Directives would prohibit abortion and referrals for abortion even if the pregnancy resulted from rape.²⁷⁵ They would also prohibit physician-assisted suicide.²⁷⁶ However, he also testified there would be no interference between physician and patient, because the Directives are not “a rule book.”²⁷⁷

Fraser's testimony was crucial on several points: there was no compelling economic need for the merger, policy and practice would in fact change,

and governance would pass from the Health District to Providence. Equally important, the Roman Catholic symbols would be affixed to the Health District's buildings and stationery.²⁷⁸ His testimony also revealed that Fraser himself would be the new CEO of the Health District subunit of Providence.²⁷⁹

The testimony of Father Tuohey was also of vital importance. While Chancellor Tully had testified from the perspective of the archbishop, who knew nothing of the proposed merger, Father Tuohey could testify from Providence's perspective. He was well informed about the Directives and their impact on the mission and operations of the District post-merger.²⁸⁰ Father Tuohey's testimony may be summarized as follows:²⁸¹

As a priest/ethicist, [Tuohey] consults on cases under the Religious Directives at Providence. "The Healing Ministry of Jesus" is an essential part of Providence's mission as described in the Introduction to the Religious Directives. The Religious Directives bar tubal ligations, but due to medical objections, and would not permit vasectomies at Providence or in District facilities. A physician could refer a patient for assisted suicide, but not write the prescription. "[M]orning after" pills²⁸² and abortions are prohibited.

The Religious Directives *will* govern the [Health] District under the Operating Agreement and [apply] to physicians on Medical Staff, and to all professionals and patients and all employees.

The Directives would not be enforced on a physician, however. There is no "snooping." [The Directives] are very much like ethics text of *Beauchamp and Childress*,²⁸³ although those are not "directives" or based on God.

The Directives are implemented by Bishops to promote consistency of Roman Catholic Theology. [They] are meeting now to revise the Directives. [T]his Agreement does not require the Bishop's approval because it is not a partnership—it is a complete takeover,²⁸⁴ but the Bishop does know about it.

The Providence logo and sign have a “corporate cross” with shading. [T]he cross is the most powerful symbol in Christianity; it represents in history and theology, Christ’s suffering and its meaning. [I]t is a central symbol; in churches, in nave, with stations of the cross, on rosary beads.²⁸⁵

This testimony by Father Tuohey was highly significant because it drew from his status as a priest and a corporate ethicist. He made it clear that the Directives would impact the Health District and its services directly and pervasively.²⁸⁶ The statement that Providence would not, and does not, “snoop” tends to negate that. But actually, it suggests a very different reality. Providence was inconsistent in its enforcement of the Directives and hypocritical by declaring values while debasing them; this inconsistency was the very danger the National Conference of Catholic Bishops feared. Virginia Terhaar, a counseling practitioner and a witness for the Ad Hoc Committee, testified that the resulting ethical dilemma, along with the basic question of whether she could counsel about abortion or birth control when dealing with victims of rape, led her to withdraw from Providence’s referral list of counselors.²⁸⁷

2. Defense

The Ad Hoc Committee’s witnesses included four of its members, each of whom had health care expertise. Clearly, their opposition was not solely ideological. One witness had owned and operated health care facilities (Norman Johnson); another had set up birth control programs for the state of Oregon (Barbara Davidson); another had been director of the County Health Department (Hilda Moravick); and yet another had administered health care programs for the poor (Claudia Webster).²⁸⁸ To add to that, three witnesses had served on the board of the Health District.²⁸⁹ Each witness was able to testify to the importance of the health care services that might be lost if the merger were implemented.²⁹⁰

The testimony of Lois Backus, executive director of Planned Parenthood of the Columbia-Willamette region, was significant. She gave a state-wide

perspective on the availability of family planning and reproductive services, the importance of those services, and the impact of Roman Catholic institutions on the distribution of such services.²⁹¹

Another witness testified about loss of services at the end of life. George Eighmey, Executive Director of Compassion in Dying in Oregon and a former legislator, testified about the importance of the Oregon Death with Dignity Act²⁹² and the adamant opposition of the Catholic Church, and Providence in particular, to the Act's drafting, adoption, and implementation.²⁹³ From his work counseling dying patients, Eighmey testified in support of the need for death-support services and the scarcity of those services.²⁹⁴ In his opinion, the merger agreement would have a seriously negative impact within the Health District on end-of-life services.²⁹⁵

Two expert witnesses commented on the nature of Catholic teaching and corporate culture, tracking the axes of the issues in the case. The first expert witness was Father Golenski, a former Jesuit priest, who is now a national health care and bioethics consultant and a member of several national panels and works with several national health care providers.²⁹⁶ His testimony can be summarized as follows:²⁹⁷

The Religious Directives are due to the Bishops Conference concern for partnerships of Catholic Hospitals and non-Catholic hospitals, like this one—a Bishop's objection would be very powerful, [and] must give a *nihil obstat* [before a merger may proceed.] [T]he application is clear to the Bishops, but may not be to the hospital. [I]f the District offers prohibited services, there would be a problem when [the Bishop] learns there are instances where Bishops have interfered.

Contrary to [Father] Tuohey['s testimony], [the] Religious Directives *do* apply to the Operating Agreement between Providence and the [Health] District.

[The Religious Directives] are under revision presently. They *have* been reviewed by the Vatican's Holy Office and will be reviewed by the Pope.

The Religious Directives prohibit abortion, tubal ligations, and morning after pill[s under] a mandate from the Vatican. [P]hysician-assisted suicide would be "prohibited entirely." [The] Religious Directives are not consistent with Oregon policy on physician-assisted suicide or family planning with the Oregon Health Plan.

The actual effect may turn on interpretation by a hospital, and the Operating Agreement is silent on that; but a physician performing a prohibited service would still be violating the Directives. They don't have thought police

Although religious, Providence gets Medicare funding,²⁹⁸ but not for religious services.²⁹⁹

Father Golenski's testimony was thus an effective counterpoint to the testimony of Father Tuohey, and it was followed by the testimony of Merwyn Greenlick. Greenlick, who holds a Ph.D. in medical care organizations, is a former vice president of research for the Kaiser Foundation Health Plan and chair of the department of public health at Oregon Health Sciences University.³⁰⁰ His specialty is corporate culture and decision making.³⁰¹ An important issue in the case was the extent to which a set of values, such as the Directives, could permeate and motivate a large corporation. Professor Greenlick testified that "Providence Health System is extensively, distinctly, palpably religious and Catholic. Its message, through symbols [and] prayers, to consultant and patient is clear."³⁰²

The selective nature of the summary above is partly to illustrate the necessity for testimony to develop constitutional arguments. Theoretical abstractions, even when complex, are still relatively easy to state. However, as noted earlier, proving their application in context is frequently very difficult. It requires putting witnesses on the stand who could, with

expertise and competence, testify that religious principles actually motivate corporations; that services would in fact be lost and that those services are, in fact, important; that governmental functions would become entangled with religious practices; and that the government would begin adopting religious symbols. The testimony as to these and other “constitutional facts” must be concrete, relating directly to the context and litigants before the court, yet also address a state of affairs not yet in being.

At some level, all of this becomes a matter, not of theory, but of logistics. To prove these propositions requires finding witnesses; persuading them to appear; scheduling around their schedules and the court’s overburdened, inadequate schedule; carefully phrasing questions that will survive objection; and drawing answers that avoid mere speculation. These are problems in any kind of litigation, but they are more urgent and crucial in pro bono litigation. Pro bono witnesses must frequently be persuaded to testify without compensation; indeed, they often must bear their own expense of getting to and from a remote location, perhaps losing a day of work, to testify.³⁰³ The logistical burden for corporate litigants is far less. They not only have substantial budgets to pay attorneys and to reimburse their experts, but frequently their witnesses are paid employees, and so their testimony and travel are part of their jobs.

For public interest litigants, the imbalance of resources and power is frequently daunting and too plain to ignore.³⁰⁴ One way of correcting the inequality is by drawing on public advocacy groups such as Planned Parenthood, the National Organization for Women, and the American Civil Liberties Union to intervene as litigants or *amicus curiae*, and to provide support and attorneys. For reasons never made clear, all but the American Civil Liberties Union declined to do so in the Newport case.³⁰⁵

But in the end, as with much of public interest litigation, the resources for the public litigant must be those that he or she brings personally to the cause. In Newport, the ten members of the Ad Hoc Committee were exceptionally experienced and articulate professionals. They possessed the

experience and training necessary to be persuasive witnesses. And, beyond this, they possessed the credentials to qualify as expert witnesses. The experience, commitment, and tenacity of each, including those who did not testify, made it clear from the very outset that the Newport trial would be a fair fight.

B. Arguments and Briefs at Trial

The court instructed the parties on the close of testimony to submit briefs.³⁰⁶ The briefs of both Providence and the Health District were submitted as instructed. The brief of the Ad Hoc Committee was completed but never submitted because two days prior to the submission date, January 17, 2001, the attorneys for Providence and the Health District announced that Providence was exercising its option under the agreement to withdraw from the merger; their view was that the case was moot.³⁰⁷ Subsequently, the judge instructed counsel to “lay their pencils down.”

The briefs of Providence and the Health District reiterated the parties’ views on summary judgment; these briefs may be obtained from and are on file with the court. Given the judge’s ruling on summary judgment and the fact that the Ad Hoc Committee’s brief was never filed, it would be worthwhile to make the committee’s brief available.³⁰⁸ The brief illustrates the ways in which the testimony was woven into and supported the constitutional theory advanced by the Ad Hoc Committee.

The trial brief for the Ad Hoc Committee of citizens focused on the following arguments: (1) Providence, as a religious institution, was engaging in state action;³⁰⁹ (2) the Operating Agreement involved religious discrimination;³¹⁰ (3) the unconstitutional entanglement of government and religion was accomplished through the delegation of governmental authority and public assets to Providence, which dictated services and policies through religious principles;³¹¹ (4) Providence’s policies and the Directives dictated a loss of certain services;³¹² and (5) Oregon law mandated comprehensive health care throughout life and Providence’s

policies limited services, particularly care for the beginning and ending of life.³¹³

The record and the brief were sufficient to pose important issues for decision by the trial judge and the appellate courts, in the event of an appeal. Neither, however, was to happen.

VI. DISPOSITION AND ATTORNEY'S FEES

A. Hearing on Dismissal

Providence decided to exercise its option under the Operating Agreement to withdraw from the merger.³¹⁴ The reasons for withdrawal were never fully expressed. It seems clear that the contracting parties were not anticipating the depth of opposition posed by the Ad Hoc Committee or the delay in consummation posed by the court proceeding. It may also be that the expense of maintaining the litigation (over \$450,000 for the Health District's attorneys' fees,³¹⁵ and likely an equal amount for Providence) was not anticipated and thus chilled the ardor of the parties.

In May of 2001, the trial judge entered a judgment of dismissal without prejudice for lack of subject matter jurisdiction. The dismissal "without prejudice" was troublesome, because it meant that the Health District and Providence could potentially fashion another agreement or simply refile the validation proceeding that had initiated the litigation. Providence's withdrawal and motion to dismiss³¹⁶ merely required that the agreement submitted to the court would not be undertaken or enforced.

Nonetheless, the dismissal represented a victory for the citizens who had opposed the proposed merger. The adamant opposition within the community made it unlikely that the Health District and Providence would initiate further steps toward a merger. And, perhaps, just possibly, the parties were persuaded to reconsider the constitutional validity of the merger.

B. Attorney's Fees

Attorney fees in public interest litigation assume great importance as they are essential to the assertion of constitutional rights, and they are a disincentive to those who deny rights. The application for attorney's fees in this case was principally based upon 42 U.S.C. §§ 1983 and 1988.³¹⁷ Relief under these provisions is available when a party prevails on a counterclaim for which the law allows recovery of attorney fees.³¹⁸ If a lawsuit produces a voluntary action by the defendant that affords the plaintiff some or all of the relief requested, the plaintiff prevails.³¹⁹ In this case, if the committee's claims were a catalyst in the decision of Providence to withdraw from the agreement, which in turn resulted in the dismissal of these proceedings, the committee would qualify as a prevailing party and, thus, be entitled to attorney's fees under 42 U.S.C. § 1988. To be a catalyst, there must be (1) a causal link between the lawsuit and the relief awarded, and (2) a legal basis for the plaintiffs' claim.³²⁰ It appeared that the committee clearly met the two-prong test.

The argument and the catalyst theory, however, were short lived, and the timing of the application for attorney's fees was ill fated. The application was filed on June 7, 2001.³²¹ Six days later, the U.S. Supreme Court decided *Buckhannon Board and Care Home v. West Virginia Department of Health and Human Resources*.³²² The Supreme Court rejected the catalyst theory in *Buckhannon* as follows:

A defendant's voluntary change in conduct, although perhaps accomplishing what the plaintiff sought to achieve by the lawsuit, lacks the necessary judicial imprimatur on the change. Our precedents thus counsel against holding that the term 'prevailing party' authorizes an award of attorney's fees.³²³

After *Buckhannon*, it was clear that a "prevailing party" is only one who has been awarded some relief by the court, even if it is a consent decree or judicially entered settlement.

The denial of attorney fees in the Newport case and in *Buckhannon* is bad policy. Attorney fee awards are an essential aspect of asserting the First and Fourteenth Amendments in civil rights cases. They are the financing mechanism for leveling the playing fields of justice. That did not happen in Newport. Counsel for the Health District and Providence received a considerable amount in fees, far greater than the amount requested by Counsel for the Ad Hoc Committee, for filing litigation that ultimately did not benefit their clients. Counsel for the Ad Hoc Committee submitted a statement for 600 billable hours (\$180,000 at \$300 per hour) and received nothing; no appeal was taken.

The dissenters in *Buckhannon* got it right: if a litigant may avoid defeat by simply desisting, possibly to resume at a later time, attorney fees will rarely be awarded, and a crucial incentive for bringing suit to protect civil rights will be lost. Worse, if the wrongdoer may initiate a suit, wear down any opponents, and then walk away as they did in the Newport case, there is even less of an incentive to appear in defense of constitutional rights or to seek their protection.³²⁴

VII. CONCLUSION

Mergers are the preferred mode of growth in the health care field and are often necessary for health care organizations to survive. Governmental providers are designed to meet needs in small, rural communities and often have difficulty surviving. Catholic health systems, however, are among the largest in the nation and quite naturally seek to acquire smaller governmental providers. It is likely, therefore, that the issues raised in the Newport litigation will recur.

The economics of the agreement were clear: Providence needed the taxing income of the Health District for the proposed merger to function. Consequently, Providence kept the Health District in a functioning state, but as an extension of Providence. The government unit was essentially kept

intact and was run by a religious entity. This arrangement violated the First Amendment.

It was this point that was crucial to the litigation. Providence argued that, as a private party, it was not subject to the First Amendment's prohibitions; its services did not involve "state action." Moreover, Providence argued that it was not "pervasively religious." But the nature of the arrangement with the Health District was that the Health District would be implementing religious policies, the Ethical and Religious Directives on Health Care. Moreover, Providence would be absorbing much of the Health District's governance into its structure, exercising governmental powers and authority pursuant to religious principles. This infusion of assets and authority amounted to establishing religion and creating entanglements even if services remained unaffected.

Future mergers would benefit from avoiding these features of the Newport arrangement. Two extremes could serve as safe harbors: either a simple management agreement or a total sale and merger. Either would have avoided the witches brew of government and religion that was so objectionable in Newport. A third possibility is the creation of a third corporation to manage the public facility, free of the Directives.

The Newport litigation unearthed a surprising reality and tension surrounding the place of religion under the First Amendment. Within this tension, the National Conference of Catholic Bishops has profound concerns about the American Catholic health care establishment; they fear that the pressures of the marketplace will cause Catholic hospitals to compromise Catholic principles and engage in "scandal."³²⁵ The testimony in Newport substantiates these fears. The bishops intend the Directives to restrict and to direct the activities of Catholic health care throughout the United States. But Roman Catholic health care constitutes a multibillion dollar enterprise annually, with its own needs and agenda. The tension between these two Catholic institutions, health care and the Church, is

palpable. Indeed, this tension is precisely what the First Amendment is all about.

Over the last forty years, with the advent of Medicare and Medicaid, the national health care budget has become largely publicly funded. Over four hundred million dollars annually is provided through Medicare and Medicaid—that is through the government to private health care providers.³²⁶ The line between private and public is thereby blurred, as the government seeks to manage health care and contain cost, as well as seeking to encourage health care policy in areas like family planning. First Amendment concerns are inevitably implicated when the recipients of those federal dollars are Catholic institutions. At the same time, religious concerns are raised for those who seek to protect the Church and its ministry from the temptations of public funding.

Paradoxically, the bishops and the Ad Hoc Committee shared a common concern about the entry of Catholic institutions into the delivery of health care. From radically different starting points and perspectives, each was concerned about the compromise of principle resulting from the merger of government and religion. For both the bishops and the Ad Hoc Committee, a wall of separation is needed. For each, the problem posed was when government and religion are dependent on each other, how shall we render unto Caesar what is Caesar's and yet render unto God what is God's?³²⁷

¹ Arthur B. LaFrance is Professor of Law at Lewis & Clark Law School.

² The author served as counsel *pro bono* for the Ad Hoc Committee of the Newport residents opposing the proposed merger. He wishes to express his appreciation and admiration for the Committee members who undertook considerable personal risk in challenging a major industry in their small town and experienced substantial anxiety as the politics of this litigation unfolded. They stayed the course with courage and grace. The author also wishes to express his gratitude to Dean James Huffman of Lewis & Clark Law School, for providing research grants, assistants, and administrative support, which made it possible for a faculty member to undertake major litigation on a *pro bono* basis. Extensive research, secretarial assistance, and photocopying were indispensable to representing the clients in this case. Such an institutional commitment can be justified on a number of bases—community service, professional enhancement, and teaching enrichment—but it takes an unusual dean to appreciate this.

³ For consistency, we have used *health care* throughout this article as the preferred spelling of THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2000), including instances where *healthcare* originally appeared in excerpts.

⁴ Mergers between hospitals, insurers, and other providers, such as pharmaceutical firms, have become commonplace. What is not as obvious is the volume of mergers involving church-related providers. The following is a brief list of scholarship worth reviewing: COHEN & MORRISON, NATIONAL WOMEN'S LAW CENTER, HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES (2001); Donald H.J. Hermann, *Religious Identity and The Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers*, 34 CREIGHTON L. REV. 927 (2001); William W. Bassett, *Private Religious Hospitals: Limitations upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455 (2001); Monica Sloboda, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140 (2001); Lawrence E. Singer & Elizabeth Johnson Lantz, *The Coming Millenium: Enduring Issues Confronting Catholic Health Care*, 8 ANNALS HEALTH L. 299 (1999); Hollie J. Paine, *The Catholic Merger Crusade*, 2 J. HEALTH CARE L. & POL'Y 371 (1999); Jane Hochberg, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 OR. L. REV. 945 (1996); Lisa C. Ikemoto, *When A Hospital Becomes Catholic*, 47 MERCER L. REV. 1087 (1996); Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429 (1995); Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159 (1997).

⁵ Each entity has a Web site that may be visited for much of the factual descriptions which follow. The Web site for Pacific Communities Health District is <http://www.samhealth.org> (last visited Nov. 15, 2004). The Web site for Providence Health Systems is <http://www.providence.org/home> (last visited Nov. 15, 2004). Note that subsequent to the litigation described in this article, Pacific Communities Health District affiliated as a "partner" with Samaritan Health System, which had, while the litigation was pending, worked out a similar arrangement with North Lincoln Hospital, some twenty-five miles away.

⁶ The Health District is a special-function governmental unit, like a school, water, or fire district, with an array of governmental functions and powers, including taxation.

⁷ COMMITTEE ON DOCTRINE, NATIONAL CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed. 2001), at <http://www.usccb.org/bishops/directives.shtml> (last visited Nov. 15, 2004) [hereinafter DIRECTIVES]. The seventy-two Directives and their extensive commentary are a product of the bishops' concern for the conduct of American Catholic health care institutions and target affiliations with proposed mergers.

⁸ The Ad Hoc Committee's position was that Providence *was* religious, and even if it was not, the agreement enshrined the Directives, thereby entangling the government in religious doctrines and institutions.

⁹ In most legal scholarship, text content is footnoted to sources and authorities publicly available in libraries for hard copy or electronic retrieval. The Newport case and this article are not subject to such conventional citation given the outcome of the litigation.

However, a reader who would like to see actual filings or transcripts may do so by contacting the Court Administrator, Nancy Lamvik (as of 2004), for Lincoln County Circuit Court, P.O. Box 100, 225 W. Olive St., Room 202, Newport, Oregon, 97365. The case reference is *In the Matter of the Petition of Gary Hoagland, Charles L. Perry, Frank Armstrong, Carol A. Waters and Doctor David Long, as the Board of Pacific Communities Health District*, No. 00-1227. The court reporter's notes are retained by the administrator's office and transcripts are available at \$2.50 per page. Facsimiles of court papers may similarly be obtained through the administrator's office.

¹⁰ A preferential treatment of religion would simply look at the transfers to Providence and argue they are not supported by a *quid pro quo* analysis. The establishment argument asserts that the agreement has government supporting religion and being managed by it.

¹¹ If it were argued that the agreement created a preference for one religion over other religions, the opponents would possibly have been required to show *intent* on the part of the Health District board to favor one religion.

¹² Providence Health System, Our Mission, http://www.providence.org/phs/about_Providence/default.htm (last visited Nov. 15, 2004).

¹³ Trial Transcript, Testimony of Father John Francis Tuohey, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (“[E]thical norms that could only be enforced by snooping probably ought not to be enforced.”) (on file with the author) [hereinafter Testimony of Tuohey]. See also *infra* Part V.A. It was confirmed, in part, by testimony of the Health District's professionals that they were unaware of the Directives and believed their practices after the merger would continue as they were before. *Id.*

¹⁴ The problem posed is commonplace in civil litigation on applications for preliminary injunctions seeking to avoid future harm. But in those cases, however, there is usually a past record of abuse or misconduct to which the parties can refer. In the Newport case, such a foundation was far more difficult to establish.

¹⁵ *Brown v. Bd. of Educ.*, 347 U.S. 483, 495 (1954). In *Brown*, the Court's central finding that separate educational facilities are inherently unequal was chiefly established by reference to scholarly works and not by evidence in the trial record, although conditions in the local schools had been introduced through witnesses at trial. See *id.* at 495 n.11.

¹⁶ *Miranda v. Arizona*, 384 U.S. 436 (1966). In *Miranda*, the Court's central finding was that counsel was crucial to stationhouse interrogation and such interrogation was inherently coercive. See *id.* at 466. Manuals instructing police on how to conduct such interrogations mostly established these facts. *Id.* 448–49.

¹⁷ *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 888–898 (1992). In *Casey*, one of the Court's findings was that a small percentage of cases revealed a likelihood that a husband who was advised that his wife was seeking an abortion would resort to violence. *Id.* at 889. A subset of this finding was that husbands could not be deterred and women would therefore not exercise their constitutional right to choose. *Id.* at 890–91. These findings of fact, in addition to several hundred others, were made by the trial court and supported the conclusions ultimately reflected in Justice O'Connor's opinion in *Casey*.

¹⁸ This overview is necessarily a summary drawn from a number of sources. The best references for a reader would be the briefs of the parties on summary judgment, as well as the pleadings themselves.

¹⁹ Many of the details of the controversy and lawsuit were reported in the local newspaper, the Newport News Times. To search the archives of the Newport News Times, see <http://www.newportnewstimes.com/archives/> (last visited Nov. 15, 2004).

²⁰ The docket number for the appeal in the Oregon Court of Appeals is A 114655. The appeal was withdrawn by the citizens who had appealed on January 11, 2002.

²¹ See DIRECTIVES, *supra* note 7. Specific policy statements published by the bishops and a history of the Directives are given in the preamble and notes one and six of the Directives. *Id.* at pmb., Notes.

²² See generally *id.* For a detailed discussion of these prohibitions as a group, see *id.* at pts. IV–V. For discussion of each prohibition separately, see *id.* at pt. III, directive 36 (abortion); pt. IV, directive 45 (abortion); pt. V, directive 60 (assisted suicide); pt. IV, directives 48, 53 (reproductive surgery); pt. IV, directives 40–41, 43 (artificial reproductive techniques); pt. IV, directive 52 (natural family planning methods).

²³ As to the terms of the agreement, see *infra* Part III.B.

²⁴ DIRECTIVES, *supra* note 7, at app.

²⁵ *Id.* at pt. VI.

²⁶ *Id.* at pt. VI, directive 71. The term “scandal” in this context is a term of art, meaning confusion or compromise of basic tenets of the Church or faith. *Id.*

²⁷ *Id.* at pt. VI.

²⁸ *Id.* at pt. VI, directive 67.

²⁹ *Id.* at pt. VI, directive 68.

³⁰ *Id.* at pt. VI, directive 69.

³¹ *Id.* at pt. VI, directive 70.

³² DIRECTIVES, *supra* note 7, at gen. intro.

³³ *Id.*

³⁴ *Id.* at pmb.

³⁵ *Id.* at pt. I, directive 1.

³⁶ *Id.* at pt. I, directive 5.

³⁷ DIRECTIVES, *supra* note 7, at pt. III.

³⁸ *Id.*

³⁹ *Id.* at pt. III, directive 24.

⁴⁰ For a discussion on the treatment of sexual assault victims, see *id.* at pt. III, directive 36.

⁴¹ *Id.*

⁴² DIRECTIVES, *supra* note 7, at pt. IV, intro.

⁴³ *Id.*

⁴⁴ *Id.* at pt. IV, directives 40–42.

⁴⁵ *Id.* at pt. IV, directive 45. In addition to totally prohibiting abortion, Directive 45 provides that “abortion . . . in its moral context, includes the interval between conception and the implantation of the embryo.”

⁴⁶ *Id.* at pt. IV, intro.; *id.* at pt. IV, directive 52.

⁴⁷ *Id.* at pt. IV, directive 50.

- ⁴⁸ DIRECTIVES, *supra* note 7, at pt. V.
- ⁴⁹ *Id.* at intro.
- ⁵⁰ *Id.*
- ⁵¹ *Id.* at pt. V, directive 57.
- ⁵² *Id.* at pt. V, directive 59.
- ⁵³ *Id.* at pt. V, directive 60.
- ⁵⁴ *Id.*
- ⁵⁵ DIRECTIVES, *supra* note 7, at pt. VI, directive 70.
- ⁵⁶ Operating Agreement between Providence Health System, Oregon, and Pacific Communities Health District 65 (June 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter OA].
- ⁵⁷ *Id.* at 1.
- ⁵⁸ OA, *supra* note 56, at 1.
- ⁵⁹ *Id.*
- ⁶⁰ PROVIDENCE HEALTH SYSTEM, CONSOLIDATED FINANCIAL STATEMENTS 2 (2004) <http://www.providence.org/resources/phs/2003PHSCombined.pdf> (last visited Nov. 16, 2004); Providence Health System, A Focus on Excellence Inspired by Mission: The Good Work 2004 Fact Sheet 3 (2004), <http://www.providence.org/resources/phs/tgw2003/2004FactSheet.pdf> (last visited Nov. 16, 2004) (as of 2004, Providence has nearly 33,000 employees).
- ⁶¹ OA, *supra* note 56, at 1.
- ⁶² Providence Health System, *Hospitals in the Providence Health System*, available at <http://www.providence.org/PHS/Locations/default.htm> (last visited Nov. 16, 2004).
- ⁶³ Restated Articles of Incorporation of the Sisters of Providence in Oregon (May 8, 1991) (on file with the *Seattle Journal for Social Justice*) [hereinafter Restated Articles].
- ⁶⁴ *See* OA, *supra* note 56, at 65.
- ⁶⁵ *Id.* at 1.
- ⁶⁶ *Id.*
- ⁶⁷ *See, e.g.*, Letter from Corrinne C. Williams, Counsel for the Ad Hoc Committee, to Gary Hoagland, Chair of Board of Pacific Communities Health District (Feb. 17, 2000) (on file with the *Seattle Journal for Social Justice*) (providing a mark-up of the “Affiliation Agreement”).
- ⁶⁸ *Id.*
- ⁶⁹ *See* OA, *supra* note 56.
- ⁷⁰ *See* Letter from Corrinne C. Williams, *supra* note 67.
- ⁷¹ *See* OA, *supra* note 56.
- ⁷² *Id.* at 1–2.
- ⁷³ *Id.* at 3.
- ⁷⁴ *Id.*
- ⁷⁵ *Id.* at 4.
- ⁷⁶ *Id.*
- ⁷⁷ *Id.* at 4–5.
- ⁷⁸ *Id.* at 6.
- ⁷⁹ *Id.* at 7.
- ⁸⁰ *Id.*

⁸¹ *Id.* at 9.

⁸² *Id.* at 9–10.

⁸³ *Id.* at 10.

⁸⁴ *Id.*

⁸⁵ *Id.* at 11.

⁸⁶ *Id.* at 11–12.

⁸⁷ *Id.* at 13.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.* at 14.

⁹¹ *Id.* at 15.

⁹² *Id.*

⁹³ *Id.* at 16.

⁹⁴ *Id.* at 16–18.

⁹⁵ *Id.* at 19.

⁹⁶ *Id.* at 29.

⁹⁷ *Id.* at 31 (emphasis added).

⁹⁸ *Id.* at 23.

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 24.

¹⁰¹ *Id.* at 40.

¹⁰² *Id.*

¹⁰³ *Id.* at 42.

¹⁰⁴ *Id.* at 42–43.

¹⁰⁵ *Id.* at 44.

¹⁰⁶ *Id.* at 45.

¹⁰⁷ *Id.* at 28.

¹⁰⁸ *Id.* at C-1, C-2.

¹⁰⁹ *Id.* 54–56.

¹¹⁰ *Id.* at 55.

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ Letter from Arthur LaFrance, Counsel for the Ad Hoc Committee, to Gary Hoagland, Chair of Board of Pacific Communities Health District (Dec. 23, 1999) (on file with the author).

¹¹⁴ *Id.*

¹¹⁵ Letter from Corrine C. Williams, *supra* note 67.

¹¹⁶ OR. CONST. art. 1, §§ 2–3, 5. By agreement of counsel, the state law issues were briefed by counsel for the ACLU in its appearance on the summary judgment motion—its only appearance in the litigation. That briefing was incorporated by reference in the Ad Hoc Committee’s filings. Despite repeated requests, neither the ACLU nor any other public interest group, including Planned Parenthood, NOW, or NARAL, entered the case in support of the Ad Hoc Committee. Obviously, their stature and expertise would have been major resources.

¹¹⁷ 42 U.S.C. § 1983 (2004).

¹¹⁸ Obviously, the subjects of § 1983 actions and federal jurisdiction are peripheral to the Newport case, which went forward in state court. Therefore, there is no need to discuss or to cite to relevant case law for the proposition that, as a First Amendment case, the Newport litigation might properly have been brought in federal court. The Supreme Court decisions discussed *infra* in Part V.B are ample support for that proposition.

¹¹⁹ For over a decade, the author of this article directed the legal services for a national litigation conference series on federal litigation offered by the Legal Services Corporation and has also written on the subject of public interest litigation. See generally Arthur B. LaFrance, *Federal Litigation for the Poor*, LAW & SOC. ORDER, 1972, at 1; Arthur B. LaFrance, *Federal Rule 11 and Public Interest Litigation*, 22 VAL. U. L. REV. 331 (1988); Arthur B. LaFrance, *Tobacco Litigation: Smoke, Mirrors and Public Policy*, 26 AM. J.L. & MED. 187 (2000). He most recently served as counsel for the American Cancer Society in the multistate tobacco litigation and served as amicus for the Northwest Consortium of Law Schools in the conversion proceeding involving Premera Blue Cross.

¹²⁰ The judge in Eugene, Oregon, who would have heard cases from Newport, Oregon, had earlier written an extremely conservative opinion invalidating Oregon's assisted suicide law. OR. REV. STAT. § 127.805 (2003). See *Lee v. Oregon*, 869 F. Supp. 1491, 1503 (D. Or. 1994), *vacated by* 107 F.3d 1382 (9th Cir. 1997). In contrast, one of the judges in Portland, Oregon, invalidated a directive by John Ashcroft that criminalized assisted suicide. *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1093 (D. Or. 2002), *aff'd*, 368 F.3d 1118, 1131 (9th Cir. 2004).

¹²¹ The point of this article is not to critique the state trial judge who ultimately heard the case, but it is fair to point out the limitations that he imposed upon counsel. At the beginning, despite counsel's response that the Ad Hoc Committee needed a week to present its case, a single week was allowed for the presentation of both sides. At the end of the litigation, Providence and the Health District arranged to confer *ex parte* with the judge to dismiss the case.

¹²² Petition for Judicial Examination and Judgment, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter *Petition*]. It recited preliminarily:

In recent years there have been rapid changes in the nature of the delivery of health care services and in the insurance and government programs that fund such services, which has [*sic*] caused great instability and unpredictability in the financial environment for the provision of health care. Some small health care providers have been forced to close, and the [Health] District has seen its financial position erode. In response to these changes, the Board determined that an affiliation with a large health care system would help reduce costs, provide support against sudden fluctuations in costs, and generally provide a more stable environment in which to ensure that quality health care services continue to be available to residents of the [Health] District.

* * *

Following its evaluation of the proposals, the Board determined unanimously that the proposal submitted by Providence would best meet the needs of the District and its residents and best satisfy the goals articulated in *The Principles*

of Affiliation. Accordingly, the Board entered into negotiations for an operating agreement with Providence.

* * *

The full legal name of Providence is “Providence Health System-Oregon,” which is an Oregon nonprofit corporation that is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code. The sole member of Providence is “Sisters of Providence-Mother Joseph Province,” which is the Northwest geographic region of the Sisters of Providence, a Catholic religious community with its headquarters in Montreal, Canada. Providence has a long history of providing high quality health and managed care services in communities throughout Oregon.

* * *

The negotiations between the [Health] District and Providence continued for several months, and eventually matured into the Agreement. Under the Agreement, the [Health] District has agreed to lease and transfer operation, but not ownership, of certain of its real and personal property to Providence, in exchange for which Providence has agreed to operate the property in a mutually agreed upon manner and in accordance with all applicable state and federal laws in order to ensure that quality health care services continue to be available to residents of the [Health] District. A copy of the Agreement is attached as Exhibit C, and is incorporated by this reference.

Id. at 3–4, ¶¶ 9, 12–14.

¹²³ See OR. REV. STAT § 33.710 (2003); OR. REV. STAT § 33.720 (2003). This action is a statutory vehicle closely akin to a declaratory judgment proceeding.

¹²⁴ Petition, *supra* note 122, at 6.

¹²⁵ *Id.* at 7, ¶ 4. Hence, the proceeding was styled a validation proceeding; a kind of declaratory judgment was sought. However, the Health District and Providence named no defendants, so the proceeding also had the qualities of an *in rem* or condemnation proceeding. Although a validation proceeding is a familiar device in municipal law, it has few counterparts anywhere else in civil or criminal law.

¹²⁶ *Id.* at 1, ¶ 1.

¹²⁷ *Id.* at 1.

¹²⁸ See *id.*

¹²⁹ *Id.* at Ex. A.

¹³⁰ *Id.*

¹³¹ See *id.* at Ex. B.

¹³² See *id.* at Ex. C.

¹³³ OA, *supra* note 56, at C-2.

¹³⁴ *Id.* Obviously, the “healing ministry of Jesus” is a religious concept, but without more, it is unexceptionable. The “core values” were not offensive to the Constitution or to the Ad Hoc Committee; rather, it was what these values translated into—the Directives—that the Committee found objectionable. However, the Directives were not mentioned in the agreement or the accompanying exhibits.

¹³⁵ See, e.g., Bd. of Klamath County Comm’rs v. Select County Employees, 939 P.2d 80 (Or. Ct. App. 1997); Drummond v. Oregon Dep’t of Transp., 730 P.2d 582 (Or. Ct. App.

1986); *Rogers v. Lane County*, 771 P.2d 254 (Or. 1989); *Eustace v. Speckhart*, 514 P.2d 65 (Or. Ct. App. 1973).

¹³⁶ See *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950); *Eisen v. Carlisle & Jaquelin*, 417 U.S. 156, 174–75 (1974); *Mennonite Bd. of Missions v. Adams*, 462 U.S. 791, 795 (1983); OR. R. CIV. P. 7(D)(6)(a–d).

¹³⁷ Motion to Intervene, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with author).

¹³⁸ OR. R. CIV. P. 29(A)(1); *Hudson v. Feder*, 836 P.2d 779 (Or. Ct. App. 1992). An argument might also have been made that the local Diocese was an indispensable party. It is not clear that Providence was required to intervene, since it was, strictly speaking, a part of the world against which the Health District was proceeding *in rem*. The Ad Hoc Committee declined to intervene and appeared instead as a defendant, more accurately reflecting its position and avoiding some of the burdens and hazards confronting interveners.

¹³⁹ Motion to Dismiss, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Motion to Dismiss].

¹⁴⁰ Defendants' Memorandum on Motion to Dismiss at 1–2, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Defendant's Memorandum on Motion to Dismiss]. The arguments and case law underlying the motion to dismiss were developed more elaborately on the motions for summary judgment and are discussed there. See *infra* Part IV.D.

¹⁴¹ *Id.* A separate motion to dismiss was filed *pro se* by an individual intervener, a Newport attorney who had initially been affiliated with the Ad Hoc Committee. The motion to dismiss argued that there was a lack of subject matter jurisdiction, personal jurisdiction, and sufficiency of summons; moreover, the petition failed to state ultimate facts sufficient to state a claim on which relief might be granted. The motion to dismiss challenged bringing the action as *in rem*. It also maintained that the petition was proceeding under a statute that unlawfully delegated power from the executive or legislative branch to the judicial branch. The motion to dismiss maintained that the Health District lacked authority to bring the proceeding and that notice had been insufficient to comport with due process. It was denied and ultimately, after filing other papers and interlocutory appeals, the attorney retained counsel a few weeks before trial.

¹⁴² Counterclaims for Damages Injunctive Relief and Attorneys Fees, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Counterclaims].

¹⁴³ *Id.* at 4, ¶ 8.

¹⁴⁴ *Id.* at 5–6, ¶¶ 11–12.

¹⁴⁵ *Id.* at 6–7, ¶¶ 15–16.

¹⁴⁶ *Id.* at 7, ¶¶ 17–21.

¹⁴⁷ *Id.* at 9, ¶¶ 22–27.

¹⁴⁸ *Id.* at 11, ¶¶ 28–32. This claim for relief was subsequently withdrawn.

¹⁴⁹ *Id.* at 15, ¶ 37(f). The Oregon validation statute denied a jury trial, possibly because *in rem* proceedings partake of injunction proceedings in equity. See OR. REV. STAT § 33.710, *supra* note 123. However, the Ad Hoc Committee's counterclaims were clearly

the stuff of jury trials. To economize on resources, the claim to the jury was withdrawn. *Contra* Counterclaims, *supra* note 142, at 15, ¶ 37(f).

¹⁵⁰ See Counterclaims, *supra* note 142.

¹⁵¹ The modifier “direct” is unclear. Several people connected with Providence or the Health District used the term, implying that some abortions are not “direct” and would be permitted. Perhaps the term “direct” refers to abortions that are for the purpose of ending a pregnancy, instead of another purpose, such as saving the life of the mother.

¹⁵² Significantly, this was one of the concessions between Providence and the [Health] District regarding changes in practice or policy after the merger. Such a change could only be attributed to religious principles, found in the Directives. However, later Providence and the Health District argued that there were no abortions being performed, and so the “change” was really no change at all. Regardless, the Ad Hoc Committee’s position was that a change in policy was itself sufficient to trigger constitutional prohibitions.

¹⁵³ The reproductive rights claims were closely aligned with the claims concerning religion, but they were not identical. Even if family planning, abortion, or other reproductive issues were unaffected by the merger, there would still have been issues raised by a religious organization that received aid from the government and controlled it.

¹⁵⁴ For example, a leading heart surgeon, Albert Starr, so testified at trial. Trial Transcript, Testimony of Dr. Albert Starr, *In re* Gary Hoagland, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Starr]. Similarly, Health District physicians testified that they anticipated no impact on the way they would practice medicine. Trial Transcript, *In re* Gary Hoagland, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Trial Transcript].

¹⁵⁵ See discussion *infra* Part V.B.

¹⁵⁶ Again, see discussion *infra* Part V.B. for relevant Supreme Court decisions under the *Lemon v. Kurtzman* entanglement standard. *Lemon v. Kurtzman*, 403 U.S. 602, 615 (1971).

¹⁵⁷ As the depositions and trial testimony unfolded, it appeared that the [Health] District had sought proposals only from religiously affiliated hospital systems, although a for-profit hospital was operated in McMinnville, a community only fifty miles away. This was intentional religious discrimination. See discussion *infra* Part V.B.

¹⁵⁸ Ultimately, Providence’s ethicist, Father Tuohey, testified that enforcement varied from place to place, while the Diocese’s chancellor (subpoenaed without having been interviewed by the intervener) testified that the bishop would not interfere. The Committee’s witness, Father Golinski, testified that the bishop’s *nihil obstat* was indispensable, as the Directives themselves essentially provide. See *supra* Part II.A.; *infra* Part V.A.

¹⁵⁹ Matters of constitutional fact have been important in such landmark cases as *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954), and *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992). See Introduction, *supra* Part I.A.

¹⁶⁰ Intervenor Providence Health System-Oregon’s Motion for Summary Judgment, *In re* Gary Hoagland, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Intervenor Motion for Summary Judgment].

¹⁶¹ *Id.* at 2.

¹⁶² Affidavit of Mark May in Support of Intervenor Providence Health System-Oregon’s Motion for Summary Judgment at 1, ¶ 2, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Aff. of Mark May].

¹⁶³ *Id.* at 1, ¶ 3.

¹⁶⁴ *Id.* at 2, ¶ 4.

¹⁶⁵ *Id.* at 2, ¶¶ 6–7.

¹⁶⁶ *Id.* at 2, ¶¶ 7–8.

¹⁶⁷ *Id.* at 2, ¶ 8.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 3, ¶ 9. This last point was important, but hardly one that the Directives would support, except in the most formal sense, or that an aggressive bishop would necessarily concede.

¹⁷⁰ *Id.* at 3, ¶ 10.

¹⁷¹ *Id.* at 4, ¶ 13. Of course, all of this was true, in a general way. However, important concerns were not addressed: exactly *how* did the Directives impact services, and what was meant by May’s statement that the services would not be “religious”? The services were health care, and not to proselytize, evangelize, conduct religious instruction, or worship (except perhaps in chapels), but if the services were limited or directed by religious principles in ways nonsectarian hospitals were not, in *that sense* they were “religious.”

¹⁷² *Id.*

¹⁷³ *Id.* 4, ¶ 14.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 4–5, ¶ 15.

¹⁷⁶ Restated Articles, *supra* note 63, at 1.

¹⁷⁷ Supplemental Affidavit of Mark May at 1, ¶ 2, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*); Resolutions of Board of Directors of the Pacific Communities Health District, Resolution No. 00-02 (March 2, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Resolution No. 00-02].

¹⁷⁸ Resolution No. 00-02, *supra* note 177, at 1. Each one of these hospital systems is church affiliated. It appears that the Health District deliberately chose not to seek bids from other nonprofits or for-profit providers.

¹⁷⁹ *Id.* at 2.

¹⁸⁰ Defendants’ Cross-Motion on Summary Judgment, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Defendants’ Cross-Motion].

¹⁸¹ *Id.* at 1–2, ¶ 1.

¹⁸² *Id.* at 2, ¶ 2.

¹⁸³ *Id.* at 2, ¶ 3.

¹⁸⁴ *Id.* at 2–3, ¶ 5(b)–(c).

¹⁸⁵ *Id.* at 1.

¹⁸⁶ *Id.* at 3–4, ¶ 6.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 2–3, ¶ 5(a)–(c).

¹⁸⁹ *Id.* at 2, ¶ 2.

¹⁹⁰ *Id.* at 1–2, ¶¶ 1–4.

¹⁹¹ OR. R. CIV. P. 47(C) (2003).

¹⁹² OR. REV. STAT. § 435.475 (3) (2003).

¹⁹³ *Lemon*, 403 U.S. at 615 (“In order to determine whether the government entanglement with religion is excessive, we must examine the character and purposes of the institutions that are benefited, the nature of the aid that the State provides, and the resulting relationship between the government and the religious authority.”).

¹⁹⁴ Brief in Support of Motion for Summary Judgment of Intervenor Providence Health System-Oregon at 18–20, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Brief in Support of Motion for Summary Judgment].

¹⁹⁵ *Id.*

¹⁹⁶ Defendants’ Memorandum on Summary Judgment, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Defendants’ Memorandum on Summary Judgment].

¹⁹⁷ *See Bd. of Educ. of Kiryas Joel Vill. Sch. Dist. v. Grumet*, 512 U.S. 687 (1994) (invalidating a state statute drawing a special school district boundary around a religious community).

¹⁹⁸ *Larkin v. Grendel’s Den, Inc.*, 459 U.S. 116 (1982) (invalidating a state statute that allowed religious institutions to effectively veto a business’s application for a liquor license).

¹⁹⁹ Defendants’ Memorandum on Summary Judgment, *supra* note 196, at 17 (citing *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290 (2000) (ruling on whether a school district’s practice of allowing student-led prayer before football games violated the Establishment Clause); *Lee v. Weisman*, 505 U.S. 577 (1992) (holding that clerical members offering prayers as part of the official school graduation ceremony was inconsistent with the Establishment Clause)). *See also* *Lynch v. Donnelly*, 465 U.S. 668 (1984) (holding that a city had not impermissibly advanced religion by including a crèche in a Christmas display); *County of Allegheny v. ACLU*, 492 U.S. 573 (1989) (holding that the display of a crèche outside a county courthouse without other secular decorations violated the Establishment Clause).

²⁰⁰ *See Moore v. Judicial Inquiry Comm’n.*, No. 1030398, 2004 WL 922668, at 2–3 (Ala. Apr. 30, 2004).

²⁰¹ *See* Defendants’ Memorandum on Summary Judgment, *supra* note 196, at 24–31.

²⁰² *See id.* at 24.

²⁰³ *See id.* at 25.

²⁰⁴ *See* OA, *supra* note 56, at 28.

²⁰⁵ *See Lemon*, 403 U.S. at 615. At this point in their argument, the defendant particularly looked to *Mitchell v. Helms*, 530 U.S. 793 (2000); *Meek v. Pittenger*, 421 U.S. 349 (1975), *overruled by Mitchell v. Helms*, 530 U.S. 793 (2000); and *Agostini v. Felton*, 521 U.S. 203 (1997). Defendants’ Memorandum on Summary Judgment, *supra* note 196, at 26. *Agostini* recast the *Lemon* three-part test in the entanglement inquiry as a singular determination of a statute’s effect and created three primary criteria for determining a

statute's effect: state assistance advances religion if it (1) results in governmental indoctrination, (2) defines its recipients by reference to religion, or (3) creates an excessive entanglement. *Id.* at 232–233.

²⁰⁶ Defendants' Memorandum on Summary Judgment, *supra* note 196, at 31–38 (relying on *Witters v. Wash. Dept. of Servs. for the Blind*, 474 U.S. 481 (1986); *Bowen v. Kendrick*, 487 U.S. 589 (1988); and *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1 (1989)).

²⁰⁷ Defendants' Memorandum on Summary Judgment, *supra* note 196, at 36.

²⁰⁸ *Id.* at 35 (citing *Abood v. Detroit Bd. of Educ.*, 431 U.S. 209 (1977)).

²⁰⁹ Defendants' Memorandum on Summary Judgment, *supra* note 196, at 36 (citing *Keller v. State Bar of Cal.*, 496 U.S. 1 (1990)).

²¹⁰ Defendants' Memorandum on Summary Judgment, *supra* note 196, at 36.

²¹¹ *Id.* at 38–54.

²¹² *Id.* at 38.

²¹³ *Id.* at 42 (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

²¹⁴ Defendants' Memorandum on Summary Judgment, *supra* note 196, at 42 (citing *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992)).

²¹⁵ Defendants' Memorandum on Summary Judgment, *supra* note 196, at 42–47 (citing and discussing *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992)).

²¹⁶ Reply Brief in Support of Motion for Summary Judgment of Intervenor Providence Health System-Oregon, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Reply Brief].

²¹⁷ *Id.* at 1.

²¹⁸ *Id.* at 2.

²¹⁹ *Id.* at 12.

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.*

²²³ *Id.*

²²⁴ *Id.* at 13.

²²⁵ *Id.* The point at this juncture of the article is simply to report the positions of the parties, not to litigate them. However it may be appropriate to note that the affidavit had not been subject to cross-examination; at trial, under cross-examination, Mr. Fraser agreed that the hospital was solvent and had been consistently in the black over the preceding years. *See infra* Part V.A.1.

²²⁶ Reply Brief, *supra* note 216, at 14.

²²⁷ *Id.* at 16–17.

²²⁸ *Id.* at 16.

²²⁹ *Id.* Whatever merit that distinction has in the education cases involved in *Lemon*, it has little relevance to instances where, as in the Newport case, the Health District was not only transferring monies to a church-affiliated entity but also governance of itself, adopting the religious principles and symbols of the religious entity in the process.

²³⁰ *Id.* at 20. However, ownership still remained in the Health District, as did its identity and participation in funding and governance within the new Providence structure.

²³¹ *Id.* at 20–21.

²³² *Id.* at 20.

²³³ *Id.* at 28–36.

²³⁴ Ruling on Rule 47 Motions for Summary Judgment, Memorandum Opinion and Order, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Ruling on Motions for Summary Judgment].

²³⁵ *Id.* at 1–15. This part of the ruling is notable for criticizing defense counsel for filing a summary judgment motion dependent upon lengthy depositions and then preparing and presenting at oral argument a fourteen-page outline analysis of the issues and that evidence.

²³⁶ *Id.* at 16.

²³⁷ *See id.* at 18. Of course, this would mean a constitutional challenge could never succeed where the religious entity’s religious “function” was to do nothing, as with withholding end of life or reproductive services for religious reasons.

²³⁸ *Id.*

²³⁹ *Id.* at 18–19. Of course, that question is also raised under the First Amendment to the United States Constitution.

²⁴⁰ *Id.* at 21.

²⁴¹ *Id.*

²⁴² *Id.* at 22.

²⁴³ *Id.*

²⁴⁴ *Id.* at 23.

²⁴⁵ *Id.* at 24.

²⁴⁶ *Id.*

²⁴⁷ *Id.* at 26.

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ *Cf. Mitchell*, 530 U.S. at 892–93. That an entity is pervasively religious is a legal conclusion rather than an element of the burden of proof the Ad Hoc Committee had to bear.

²⁵¹ *See generally* OA, *supra* note 56.

²⁵² *Cf. Burton v. Wilmington Parking Auth.*, 365 U.S. 715 (1961) (holding that a lessee of space in a public parking garage was engaged in “state action” sufficiently to offend the Fourteenth Amendment by denying service to African Americans).

²⁵³ Trial Transcript, *supra* note 154.

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ Trial Transcript, Testimony of John Lee, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Lee].

²⁵⁷ *Id.*

²⁵⁸ *Id.* This would be a linchpin of the citizens’ argument concerning state action, as well as entanglement for First Amendment purposes.

²⁵⁹ Trial Transcript, Testimony of Dr. Cely, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Cely].

²⁶⁰ *Id.*

²⁶¹ *Id.*

²⁶² *See id.*

²⁶³ Trial Transcript, Testimony of Dr. Long, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Long].

²⁶⁴ *Id.*

²⁶⁵ Trial Transcript, Testimony of Mary Jo Tully, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter testimony of Tully].

²⁶⁶ *Id.*

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ *Id.*

²⁷⁰ *See* Trial Transcript, Testimony of Michael Fraser, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Fraser].

²⁷¹ *Id.*

²⁷² This, of course, is religious discrimination—an independent basis for challenging the Agreement quite apart from the many arguments about entanglement and service and funding of religion. *See infra* Part V.B.

²⁷³ That affiliation is now complete, and as a result the Health District signs reflect the name of the hospital as Samaritan Pacific Communities Hospital.

²⁷⁴ Testimony of Fraser, *supra* note 270.

²⁷⁵ *Id.*

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ *Id.*

²⁷⁹ *Id.*

²⁸⁰ *See* Testimony of Tuohey, *supra* note 13.

²⁸¹ *Editor’s Note:* This summary was taken from Defendants’ Closing Brief rather than from the actual trial testimony in part because the *Seattle Journal for Social Justice* does not have the entire trial testimony on file.

²⁸² Chiefly RU-486, an abortifacient, widely used in Europe but under consideration for use in the United States by the FDA at the time of this litigation. The Catholic Church would similarly oppose use of hormonal cocktails to prevent implantation of a fertilized egg.

²⁸³ *See generally* TOM. L. BEAUCHAMP & JAMES. F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (5th ed. 1979). This is a comprehensive review of the content and history of ethical and moral philosophy, and it develops basic concepts such as autonomy, beneficence, non-maleficence, and justice. In no sense is it a prescriptive set of mandates like the Ethical and Religious Directives.

²⁸⁴ The agreement was not, in fact, a “complete takeover.” Even if it were, the last four Directives express a concern for “scandal”—that is, moral compromise and confusion—which would apply to either partnerships or “complete takeovers.” Significantly, Providence and the trial judge had, for other purposes, found that there was *not* a complete takeover, thereby avoiding attributing state action to Providence’s running of the hospital.

²⁸⁵ Defendants' Closing Brief at 11–12, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Closing Brief].

²⁸⁶ See Testimony of Tuohey, *supra* note 13.

²⁸⁷ Trial Transcript, Testimony of Virginia Terhaar, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Terhaar].

²⁸⁸ Trial Transcript, *supra* note 154.

²⁸⁹ *Id.*

²⁹⁰ See *id.*

²⁹¹ Trial Transcript, Testimony of Lois Backus, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Backus].

²⁹² OR. REV. STAT. § 127.800 (2003).

²⁹³ Trial Transcript, Testimony of George Eighmey, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Eighmey].

²⁹⁴ *Id.*

²⁹⁵ See *id.*

²⁹⁶ Trial Transcript, Testimony of Father John Golenski, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Golenski].

²⁹⁷ See *supra* note 281.

²⁹⁸ The significance of Medicare funding is deceptive. Providence technically receives Medicare payments only because Medicare patients choose to use its hospitals or managed care plans. For HHS to prevent this would be religious discrimination; to allow it, of course, is not establishing religion, because it is the patient's choice. In contrast, the Health District was transferring money, facilities, and its very governance directly to Providence, a far more direct and comprehensive transfer.

²⁹⁹ Closing Brief, *supra* note 285, at 8–9.

³⁰⁰ Trial Transcript, Testimony of Merwyn Greenlick, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the author) [hereinafter Testimony of Greenlick].

³⁰¹ *Id.*

³⁰² *Id.*

³⁰³ Again, this raises the considerations that made federal court an attractive venue in this case, although the travel and attendance burdens on the clients would then have been greater.

³⁰⁴ In Newport, each of the corporate petitioners was represented by a large, experienced trial firm that had one senior partner, one junior associate, and one paralegal in the courtroom throughout the trial. The wall was lined with lawyer boxes. The flow of exhibits was nonstop and elegant. This is not the biggest display that the author has faced; in the tobacco litigation, there were eighteen attorneys in the courtroom during one day. See articles cited *supra* note 119.

³⁰⁵ Brief of Amicie Curiae, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000), <http://www.aclu-or.org/litigation/newport.htm> (last visited Nov. 20, 2004).

³⁰⁶ Trial Transcript, *supra* note 154.

³⁰⁷ See Joel Gallo, *Providence Backs Out of Affiliation Agreement with Pacific Communities*, NEWPORT NEWS-TIMES, Jan. 19, 2001, available at <http://www.newportnewstimes.com/articles/2001/01/19/general/news-03.txt> (posted on Feb 26, 2004).

³⁰⁸ A copy of the original may be obtained on the *Seattle Journal for Social Justice* Web site at <http://www.seattleu.edu/sjsj>.

³⁰⁹ Closing Brief, *supra* note 285, at 17–29. The brief notes the following:

[T]he [Health] District proposes a partnership with Providence under an Operating Agreement which will terminate employment of any employee refusing to accept the Roman Catholic Religious Directives imposed by Providence. This is clear discrimination *against* people on religious grounds. Discrimination *favoring* Roman Catholic beliefs is equally clear: governance is shared with Providence, subject to the Directives; religious endorsement and symbols will be institutionalized; present and future services will be limited by Catholic Religious Directives; the administration of the Agreement will require ongoing entanglement of the District and Providence, not only to sort out the impact of the Religious Directives on needed medical services, but also to work out huge ambiguities in performance requirements. . . . This is a governmental involvement—state action—with a pervasively religious entity.

Defendants do not claim that Providence is “pervasively religious” in the sense that *all* aspects of its operations are somehow religious. No *entity* is *all* only one thing. Catholic schools or HMO’s or hospitals or orphanages are not *only* about religion. They provide services much like those of their nonreligious counterparts. What distinguishes them are their governing religious principles, and the impact on consumers, employees and services. In the realm of church/state analysis under the Constitution, any arrangement is invalid if it discriminates in favor of religion or helps a religiously-grounded entity in its religious mission. Both of those are true here, even though much—perhaps most—of what Providence does is health care done elsewhere.

Id. at 17–18.

³¹⁰ *Id.* at 30–45. The brief further notes the following:

The symbolic endorsement of religion in this case is remarkable in at least two respects. *Unlike any other Providence hospital*, the sign in Newport will have not just the Providence name and location (e.g., Providence/Milwaukee) but the name of a *governmental agency as well*. The name will be “Providence *Pacific Communities* Hospital” When asked, Norman Johnson, an experienced health care administrator and former District Board member, easily identified the logo as conveying a joint partnership of government and religion. Indeed, that is the arrangement created by the Operating Agreement. This linkage of government and religion will be conveyed also by the new letterhead and all promotional materials—Providence *Pacific Communities* Hospital.

* * *

The decisions of the United States Supreme Court are uniform; government may not adopt religious symbols or employ or display them. Such symbols may range from endorsing doctrine to adopting logos, as in this case, to espousing religious teaching, such as [t]he Ten Commandments, or sponsoring prayer, such as The Lord's Prayer. Each of these, in some degree, involves the *practice* of religion. But all have in common the centrally offensive element of *endorsing* religion. Thus, most recently, in *Sante Fe Independent School v. Doe*, 120 S. Ct. 226 (2000), the Supreme Court invalidated a practice of student led, student-initiated invocations prior to football games at a Texas high school. The opinion by Justice Stevens found the practice indistinguishable from that invalidated in *Lee v. Weisman*, 505 U.S. 577 (1992), where a prayer had been delivered by a Rabbi at a middle school graduation. To some extent, both prayer exercises were invalidated because they were coercive of the people in attendance. But the fact that only one prayer was permitted at a time was equally troublesome, since it singled out that point of view for favorable endorsement.

Id. at 36–38.

³¹¹ *Id.* at 46–66. The brief continues:

First, substantial governmental authority and functions have either been delegated to, or shared with, Providence by the [Health] District Board. Second, services and policy are restricted on terms dictated by the religious principles of Providence, and The Healing Ministry of Jesus. Thirdly, an irresponsibly favorable transfer of assets and aid to a religious body, The Sisters of Providence, is being made, on terms and under circumstances assuring unconstitutional entanglement between government and religion. . . . The most important transfer, in this case, is not in the financial, physical or service levels. It is on the governmental level. The [Health] District is a governmental unit, charged by Oregon law with health care responsibilities to [Health] District residents. . . . Those responsibilities have now been largely delegated to, or shared with, a religiously-affiliated hospital chain. Whether present services or personnel will be adversely affected is simply irrelevant. The *delegation itself* is government action, emphatically subject to religious controls and criteria. The subordination of public authority to religious decisionmaking [*sic*] suffices to offend the Oregon and [U]nited States Constitutions, as tending to establish religion.

Id. at 46, 48.

³¹² *Id.* at 67–83. The brief notes the following:

The pervasively religious nature of Providence and the resulting impact on health care were amply developed by witness George Aighmey [*sic*]. [E]ighmey is an estates attorney, a former Oregon legislator who was intimately involved in the passage of Oregon's Death With Dignity Act, and is presently Executive Director of Compassion in Dying. In that capacity he has directly counseled or worked with many dying patients, some in Lincoln County. Their capacity to obtain assistance will be seriously compromised under the Operating Agreement, because of the Religious Directives, as

confirmed by [E]ighmey's direct experience in dealing with Providence. That experience includes taking testimony as a legislator on the Judiciary Committee, in which Providence opposed physician-assisted suicide; administering an AIDS hospice owned by Providence, which limited contacts between homosexuals; and meeting and discussing these issues with John Lee and Father Tuohey, where they expressed the views reflected in the Religious Directives. There *will* be an impact on services in Lincoln County.

Lois Backus, the Executive Director of Planned Parenthood, testified to the same effect. As such she is responsible for developing and delivering educational and clinical programs and services involving abortion, sterilization, contraception and family planning. All of these would be prohibited under the Operating Agreement, because of the Religious Directives. The impact of this was dramatized by the simple testimony that the most widely used method of contraception is tubal ligation, performed upon many women after labor and delivery. All agree this is now available at the Newport Hospital. It would not be available under the partnership with Providence's management.

Id. at 64.

³¹³ *Id.* at 67. The brief notes the following:

The Agreement with Providence will affect present or potential health care services at the beginning of life, such as assisted reproduction, tubal ligations, vasectomies, and abortion. End of life health care will also be burdened or precluded, particularly...advance Directives and physician assisted suicide under Oregon's Death With Dignity Act. . . . A similar fate awaits family planning and contraception. All of this has been amply argued previously. . . . Here, however, a different emphasis and context are presented. The [Health] District by its Agreement with Providence is sharply curtailing its role as health care provider. It has deliberately chosen a provider who will inadequately assume the [Health] District's responsibilities. [Health] District residents will have to travel great distances or go without beginning of life and end of life services. The [Health] District, through Providence, is burdening residents' interests in those services, interests which are constitutionally protected

The three sources of entitlement here—substantive statutes, organic statutes setting up the [Health] District, and the [Health] District's own Bylaws—create legitimate expectations in the citizens in the [Health] District. These interests are protected under the Due Process Clause of the Fourteenth Amendment to the United States Constitution. The Due Process Clause protects citizens of the [Health] District from the loss of liberty without Due Process of law. Liberty may be procedural, protected by the right to a hearing, or it may be “substantive”, that is, a form of “liberty” created by statutory expectancy or entitlement under state law, as noted above. There is a third form of “liberty” protected by the Fourteenth Amendment, and that consists of

liberties created by the United States Constitution itself. These liberties are endangered, unduly burdened, when government as here—arbitrarily abandons its role and curtails service, entrusting its services to a hostile provider.

The merit of—and need for—the partnership Agreement with Providence bears directly on its constitutionality. There are two grounds of Constitutional invalidity: that the First Amendment[’s] and Article I’s bars on aid to religion are violated, and that the Fourteenth Amendment Due Process protection of liberty, including choice and autonomy in health care, is infringed. These infringements can only be justified by governmental interests that are so “compelling” that the infringements are not “undue burdens.” But the Operating Agreement does not serve even minimally rational interests, let alone *compelling* interests.

John Lee and Michael Fraser testified (as did Mark May) that the [Health] District does not need to be “saved.” The [Health] District has consistently operated “in the black” and—indeed—has built \$8,000,000 in reserves over the past two decades from operating income. At most, there is a danger of financial risk faced over the next few years by small, rural hospitals. But Father John Golenski testified that the 1994 Balanced Budget Act, which cut back on hospital revenues, causing those economic difficulties, is under review and revision. His present position requires reviewing such developments for a consortium of health care and community agencies.

Id. at 67–68, 73–74.

³¹⁴ See Gallo, *supra* note 307.

³¹⁵ See Counterclaims for Damages and Injunctive Relief at 8, 12, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*) [hereinafter Counterclaims for Damages].

³¹⁶ Intervenor Providence Health System-Oregon’s Motion to Dismiss for Lack of Subject Matter Jurisdiction, *In re Gary Hoagland*, No. 00-1227 (Cir. Ct. Or. filed Mar. 16, 2000) (on file with the *Seattle Journal for Social Justice*).

³¹⁷ 42 U.S.C. § 1983 (1994).

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer’s judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

Id.; 42 U.S.C. § 1988(b) (1988).

In any action or proceeding to enforce [provisions in the vindication of civil rights] . . . the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney’s fee as part of the costs, except that in any action brought against a judicial officer for an act or omission taken in such officer’s judicial capacity such officer shall not be held liable for any costs, including attorney’s fees, unless such action was clearly in excess of such officer’s jurisdiction.

Id.

³¹⁸ *See id.*

³¹⁹ *See, e.g.,* Hewitt v. Helms, 482 U.S. 755, 760–761 (1987); Kilgour v. City of Pasadena, 53 F.3d 1007, 1010 (9th Cir. 1995) (holding that even in the absence of a favorable judgment, a litigant may be a “prevailing party” for purposes of an attorney fee award if his or her action was a “catalyst” which motivated the opponents to change their unlawful conduct); Citizens Against Tax Waste v. Westerville Sch. Dist. Bd. of Educ., 985 F.2d 255 (6th Cir. 1993) (finding citizens who brought suit which caused the Board to change its policy were a prevailing party entitled to attorney’s fees despite no final judgment or decree in the citizens’ favor).

³²⁰ Stivers v. Pierce, 71 F.3d 732, 752 (1995).

³²¹ Counterclaims for Damages, *supra* note 315, at 16.

³²² Buckhannon Bd. & Care Home, Inc. v. W. Va. Dep’t of Health & Human Res., 532 U.S. 598 (2001).

³²³ *Id.* at 605.

³²⁴ Having served as the attorney for the citizen litigators, the author would be remiss if he did not acknowledge the courage and commitment of his witnesses and clients. A number of witnesses have been noted above. Several had no stake in the case and came forward at some personal risk, as was the case with Virginia Terhaar and Lois Backus. Others, such as George Eighmey, Father Golinsky, and Merwyn Greenlich, with great professional expertise, faced substantial logistical burdens in presenting their testimony. From the Ad Hoc Committee itself, Hilda Moravick and Claudia Williams brought expertise as professionals to their roles as witnesses. No case is better than its witnesses, and we were blessed with excellent, public-spirited witnesses in Newport.

The clients are deserving of equal or higher praise. Many have been mentioned above and their invaluable contributions duly noted. Particularly deserving mention are Corrinne Williams, Norman Johnson, and Barbara Davidson, who served in leadership roles, bearing much of the exposure generated by major controversy in a small community. Carol Gundlach, herself a health care professional and consultant, made the initial contact with the author, and provided valuable expertise and a sustaining commitment, despite the demands of a practice and the pursuit of a graduate degree at Oregon State University. Hospitality and housing for an itinerant barrister were provided generously by committee members Pat Wold and Nel Ward—the latter in particular offered the top floor of a bed-and-breakfast as a war room during the trial itself.

Civil liberties and community governance in a democracy are won and sustained only by committed people, willing to take risks in the face of hazard. When Benjamin Franklin, upon leaving the Constitutional Convention in Philadelphia, was asked whether

we had a monarchy or a republic, he reportedly replied, “We have a republic, madam. If we can keep it.” I am greatly indebted to the members of the Ad Hoc Committee (as are the people of Newport) for their investment in our republic and their commitment to our Constitution.

³²⁵ See DIRECTIVES, *supra* note 7, at pt. VI, directives 68–71.

³²⁶ See Press Release, George W. Bush, Framework to Modernize and Improve Medicare Fact Sheet (Mar. 4, 2003), <http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html> (last visited Nov. 20, 2004).

³²⁷ See *Matthew 22:21*.