MANATT, PHELPS & PHILLIPS, LLP
BARRY S. LANDSBERG (Bar No. CA 117284)
E-mail: blandsberg@manatt.com
HARVEY L. ROCHMAN (Bar No. CA 162751)
E-mail: hrochman@manatt.com
JOANNA S. McCALLUM (Bar No. 187093)
E-mail: jmccallum@manatt.com
COLIN M. MCGRATH (Bar No. CA 286882)
E-mail: CMcGrath@manatt.com
2049 Century Park East
Suite 1700
Los Angeles, California 90067
Telephone: 310.312.4000
Facsimile: 310.312.4224

Attorneys for Defendant
ST. JOSEPH HEALTH NORTHERN CALIFORNIA, LLC

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF HUMBOLDT

THE PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff,

v.

ST. JOSEPH HEALTH NORTHERN CALIFORNIA, LLC AND DOES 1-10,

Defendants.

Case No. CV2401832

DEFENDANT ST. JOSEPH HEALTH NORTHERN CALIFORNIA, LLC'S REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF:

(1) MOTION TO MODIFY OR DISSOLVE STIPULATION ORDERED ON OCTOBER 29, 2024; AND

(2) OPPOSITION TO PLAINTIFF'S MOTION TO ENFORCE STIPULATION

Filed concurrently with:
(1) Defendant's Motion/Opposition Brief
(2) Declaration of the Most Revered Robert F. Vasa;
(3) Declaration of Dougal Hewitt
(4) Declaration of Sr. Sharon Becker, CSJ;
(5) Declaration of Traci Ober;

Hearing Date: August 29, 2025
Time: 10:30 a.m.
Dept.: 4

TO THE COURT, ALL PARTIES, AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE THAT Defendant St. Joseph Health Northern California, LLC hereby requests that the Court take judicial notice of the following pursuant to California Evidence Code section 452(h). All of the materials listed below are relevant to arguments made in St. Joseph Health Northern California, LLC's Demurrer to Plaintiff's Complaint.

1. The Ethical and Religious Directives for Catholic Health Care Services ("ERDs"), 6th Edition, issued by the United States Conference of Catholic Bishops (June 2018), a true and correct copy of which is attached hereto as **Exhibit 1**. This Court has previously taken judicial notice of the ERDs in this case, in its May 5, 2025 Ruling on Defendant's Demurrer to Complaint (at 4:5-6).

Judicial notice of the ERDs is proper under Evidence Code section 452(h), which permits courts to take judicial notice of "[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." Courts have taken judicial notice of the ERDs. *See Overall v. Ascension*, 23 F. Supp. 3d 816, 825 (E.D. Mich. 2014 ("This is a publication promulgated by the United States Council Conference of Bishops. The Ethical and Religious Directives are widely disseminated and must be followed by all Catholic Health Organizations. As the Ethical and Religious Directives are from a source whose accuracy cannot reasonably be questioned, the Court may take judicial notice of this document.").

2. The fact that St. Joseph Hospital – Eureka ("SJH") is required to apply the Ethical and Religious Directives on a case-by-case basis under the Conditions to Change in Control and Governance of St. Joseph Hospital of Eureka and Approval Health System Combination Agreement by and between St. Joseph Health System and Providence Health & Services and the Supplemental Agreement by and between St. Joseph Health System, Providence Health & Services, and Hoag Memorial Hospital Presbyterian ("AG Conditions – SJH-Eureka"). A true and correct copy of relevant excerpts of the AG Conditions – SJH-Eureka is attached hereto as **Exhibit 2**. This Court has previously taken judicial notice of this fact in this case, in its May 5, 2025 Ruling on Defendant's Demurrer to Complaint (at 4:5-6).

Judicial notice of this fact is proper under Evidence Code section 452(c), which permits courts to take judicial notice of "official acts of the legislative, executive, and judicial departments of the United States and any state of the United States", and section 452(h), which permits courts to take judicial notice of "[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." A copy of the full AG Conditional Consent document, which includes the AG Conditions – SJH-Eureka, is publicly available on the Attorney General's website at https://oag.ca.gov/charities/content/nonprofithosp_archive#notice-sjhs-provident (scroll down to "Notices for St. Joseph Health System and Providence Health & Services"), and also at https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/final-conditions.pdf.

3. The Stipulation and Order entered by the Court in this action on October 29, 2024 (the "Stipulation"), a true and correct copy of which is attached hereto as **Exhibit 3**. Judicial notice of the Stipulation is proper under Evidence Code section 452(d)(1), which permits courts to take judicial notice of records of "any court of this State." The Stipulation is part of this Court's file for this action, therefore it is a proper subject of judicial notice.

4. The press release issued by the AG on September 30, 2024 regarding its filing of this lawsuit. A true and correct copy of the AG's press release is attached hereto as **Exhibit 4**. Judicial notice of this fact is proper under Evidence Code section 452(c), which permits courts to take judicial notice of "official acts of the legislative, executive, and judicial departments of the United States and any state of the United States", and section 452(h), which permits courts to take judicial notice of "[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." The AG's press release is also publicly available on the AG's website, at https://oag.ca.gov/news/press-releases/attorney-general-bonta-draconian-hospital-policies-deny-emergency-abortion-care.

Dated: July 22, 2025

MANATT, PHELPS & PHILLIPS, LLP

By: _____

Harvey L. Rochman
Attorneys for Defendant
ST. JOSEPH HEALTH NORTHERN CALIFORNIA, LLC

Exhibit 1

Ethical and Religious Directives for Catholic Health Care Services

Sixth Edition

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

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

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

Digital Edition, June 2018

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Preamble

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

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

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

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

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

medical research or new requirements of public policy.

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

General Introduction

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

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

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

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

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

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

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

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

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

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

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

PART ONE
The Social Responsibility of Catholic Health Care Services

Introduction

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

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

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

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

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

Directives

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

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

3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles.

5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.

6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.[10]

7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.

8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.

9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

PART TWO
The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

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

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

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

Directives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART THREE
The Professional-Patient Relationship

Introduction

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

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

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

Directives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART FOUR
Issues in Care for the Beginning of Life

Introduction

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

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

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

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

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

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

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

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

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

Directives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

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

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

PART FIVE
Issues in Care for the Seriously Ill and Dying

Introduction

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

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

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

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

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

Directives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

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

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

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

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

morally justified, distinguishing between "formal" and "material" cooperation. *Formal* cooperation "occurs when an action, either by its very nature or by the form it takes in a concrete situation, can be defined as a direct participation in an [immoral] act . . . or a sharing in the immoral intention of the person committing it."[46] Therefore, cooperation is formal not only when the cooperator shares the intention of the wrongdoer, but also when the cooperator directly participates in the immoral act, even if the cooperator does not share the intention of the wrongdoer, but participates as a means to some other end. Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending it, or giving specific direction about carrying it out. Formal cooperation, in whatever form, is always morally wrong.

The cooperation is *material* if the one cooperating neither shares the wrongdoer's intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is causally related but not essential to the immoral act itself. While some instances of material cooperation are morally wrong, others are morally justified. There are many factors to consider when assessing whether or not material cooperation is justified, including: whether the cooperator's act is morally good or neutral in itself, how significant is its causal contribution to the wrongdoer's act, how serious is the immoral act of the wrongdoer, and how important are the goods to be preserved or the harms to be avoided by cooperating. Assessing material cooperation can be complex, and legitimate disagreements may arise over which factors are most relevant in a given case. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation.

Any moral analysis of a collaborative arrangement must also take into account the danger of scandal, which is "an attitude or behavior which leads another to do evil."[47] The cooperation of a Catholic institution with other health care entities engaged in immoral activities, even when such cooperation is morally justified in all other respects, might, in certain cases, lead people to conclude that those activities are morally acceptable. This could lead people to sin. The danger of scandal, therefore, needs to be carefully evaluated in each case. In some cases, the danger of scandal can be mitigated by certain measures, such as providing an explanation as to why the Catholic institution is cooperating in this way at this time. In any event, prudential judgments that take into account the particular circumstances need to be made about the risk and degree of scandal and about whether they can be effectively addressed.

Even when there are good reasons for establishing collaborative arrangements that involve material cooperation with wrongdoing, leaders of Catholic healthcare institutions must assess whether becoming associated with the wrongdoing of a collaborator will risk undermining their institution's ability to fulfill its mission of providing health care as a witness to the Catholic faith and an embodiment of Jesus' concern for the sick. They must do everything they can to ensure that the integrity of the Church's witness to Christ and his Gospel is not adversely affected by a collaborative arrangement.

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

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

Directives

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

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

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

Conclusion

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

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

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

Notes

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

Holy Spirit."

15. Cf. c. 883, 3º.

16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.

17. Cf. directive 53.

18. *Declaration on Euthanasia,* Part IV; cf. also directives 56-57.

19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810.

20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical Association," *Acta Apostolicae Sedis* 76 (1984): 390.

21. Second Vatican Ecumenical Council, *Pastoral Constitution on the Church in the Modern World* (*Gaudium et Spes*) (1965), no. 49.

22. Ibid., no. 50.

23. Pope Paul VI, Encyclical Letter *On the Regulation of Birth* (*Humanae Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 14.

24. Ibid., no. 12.

25. Pope John XXIII, Encyclical Letter *Mater et Magistra* (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae,* no. 4.

26. Pope John Paul II, Encyclical Letter *The Splendor of Truth* (*Veritatis Splendor*) (Washington, DC: United States Conference of Catholic Bishops, 1993), no. 50.

27. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose" (*Donum Vitae,* Part II, B, no. 6; cf. also Part I, nos. 1, 6).

28. Ibid., Part II, A, no. 2.

29. "Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes "the full sense of mutual self-giving and human procreation in the context of true love"'" (*Donum Vitae,* Part II, B, no. 6).

30. Ibid., Part II, A, no. 3.

31. Cf. directive 45.

32. *Donum Vitae,* Part I, no. 2.

33. Cf. ibid., no. 4. (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.

34. Cf. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, *Origins* 24 (1994): 211-212.

35. Pope John Paul II, Apostolic Letter *On the Christian Meaning of Human Suffering* (*Salvifici Doloris*) (Washington, DC: United States Conference of Catholic Bishops, 1984), nos. 25-27.

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

37. See *Declaration on Euthanasia.*

38. Ibid., Part II.

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

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

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

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

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

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

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

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

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

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

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

Exhibit 2

Conditions to Change in Control and Governance of St. Joseph Hospital of Eureka[1] and Approval Health System Combination Agreement by and between St. Joseph Health System and Providence Health & Services and the Supplemental Agreement by and between St. Joseph Health System, Providence Health & Services, and Hoag Memorial Hospital Presbyterian

I.

These Conditions shall be legally binding on the following entities: Providence St. Joseph Health, a Washington nonprofit corporation, Providence Health & Services, a Washington nonprofit corporation, St. Joseph Health System, a California nonprofit public benefit corporation, St. Joseph Health Ministry, a California nonprofit public benefit corporation, Covenant Health Network, Inc., a California nonprofit public benefit corporation, St. Mary Medical Center, a California nonprofit public benefit corporation, St. Joseph Hospital of Eureka (St. Joseph Hospital of Eureka Corporation), a California nonprofit public benefit corporation, Redwood Memorial Hospital of Fortuna, California nonprofit public benefit corporation, Queen of the Valley Medical Center, a California nonprofit public benefit corporation, Hoag Memorial Hospital Presbyterian, a California nonprofit public benefit corporation, Mission Hospital Regional Medical Center, a California nonprofit public benefit corporation, St. Joseph Hospital of Orange, a California nonprofit public benefit corporation, St. Jude Hospital, a California nonprofit public benefit corporation, Santa Rosa Memorial Hospital, a California Nonprofit public benefit corporation, SRM Alliance Hospital Services, a California nonprofit public benefit corporation, Providence Health System – Southern California, a California nonprofit religious corporation, Providence Saint John's Health Center, a California nonprofit religious corporation, any other subsidiary, parent, general partner, limited partner, member, affiliate, successor, successor in interest, assignee, or person or entity serving in a similar capacity of any of the above-listed entities, any entity succeeding thereto as a result of consolidation, affiliation, merger, or acquisition of all or substantially all of the real property or operating assets of St. Joseph Hospital of Eureka, or the real property on which St. Joseph Hospital is located, any and all current and future owners, lessees, licensees, or operators of St. Joseph Hospital of Eureka, and any and all current and future lessees and owners of the real property on which St. Joseph Hospital of Eureka is located.

II.

The transaction approved by the Attorney General consists of the Health System Combination Agreement by and between St. Joseph Health System and Providence Health & Services, dated November 23, 2015, and the Supplemental Agreement made and entered into by and between St. Joseph Health System, Providence Health & Services, and Hoag Memorial Hospital

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[1] Throughout this document, the term "St. Joseph Hospital of Eureka" shall mean the general acute care hospital located at 2700 Dolbeer St., Eureka, CA 95501-4736, and "The General Hospital" located at 2200 Harrison Ave., Eureka, CA 95501-3215, and any other clinics, laboratories, units, services, or beds included on the license issued to St. Joseph Hospital of Eureka (also referred to as St. Joseph Hospital) by the California Department of Public Health, effective November 1, 2015, unless otherwise indicated.

Presbyterian, dated September 30, 2015, and any and all amendments, agreements, or documents referenced in or attached to as an exhibit or schedule to the Health System Combination Agreement and the Supplemental Agreement.

All of the entities listed in Condition I shall fulfill the terms of these agreements or documents and shall notify the Attorney General in writing of any proposed modification or rescission of any of the terms of these agreements or documents. Such notifications shall be provided at least sixty days prior to their effective date in order to allow the Attorney General to consider whether they affect the factors set forth in Corporations Code section 5923.

III.

For eleven fiscal years from the closing date of the Health System Combination Agreement, Providence St. Joseph Health, St. Joseph Health System, St. Joseph Hospital of Eureka Corporation, and all future owners, managers, lessees, licensees, or operators of St. Joseph Hospital of Eureka shall be required to provide written notice to the Attorney General sixty days prior to entering into any agreement or transaction to do any of the following:

(a) Sell, transfer, lease, exchange, option, convey, manage, or otherwise dispose of St. Joseph Hospital of Eureka; or

(b) Transfer control, responsibility, management, or governance of St. Joseph Hospital of Eureka. The substitution or addition of a new corporate member or members of Providence St. Joseph Health, St. Joseph Health System, or St. Joseph Hospital of Eureka Corporation that transfers the control of, responsibility for, or governance of St. Joseph Hospital of Eureka shall be deemed a transfer for purposes of this Condition. The substitution or addition of one or more members of the governing bodies of Providence St. Joseph Health, St. Joseph Health System, or St. Joseph Hospital of Eureka Corporation, or any arrangement, written or oral, that would transfer voting control of the members of the governing bodies of Providence St. Joseph Health, St. Joseph Health System, or St. Joseph Hospital of Eureka Corporation shall also be deemed a transfer for purposes of this Condition.

IV.

For ten years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall operate and maintain St. Joseph Hospital of Eureka as a licensed general acute care hospital (as defined in California Health and Safety Code Section 1250).

V.

For five years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall maintain and provide the following 24-hour emergency medical services at current[2] licensure and designation with the current types and/or levels of services at St. Joseph Hospital of Eureka:

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[2] The term "current" or "currently" throughout this document means as of November 1, 2015.

a) 20 emergency treatment stations at a minimum and designation as a Modified Base Hospital; and
b) Sexual Assault Response Team.

VI.

For five years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall maintain and provide the following healthcare services at current licensure and designation with the current types and/or levels of services at St. Joseph Hospital of Eureka:

a) Cardiac services, including a minimum of two cardiac catheterization labs;
b) Intensive care services, including a minimum of 8 intensive care beds and 4 coronary care beds;
c) Obstetrics services, including a minimum of 11 obstetrics beds;
d) Neonatal intensive care services, including a minimum of 5 neonatal intensive care beds and designation as a Level II Neonatal Intensive Care Unit;
e) Pediatric services; and
f) Inpatient and outpatient rehabilitation services, including a minimum of 10 rehabilitation beds to be provided at either St. Joseph Hospital-Eureka or Redwood Memorial Hospital;
g) The Care Transitions Program; and
h) Women's services, including digital mammography and stereotactic breast biopsy and those services provided at the Diagnostic Imaging Services Outpatient Imaging Center.

St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall not place all or any portion of the above-listed licensed-bed capacity or services in voluntary suspension or surrender its license for any of these beds or services.

VII.

For five years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall maintain and provide the following healthcare services at St. Joseph Hospital of Eureka at current licensure and designation with the current types and/or levels of services as committed to in Exhibit 8.13 of the Health System Combination Agreement attached hereto as Exhibit 1:

a) Cancer care services;
b) Gastroenterology services;
c) Imaging/radiology services;
d) Interventional radiology services;
e) Laboratory services;
f) Neurosciences services;
g) Orthopedics services;
h) Palliative care services; and
i) Surgical services.

Within the first year after the closing date of the Health System Combination Agreement, Providence Health & Services, St. Joseph Health System, and Providence St. Joseph Health shall begin implementation of the Providence Health & Services' Clinical Institutes' program across the system in order to deliver better patient outcomes across the most common conditions causing hospitalization. Such implementation shall include the areas of cancer care and musculoskeletal disease. Within two years after the closing date of the Health System Combination Agreement, Providence Health & Services, St. Joseph Health System, and Providence St. Joseph Health implementation of the Providence Health & Services' Clinical Institutes' program shall also include the areas of neurosciences, cardiovascular, and digestive health.

VIII.

For five years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall:

a) Be certified to participate in the Medi-Cal program at St. Joseph Hospital of Eureka;

b) Maintain and have Medi-Cal Managed Care contracts with Partnership Health Plan or its successor, to provide the same types and levels of emergency and non-emergency services at St. Joseph Hospital of Eureka to Medi-Cal beneficiaries (both Traditional Medi-Cal and Medi-Cal Managed Care) as required in these Conditions, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service or diminution in quality, or gap in contracted hospital coverage, unless the contract is terminated for cause; and

c) Be certified to participate in the Medicare program by maintaining a Medicare Provider Number to provide the same types and levels of emergency and non-emergency services at St. Joseph Hospital of Eureka to Medicare beneficiaries (both Traditional Medicare and Medicare Managed Care) as required in these Conditions.

IX.

For six fiscal years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall provide an annual amount of Charity Care (as defined below) at St. Joseph Hospital of Eureka equal to or greater than $2,061,068 (the Minimum Charity Care Amount). For purposes hereof, the term "charity care" shall mean the amount of charity care costs (not charges) incurred by St. Joseph Health System and St. Joseph Hospital of Eureka Corporation in connection with the operation and provision of services at St. Joseph Hospital of Eureka. The definition and methodology for calculating "charity care" and the methodology for calculating "costs" shall be the same as that used by Office of Statewide Health Planning Development (OSHPD) for annual hospital reporting purposes.[3] St. Joseph Health System and St. Joseph Hospital of Eureka Corporation

[3] OSHPD defines charity care by contrasting charity care and bad debt. According to OSHPD, "the determination of what is classified as . . . charity care can be made by establishing whether

shall use and maintain a charity care policy that is no less favorable than its current charity care policy at St. Joseph Hospital of Eureka and in compliance with California and Federal law.

St. Joseph Health System's and St. Joseph Hospital of Eureka Corporation's obligation under this Condition shall be prorated on a daily basis if the closing date of the Health System Combination Agreement is a date other than the first day of St. Joseph Health System's and St. Joseph Hospital of Eureka Corporation's fiscal year.

For the second fiscal year and each subsequent fiscal year, the Minimum Charity Care Amount shall be increased (but not decreased) on an annual basis by the rate of inflation as measured by the Consumer Price Index for the West Region.

After the closing date of the Health System Combination Agreement, if the actual amount of charity care provided at St. Joseph Hospital of Eureka for any fiscal year is less than the Minimum Charity Care Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such fiscal year, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall pay an amount equal to the deficiency to one or more tax-exempt entities that provide direct health care services to residents in St. Joseph Hospital of Eureka's service area (40 ZIP codes), as defined on page 50 of the Health Care Impact Report, dated March 28, 2016, and attached hereto as Exhibit 2. Such payment(s) shall be made within four months following the end of such fiscal year.

The 2010 Federal Patient Protection and Affordable Care Act may cause a reduction in future needs of charity care. Any actual reduction will be considered "unforeseen" for purposes of Title 11, California Code of Regulations, section 999.5, subdivision (h).

X.

For six fiscal years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall provide an annual amount of Community Benefit Services at St. Joseph Hospital of Eureka equal to or greater than $2,668,736 (the "Minimum Community Benefit Services Amount") exclusive of any funds from grants. For six fiscal years, the following community benefit programs and services shall continue to be offered:

a) Healthy Kids Humboldt;
b) Evergreen Lodge Cancer Patient Housing; and
c) Support for Humboldt Open Door Clinic.

St. Joseph Health System's and St. Joseph Hospital of Eureka Corporation's obligation under this Condition shall be prorated on a daily basis if the effective date of the Health System Combination Agreement is a date other than the first day of St. Joseph Health System's and St. Joseph Hospital of Eureka Corporation's fiscal year.

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or not the patient has the ability to pay. The patient's accounts receivable must be written off as bad debt if the patient has the ability but is unwilling to pay off the account."

For the second fiscal year and each subsequent fiscal year, the Minimum Community Benefit Services Amount shall be increased (but not decreased) on an annual basis by the rate of inflation as measured by the Consumer Price Index for the West Region.

If the actual amount of community benefit services provided at St. Joseph Hospital of Eureka for any fiscal year is less than the Minimum Community Benefit Services Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such fiscal year, St. Joseph Health System, and St. Joseph Hospital of Eureka shall pay an amount equal to the deficiency to one or more tax-exempt entities that provide community benefit services for residents in St. Joseph Hospital of Eureka's service area (40 ZIP codes), as defined on page 50 of the Health Care Impact Report, dated March 28, 2016, and attached hereto as Exhibit 2. Such payment(s) shall be made within four months following the end of such fiscal year.

XI.

For five years from the closing date of the Health System Combination Agreement, St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall maintain their contracts, including any superseding, successor, or replacement contracts, and any amendments and exhibits thereto with the County of Humboldt and/or its subdivisions, departments, or agencies for services at St. Joseph Hospital of Eureka including the following[4]:

a) Behavioral Health Agreement, dated January 1, 2015;
b) Use of Short Wave Radio Equipment Agreement dated January 3, 1995;
c) Memorandum of Understanding for Death Review Panel, dated February 1, 2001;
d) Charter Agreement dated January 1, 2006;
e) Memorandum of Understanding, related to Healthy Kids Humboldt Program, dated February 14, 2012;
f) Modified Base Hospital Medical Control Agreement, dated July 21, 2012;
g) Agreement for Services, related to CalFresh Program, dated January 5, 2016;
h) Service Agreement for Hospital Services with the Mental Health Branch, dated December 16, 2014 and December 16, 2015;
i) Memorandum of Understanding for 340B Program, dated January 1, 2015;
j) Work Exploration Agreement for High School Students, dated February 3, 2014;
k) Memorandum of Understanding Between the Humboldt County Department of Health and Human Services, Public Health Branch and Contractor [St. Joseph Hospital], related to the transfer of medical surge assets, dated June 21, 2012; and
l) Reciprocal Transfer Agreement, dated June 7, 2014.

[4] The dates referenced in this Condition are either the date the agreement was entered into, the date the agreement was executed, in the title of the agreement, or the original or current effective date of the agreement.

XII.

Providence St. Joseph Health, St. Joseph Health System, and St. Joseph Hospital of Eureka Corporation shall commit the necessary investments required to meet and maintain OSHPD seismic compliance requirements at St. Joseph Hospital of Eureka through 2030 under the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act, (Health & Saf. Code, § 129675-130070).

XIII.

Providence St. Joseph Health, St. Joseph Health System, and St. Joseph Hospital of Eureka Corporation shall complete any capital projects as committed to in the Health System Combination Agreement and the Supplemental Agreement.

Within the first three years after the closing date of the Health System Combination Agreement, Providence Health & Services, St. Joseph Health System, and Providence St. Joseph Health shall implement a mental health initiative, with an initial expenditure of $30 million, in the California communities served by their local ministries ($10 million per year for each of the first 3 years after the closing date). These funds will be expended solely in California and will be used to identify and address the treatment and causes of mental illness including, but not limited to, mental health counseling, disorders affecting children, depressive disorders, psychotic disorders, treatment for addictive behavior, homelessness and other root causes and effects of mental illness.

XIV.

St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall maintain privileges for current medical staff at St. Joseph Hospital of Eureka who are in good standing as of the closing date of the Health System Combination Agreement. Further, the closing of the Health System Combination Agreement shall not change the medical staff officers, committee chairs, or independence of the medical staff, and such persons shall remain in good standing for the remainder of their tenure at St. Joseph Hospital of Eureka.

For eleven fiscal years after the closing date of the Health System Combination Agreement, all of the entities listed in Condition I shall continue to maintain multi-disciplinary local ministry ethics teams at each hospital and the teams shall consist of physicians, nurses, social workers, chaplains, and ethicists. The application of the Ethical and Religious Directives shall continue to be conducted on a case-by-case basis taking into account the clinical and ethical factors presented in each case by the multi-disciplinary local ministry ethics teams.

XV.

There shall be no discrimination against any lesbian, gay, bisexual, or transgender individuals at St. Joseph Hospital of Eureka. This prohibition must be explicitly set forth in St. Joseph Hospital of Eureka Corporation's written policies, adhered to, and strictly enforced.

XVI.

For eleven fiscal years from the closing date of the Health System Combination Agreement St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall submit to the Attorney General, no later than four months after the conclusion of each fiscal year, a report describing in detail compliance with each Condition set forth herein.

Such report shall also describe in detail the specific steps taken by all of the entities listed in Condition I and provide any supporting and objective evidence and documentation that set forth how the below enumerated transaction benefits are being accomplished with respect to all of the entities listed in Condition I:

a) Optimize clinical services and health benefits;

b) Expand community benefit programs;

c) Achieve greater affordability and access for health care services;

d) Share clinical and administrative best practices across regions and communities;

e) Promote outstanding clinical care and greatly improve the patient experience;

f) Develop the necessary infrastructure for a population health management effort that truly advances healthier communities;

g) Advance innovations in health care that will benefit future generations;

h) Create broader opportunities for advocacy in connection with social justice, with particular emphasis on the poor and vulnerable;

i) Make possible closer integration and/or adoption of specific programs to address the needs of the poor and vulnerable;

j) Enhance the delivery of health care through a nonprofit, charitable model;

k) Improve patient access, patient safety, the quality, continuity and coordination of care and improved patient satisfaction with the care and service provided, utilizing a holistic approach focused on the body, mind and spirit;

l) Develop a stronger infrastructure, including clinical and administrative expertise, for serving specific populations, such as Medi-Cal and the uninsured, in order to promote the health of recipients and use resources more effectively;

m) Provide a greater ability to combine and coordinate the response to community needs across increased scale and a broader geography;

n) Spread and adopt the triple aim in the areas of clinical expertise, growth, diversification, innovation and shared services;

o) Obtain specific financial benefits through access to capital through the creation of a single obligated group that will allow both health systems to become jointly and severally liable for all combined organization tax-exempt debt, allocate risk and optimize borrowing strategy for all of the entities listed in Condition I;

p) Strengthen and enhance the work environment for all of the entities listed in Condition I;

q) Support the ability of all of the entities listed in Condition I to attract and retain the talent and expertise required to best serve community needs, including but not limited to, clinical talent to those particular communities where it has previously been challenging to do so;

r) Maintain and enhance medical group management infrastructure to benefit clinical practice, including sharing of clinical and administrative best practices;

s) Pursue innovations in virtual healthcare and wellness;

t) Provide cost-effective care to the communities served by all of the entities listed in Condition I with a special attention to the poor and vulnerable;

u) Patient benefits from the anticipated stronger infrastructure;

v) Patient benefits from the creation of new programs to fully advance the hospital systems' charitable missions;

w) Community benefits from the anticipated unprecedented service and community benefit guarantees; and

x) Community, particularly the poor and vulnerable, benefits from the strengthened healthcare systems.

Such report shall also include a copy of the following documents with respect to all of the entities listed in Condition I:

a) Copies, if any, of new contractual arrangements with any of their affiliated or joint-venture providers, hospitals, surgery, ambulatory or medical centers, facilities, practice or physician groups, and other entities providing medical services for or on behalf of the entities listed in Condition I under these new contracts;

b) Any new notices to insurers, insureds, other health care providers or competitors, or government regulators regarding the addition of any newly-affiliated medical provider to the entities listed in Condition I; and

c) All new studies, analyses, and evaluations of or documents referring to the identity of any patient service areas, and geographic and product markets of each of the providers, independent physician associations, groups, centers, facilities, hospitals, centers, and affiliates owned or operated by the entities listed in Condition I providing medical services under any of the entities listed in Condition I's contracts.

The Chairman(s) of the Board of Directors of both St. Joseph Health System and St. Joseph Hospital of Eureka Corporation and the Chief Executive Officers of both St. Joseph Health System and St. Joseph Hospital of Eureka Corporation shall each certify that the report is true, accurate, and complete and provide documentation of the review and approval of the report by both Boards of Directors.

XVII.

At the request of the Attorney General, all of the entities listed in Condition I shall provide such information as is reasonably necessary for the Attorney General to monitor compliance with these Conditions and the terms of the transaction as set forth herein. The Attorney General shall, at the request of a party and to the extent provided by law, keep confidential any information so produced to the extent that such information is a trade secret or is privileged under state or federal law, or if the private interest in maintaining confidentiality clearly outweighs the public interest in disclosure.

XVIII.

Once the Health System Combination Agreement is closed, all of the entities listed in Condition I are deemed to have explicitly and implicitly consented to the applicability and compliance with each and every Condition and to have waived any right to seek judicial relief with respect to each and every Condition.

The Attorney General reserves the right to enforce each and every Condition set forth herein to the fullest extent provided by law. In addition to any legal remedies the Attorney General may have, the Attorney General shall be entitled to specific performance, injunctive relief, and such other equitable remedies as a court may deem appropriate for breach of any of these Conditions. Pursuant to Government Code section 12598, the Attorney General's office shall also be entitled to recover its attorney fees and costs incurred in remedying each and every violation.

Exhibit 8.13

Service Commitments

The Service Commitments of the Parties, as referenced in Section 8.13 of the Health System Combination Agreement, are set forth in Paragraphs 1.0 through 9.0 below.

1.0 List of California General Acute Care Hospitals. For the purposes of this Exhibit 8.13, each general acute care hospital sponsored by either SJHS or PH&S, and located in the State of California, is set forth in the chart immediately below.

Providence Health & Services and St. Joseph Health
Combined System Hospital Overview
Fiscal Year 2015

Hospitals
St. Mary Medical Center
Redwood Memorial Hospital
St. Joseph Hospital, Eureka
Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center
Providence Little Company of Mary Medical Center San Pedro
Providence Little Company of Mary Medical Center Torrance
Saint John's Health Center
Queen of the Valley Medical Center
Hoag Hospital - Newport Beach
Hoag Hospital - Irvine
Mission Hospital - Laguna Beach
Mission Hospital - Mission Viejo
St. Joseph Hospital of Orange
St. Jude Medical Center
Santa Rosa Memorial Hospital
Petaluma Valley Hospital

Source: Providence Health & Services and St. Joseph Health

For the purposes of this Exhibit 8.13, each of the foregoing acute care hospitals – with the exception of Providence Saint John's Health Center, Hoag Hospital-Newport Beach, Hoag Hospital-Irvine, and Petaluma Valley Hospital (which are discussed in Paragraphs 8.0 and 9.0 below, respectively) – is referred to herein as a "Hospital."

2.0 Licensed Acute Care Hospital Commitment. For a period of five (5) years from the Closing, SJHS and PH&S, individually or jointly or through NewCo, shall cause each Hospital to continue to be operated and maintained as a licensed general acute care hospital, as defined in California Health and Safety Code § 1250.

3.0 **Specialty Service Commitments.** For a period of five (5) years from the Closing, SJHS and PH&S, individually or jointly or through NewCo, shall operate and maintain certain specified services at each of the Hospitals, as set forth in Sections 3.0(a) and 3.0(b) below.

(a) **Emergency Department Commitment.** For a period of five (5) years from the Closing, each Hospital shall continue to maintain and provide twenty-four emergency medical services as currently licensed, with the same number of emergency beds/stations and with the same types of levels of service as provided as of the Closing.[1]

(b) **Service Line Commitment.** For a period of five (5) years from the Closing, each Hospital shall continue to provide the health care services listed for each corresponding Hospital as specified in the tables below:

SJHS Sponsored Hospitals

St. Jude Medical Center Programs and Services
Anesthesia Services
Cancer Care
Cardiac Center
Emergency Services (24-hour)
Gastroenterology
Imaging/Radiology Services
Interventional Radiology
Laboratory Services
Neurosciences
Obstetrics
Orthopedics/NICU
Palliative Care
Pathology Services
Rehabilitation Services
Senior Services
Speech Therapy
Surgical Services
Wellness & Fitness
Women's Services
Wound Care

Mission Hospital Programs and Services
Behavioral Health
▪ Inpatient Services
▪ Outpatient Services
Cancer Care
Cardiac Services
Diabetes Care
Emergency Services (24-hour)
Gastroenterology
Imaging/Radiology Services
Intensive Care Unit (ICU)
Laboratory Services
Neurosciences
Obstetrics/NICU
Orthopedics
Pediatric Services
Respiratory Care
Rehabilitation Services
Surgical Services
Trauma Care
Vascular Services
Women's Services

[1] This commitment is subject to reasonable and/or necessary temporary reductions in the number of emergency beds / stations in the event of construction intended to expand emergency department capacity.

St. Mary Medical Center Programs and Services

Cardiac Center
Diabetes Care
Emergency Services (24-hour)
Imaging/Radiology
Intensive Care Unit (ICU)
Laboratory Services
Obstetrics/NICU
Rehabilitation Services
Surgical Services
Women's Services
Wound Care

Queen of the Valley Medical Center Programs and Services

Cancer Care
Cardiac Center
Emergency Services (24-hour)
Imaging/Radiology
Interventional Radiology
Intensive Care Unit (ICU)
Laboratory Services
Neurosciences
Obstetrics/NICU
Orthopedics
Palliative Care
Rehabilitation Services
Surgical Services
Wellness Center
Women's Services
Wound Care

Santa Rosa Memorial Hospital Programs and Services

Bariatric Surgery
Behavioral Health
- Outpatient Services
- Partial Hospital Program

Cancer Care
Cardiac Center
Emergency Services (24-hour)
Imaging/Radiology
Interventional Radiology
Intensive Care Unit (ICU)
Laboratory Services
Neurosciences
Obstetrics
Orthopedics
Palliative Care
Rehabilitation Services
Surgical Services
Trauma Care
Vascular Services
Women's Services

Saint Joseph Hospital - Orange
Programs and Services

- Anesthesia Services
- Bariatric Surgery
- Behavioral Health
  - Inpatient Services
  - Outpatient Services
- Cancer Care
- Cardiac Center
- Emergency Services (24-hour)
- Gastroenterology
- Imaging/Radiology
- Interventional Radiology
- Intensive Care Unit (ICU)
- Kidney Dialysis Center
- Laboratory Services
- Neurosciences
- Obstetrics
- Ophthalmology
- Orthopedics
- Palliative Care
- Rehabilitation Services
- Surgical Services
- Urology
- Women's Services
- Wound Care

Petaluma Valley Hospital
Programs and Services

- Cancer Care
- Emergency Services (24-hour)
- Imaging/Radiology
- Intensive Care Unit (ICU)
- Laboratory Services
- Obstetrics
- Orthopedics
- Palliative Care
- Rehabilitation Services
- Vascular Services
- Women's Services

St. Joseph Hospital - Eureka
Programs and Services

- Cancer Care
- Cardiac Center
- Emergency Services (24-hour)
- Gastroenterology
- Imaging/Radiology
- Interventional Radiology
- Intensive Care Unit (ICU)
- Laboratory Services
- Neurosciences
- Obstetrics/NICU
- Orthopedics
- Palliative Care
- Rehabilitation Services
- Surgical Services

Redwood Memorial Hospital
Programs and Services

- Cancer Care
- Cardiac Center
- Emergency Services (24-hour)
- Gastroenterology
- Imaging/Radiology
- Intensive Care Unit (ICU)
- Laboratory Services
- Neurosciences
- Obstetrics
- Orthopedics
- Palliative Care
- Rehabilitation Services
- Surgical Services

PH&S Sponsored Hospitals

Providence Holy Cross Medical Center Programs and Services

- Ambulatory Surgery
- Cancer Care
- Cardiac Catheterization
- Cardiology
- Emergency Services (24-hour) Paramedic Base Station
- Endoscopy
- Imaging/Radiology
- Intensive Care
- Interventional Radiology
- Laboratory Services
- Neurosciences
- Orthopedics
- Palliative Care
- Pulmonary Services
- Rehabilitation Services
- Sub-Acute
- Telemetry
- Trauma Program
- Vascular Services
- Women's Health Services
  - Obstetrics
  - NICU

Providence Little Company of Mary Medical Center San Pedro Programs and Services

- Acute Psychiatric Services
- Cancer Care
- Center for Optimal Aging (Senior Services)
- Chemical Dependency
- Community Outreach
- Diabetes Care
- Emergency Services (24-hour)
- Endocrinology
- Imaging/Radiology Services
- Intensive Care Unit (ICU)
- Internal Medicine
- Laboratory Services
- Neurosciences
- Nutritional Services
- Palliative Care
- Pathology Services
- Psychiatric Services
- Rehabilitation Services
- Respiratory Care
- Spiritual Care Services
- Surgery Specialties
- Sub-Acute Care
- Women Health Services
  - Obstetrics
- Wound Care

Providence Little Company of Mary Medical Center Torrance
Programs and Services

- Blood Donor Center
- Cancer Care
- Cardiac & Vascular Services
- Community Outreach
- Emergency Services (24-hour)
- Diabetes Care
- Endocrinology
- Imaging/Radiology Services
- Intensive Care Unit (ICU)
- Internal Medicine
- Laboratory Services
- Neurosciences
- Nutritional Services
- Orthopedics
- Palliative Care
- Pathology Services
- Pediatric Services
- Respiratory Care
- Spiritual Care Services
- Surgical Services
- Rehabilitation Services
- Urology
- Volunteer Services
- Women's Health Services
  - Obstetrics
  - NICU
- Wound Care

Providence Saint Joseph Medical Center
Programs and Services

- Ambulatory Surgery
- Cancer Care
- Cardiac Catheterization
- Cardiology
- Emergency Services (24-hour)
- Paramedic Base Station
- Endoscopy
- Imaging/Radiology
- Intensive Care
- Interventional Radiology
- Laboratory Services
- Neurosciences
- Orthopedics
- Obstetrics/NICU
- Palliative Care
- Pulmonary Services
- Rehabilitation Services
- Surgical Services
- Telemetry
- Vascular Services
- Women's Health Services
  - Obstetrics
  - NICU

Providence Tarzana Medical Center Programs and Services
Ambulatory Surgery
Cancer Care
Cardiac Catheterization
Cardiology
Emergency Services (24-hour)
Endoscopy
Imaging/Radiology
Intensive Care
Interventional Radiology
Laboratory Services
Neurosciences
Orthopedics
Obstetrics/NICU
Palliative Care
Pediatric Services / Pediatric Intensive Care
Pulmonary Services
Surgical Services
Telemetry
Vascular Services
Women's Health Services
■ Obstetrics
■ NICU

4.0 Medicare / Medi-Cal Commitment. For a period of five (5) years from the Closing, SJHS and PH&S, individually or jointly or through NewCo, shall, at each Hospital:

(A) Continue to be certified to participate in the Medicare program and have a Medicare provider number to provide the same types and levels of emergency and non-emergency services as provided as of the Closing.

(B) Continue to be certified to participate in the Medi-Cal program, and continue to maintain Medi-Cal Managed Care contracts, on competitive terms, that provide the same types of and levels of emergency services and non-emergency services as the Parties' existing Medi-Cal Managed Care contracts.

5.0 City/County Contract Commitment: For a period of five (5) years from the Closing, each Hospital shall maintain each contract it has entered into with any City or County as specified on Attachment A (City/County Contract Commitments) attached hereto, unless any such contract is terminated for cause or expires in accordance with its current terms.

(continued on next page)

6.0 Charity Care Commitment. For a period of five (5) years from the Closing, SJHS and PH&S, individually or jointly or through NewCo, shall, at each Hospital, provide an annual amount of charity care (the "Minimum Charity Care Amount") that is no less than the amount set forth in the "2014-2015 Average" column for the corresponding Hospital in the chart below:

Providence Health & Services and St. Joseph Health
Cost of Charity Care Summary
Fiscal Years 2014 to 2015

Hospital	Cost of Charity to Hospital		
	2014	2015[1]	2014 - 2015 Average
St. Mary Medical Center	$7,912,528	$4,121,065	$6,016,797
Redwood Memorial Hospital	$731,156	$577,891	$654,523
St. Joseph Hospital, Eureka	$1,790,044	$1,653,541	$1,721,792
Providence Holy Cross Medical Center	$5,634,497	$4,762,251	$5,198,374
Providence Saint Joseph Medical Center	$7,319,026	$3,056,824	$5,187,925
Providence Tarzana Medical Center	$2,522,462	$1,347,479	$1,934,970
Providence Little Company of Mary Medical Center San Pedro	$2,523,959	$1,189,510	$1,856,734
Providence Little Company of Mary Medical Center Torrance	$8,767,281	$3,868,858	$6,318,069
Saint John's Health Center	Subject to AG Conditional Consent January 14, 2014		
Queen of the Valley Medical Center	$2,041,891	$1,728,615	$1,885,253
Hoag Hospital - Newport Beach and Irvine	Subject to AG Conditional Consent February 8, 2013		
Mission Hospital - Mission Viejo and Laguna Beach [2]	$7,229,156	$4,803,937	$6,016,546
St. Joseph Hospital of Orange	$9,904,721	$7,573,418	$8,739,069
St. Jude Medical Center	$7,737,027	$5,705,177	$6,721,102
Petaluma Valley Hospital	$1,132,221	$838,880	$985,550
Santa Rosa Memorial Hospital	$5,519,696	$5,230,452	$5,375,074
Total	**$70,765,664**	**$46,457,897**	**$58,611,780**

Source: OSHPD Financial Disclosure Reports (2014 figures), St. Joseph Health (2015 figures)
Note: Hoag Hospital and Saint John's Health Center charity care numbers are currently the subject of Attorney General conditions from prior transactions.
(1) FY 2014 cost-to-charge ratio applied to 2015 charity charges to calculate cost of charity to hospital. Providence 2015 data is a year-to-date annualized estimate.
(2) Mission Hospital - Mission Viejo and Mission Hospital - Laguna Beach financials are combined and submitted jointly to OSHPD.

This commitment shall be prorated on a daily basis if the Closing occurs on a date other than the first day of the Parties' fiscal year. For the second fiscal year and each subsequent fiscal year, the Minimum Charity Care Amount shall be increased (but not decreased) by an amount equal to the Annual Percent increase, if any, in the 12-Month Percent Change: Consumer Price Index – All Urban Consumers in the West Region, West Urban Area, Base Period: 1982-84=100 (CPI-West Region, as published by the U.S. Bureau of Labor Statistics). Each Hospital shall have charity care and collection policies that comply with Federal and California law.

7.0 Community Benefit Program Commitment. For a period of five (5) years from the Closing, SJHS and PH&S, individually or jointly or through NewCo, shall, at each Hospital, provide an annual amount of Community Benefit Services (the "Minimum Community Benefit Services Amount") that is no less than the amount set forth in the "Hospital Commitment" column for the corresponding Hospital in the chart below:

Providence Health and Services and St. Joseph Health System
Community Benefit Expenditures by Ministry[1]
Calendar Years 2011 to 2014

Hospital	2011	2012	2013	2014	Hospital Commitment[2]
Providence Holy Cross Medical Center	$1,044,252	$933,328	$1,050,720	$972,003	$1,000,076
Providence Little Company of Mary San Pedro	$1,836,161	$1,706,993	$1,629,022	$1,503,131	$1,668,827
Providence Little Company of Mary Torrance	$4,232,362	$2,254,286	$2,057,692	$1,896,081	$2,610,105
Providence Saint John's Health Center	Subject to AG Commitment January 14, 2014				$3,374,251
Providence Saint Joseph Medical Center	$1,172,156	$929,028	$1,058,582	$1,155,121	$1,078,722
Providence Tarzana Medical Center	$612,236	$496,883	$476,211	$801,568	$596,725
Hoag Hospital - Newport Beach and Irvine	Subject to AG Commitment February 8, 2013				$9,500,000
Mission Hospital - Mission Viejo and Laguna Beach [3]	$5,654,285	$4,775,844	$4,404,037	$4,916,303	$4,937,617
Petaluma Valley Hospital	$10,000	$92,749	$113,748	$176,846	$98,336
Queen of the Valley Medical Center	$3,215,957	$2,888,321	$3,298,694	$3,465,017	$3,216,997
Redwood Memorial Hospital	$980,213	$715,227	$793,338	$417,839	$726,654
Santa Rosa Memorial Hospital	$1,844,388	$2,135,826	$2,668,956	$2,982,791	$2,407,990
St. Joseph Hospital (Eureka)	$2,357,925	$2,501,973	$2,073,069	$2,061,441	$2,248,602
St. Joseph Hospital (Orange)	$9,984,136	$9,825,416	$6,865,777	$5,554,176	$8,057,376
St. Jude Medical Center	$8,219,100	$8,392,969	$7,476,451	$5,396,610	$7,371,283
St. Mary Medical Center	$3,533,168	$3,051,705	$2,556,292	$4,185,791	$3,331,739
Total Community Benefit Expenditures	**$44,696,339**	**$40,700,548**	**$36,522,589**	**$35,484,719**	**$39,351,049**

Source: Providence Health and Services, St. Joseph Health System

(1) The community benefit expenditures set forth in this table reflect expenditures on the types of programs that have historically been treated by the Attorney General as community benefit programs under Title 11, Code of Regulations section 999.5(d)(5)(D). The table does not include expenditures for all SB 697 reported categories. Examples of facility expenditures or costs not included in this table are (i) the unreimbursed cost of Medicare, Medi-Cal and low-margin services, (ii) unreimbursed physician fees and/or subsidies for ED, trauma and other coverage services, (iii) services funded by third parties (e.g., grants), (iv) community benefit operation or administration costs, (v) facility use, and (vi) research.

(2) The Hospital Commitment column reflects each hospital's four year average annual commitment based on the annual community benefit expenditures during the calendar years 2011 through 2014. St. John's Medical Center and Hoag Hospital community benefit commitments are addressed in Section 9.0 of this Exhibit 8.13.

(3) Mission Hospital - Mission Viejo and Mission Hospital - Laguna Beach financials are combined and submitted jointly to OSHPD.

This commitment shall be prorated on a daily basis if the Closing occurs on a date other than the first day of the Parties' fiscal year. For the second fiscal year and each subsequent fiscal year, the Minimum Community Benefit Services Amount shall be increased (but not decreased) by an amount equal to the Annual Percent increase, if any, in the 12-Month Percent Change: Consumer Price Index – All Urban Consumers in the West Region, West Urban Area, Base Period: 1982-84=100 (CPI-West Region, as published by the U.S. Bureau of Labor Statistics).

In addition, SJHS and PH&S, individually or jointly or through NewCo, shall provide support to each of the community benefit programs set forth in the charts immediately below (the

(continued on next page)

"On-Going Community Benefit Programs") for a period of five (5) years after the Closing either at the current location, at alternate locations, or through affiliation with similar organizations.

St. Joseph Health
California Acute-Care Hospitals On-Going Community Benefit Programs
September, 2015

Hospital	Community Benefit Programs
Redwood Memorial Hospital	Community Resource Centers
St. Joseph Hospital, Eureka	Paso a Paso Program/Healthy Kids Humboldt
Santa Rosa Memorial Hospital	House Calls
Petaluma Valley Hospital	Mobile Health Clinic
	Promotores de Salud (Health Promoters)
	Healthy For Life
	Circle of Sisters (COS)
	St. Joseph Dental Clinic and Mobile Dental Clinic
	The Agents of Change Training is the Neighborhoods (ACTION)
Queen of the Valley Medical Center	Community Based Care Coordination and Case Management "CARE Network"
	Children's Mobile Dental Clinic
	Obesity Prevention: "Healthy for Life"
	Perinatal Education and Support
St. Mary Medical Center	Community Clinic programs
	Health Career Programs
	San Bernardino County Public Health Initiatives
St. Jude Medical Center	St. Jude Neighborhood Health Center
	North Orange County Move More Eat Healthy Initiative
	Community Care Navigation
	Senior transportation and services to low income elderly
St. Joseph Hospital Orange	La Amistad de San Jose Family Health Center
	Puente a la Salud Mobile Community Clinics
	Imaging and laboratory Services
	Pharmacy Meds Program
Mission Hospital - Laguna Beach	Family Resource Centers
Mission Hospital - Mission Viejo	Community Mental Health Initiatives/Depression Initiatives
	Behavioral Health
	Camino Health Center (FQHC)
	Increasing Access to Health Care

Source: St. Joseph Health
(1) This program is currently fully funded with grants provided by third parties. This annual program commitment shall be contingent on the availability of the same level of current funding.

Providence Health & Services
California Acute-Care Hospitals On-Going Community Benefit Programs
September, 2015

Hospital	Community Benefit Programs
Little Company of Mary - San Pedro	Creating Opportunities for Physical Activity (COPA)
Little Company of Mary - Torrance	CHIP-Access to Los Cost/Free Primary Care Vasek Polak Medical Home for the Most Vulnerable Get Out and Live (GOAL) Partners for Healthy Kids ("PFHK") Welcome Baby[1]
Saint John's Medical Center	Venice Family Clinic Ocean Park Community Center Westside Family Health Center Cleft Palate Clinic
Providence Holy Cross Medical Center	Access to Care Program
Providence Saint Joseph Medical Center	Faith Community Health Partnership/Latino Health Promoter
Providence Tarzana Medical Center	Senior Outreach Tattoo Removal School Nurse Services

Source: Providence Health & Services
(1) This program is currently fully funded with grants provided by third parties. This annual program commitment shall be contingent on the availability of the same level of current funding.

8.0 Petaluma Valley Hospital. SJHS operates Petaluma Valley Hospital pursuant to a management contract that expires in January 2017. The commitments set forth in Sections 2.0 through 7.0 above shall apply to Petaluma Valley Hospital during the remaining term of the current management contract.

9.0 Providence Saint John's Health Center and Hoag Commitments. SJHS and PH&S, individually or jointly or through NewCo, shall insure full compliance with any and all Conditions of Consent previously issued by the California Attorney General, and the terms of any agreements with the California Attorney General, with respect to the Providence Saint John's Health Center and Hoag Memorial Hospital Presbyterian transactions, including (without limitation) (i) the Conditions of Consent set forth in the California Attorney General's January 14, 2014 and February 8, 2013 letters concerning those facilities and (ii) the March 8, 2014 Agreement between the California Attorney General and Hoag Memorial Hospital Presbyterian. Notwithstanding the foregoing, SJHS and PH&S each reserve the right (and the rights of NewCo), in accordance with Title 11, California Code of Regulations, Section 999.5(h), to seek the amendment of any such Conditions of Consent, or the terms of any other agreements with the California Attorney General, applicable to the Providence Saint John's Health Center and Hoag Memorial Hospital Presbyterian facilities.

Attachment A
SJHS – City/County Contract List

List of Contracts Between City/County and SJHS Affiliated Hospitals			
Hospital	**City / County**	**Services Covered**	**Original Eff. Date**
RMH	North Coast Emergency Medical Services	Modified Base Hospital Medical Control Agreement	4/1/06
RMH	North Coast Emergency Medical Services	EDAP Level I Designation	7/1/10
RMH	City of Blue Lake	MOU re: Blue Lake Family Resource Center	1/1/15
RMH	County of Humboldt-DHHS	Grant Agreement for Blue Lake CRC - CalWORKS and CalFresh	7/15/15
RMH	County of Humboldt-DHHS	Grant Agreement for Rio Dell CRC - CalWORKs & CalFresh	7/15/15
RMH	County of Humboldt-DHHS	Grant Agreement for Willow Creek CRC - CalWORKs & CalFresh	7/15/15
SJE	County of Humboldt Mental Health	Behavioral Health	1/1/15
SJE	County of Humboldt	Agreement Concerning Use of Short Wave Radio Equipment	1/3/95
SJE	Humboldt County	MOU for Death Review Panel	2/1/01
SJE	Humboldt County Children's Health Initiative	Charter	1/1/06
SJE	Humboldt County	MOU for Healthy Kids Humboldt Support	2/14/12
SJE	North Coast Emergency Medical Services	Modified Base Hospital Medical Control Agreement	7/21/12
SJE	County of Humboldt-DHHS	CalFresh Grant Agreement	11/1/14
SJE	County of Humboldt-DHHS-Mental Health Branch	Service Agreement for Hospital Services	1/1/15
SJE	County of Humboldt-DHHS	MOU for 340B Program	1/1/15
SJE and RMH	Humboldt County Office of Education	Work Exploration Agreement for High School Students	2/3/14

Attachment A
SJHS – City/County Contract List

List of Contracts Between City/County and SJHS Affiliated Hospitals			
Hospital	**City / County**	**Services Covered**	**Original Eff. Date**
QVMC	County of Napa	Business Associate Agreement #6165	7/1/03
QVMC	Napa County Child Welfare Services	MOU for Suspected Child Abuse	1/1/11
QVMC	County of Napa	Synergy Agreement #7167	1/6/09
QVMC	County of Napa w/Comm Hlth Clinic Ole, Kaiser,	MOU- Medical Emergency Coop Agmt for Healthcare Organizations	12/18/07
QVMC	Napa County Health & Human Services, Public	MOU for Napa Fussy Baby Collaborative	3/4/13
QVMC	County of Napa	PSA for Services re: Calif AIDS Master Grant Agmt for HIV Care #3236	7/1/13
QVMC	County of Napa	Designation as a Level III Trauma Center #7657	7/1/13
QVMC	County of Napa	Hospital Preparedness Program (HPP) Coalition Participation Agreement	8/14/13
QVMC	County of Napa	Grant Agreement #8157 Tobacco Settlement	7/1/14
QVMC	First 5 Napa County Children and Family Comm.	Grant Agreement #510-15 for Dental Van	7/1/14
QVMC	County of Napa	PSA for Medi-Cal Administrative Activities #8146	7/1/14
QVMC	Napa County Alcohol and Drug Services Division	MOU for Drug and Alcohol Counseling	3/5/15
SRMH	County of Sonoma	Provision of Services/Medication Management Grant	7/1/15
Hoag	Children's And Families Commission of OC	Agreement for early Childhood Development Svcs	2/5/14
Hoag	County of Orange	Agreement for the provision of certain HIVServices	3/1/15
Hoag	County of Orange	Indigent and Trauma Care	7/1/14

Attachment A
SJHS – City/County Contract List

List of Contracts Between City/County and SJHS Affiliated Hospitals			
Hospital	City / County	Services Covered	Original Eff. Date
MH	County of Orange	Indigent and Trauma Care	7/1/14
MH	County of Orange	Medi-Cal Admin Svcs	7/1/15
MH	County of Orange	MSN - Medical Safety Net	7/1/15
SJMC	County of Orange	Caregiver Resource Center	7/1/14
SJMC	County of Orange	Indigent and Trauma Care	7/1/14
SJMC	County of Orange	Designated ER Services	7/1/13
SJMC	Childrens and Families Commission	Early Childhood Development	2/5/14
SJMC	County of Orange	MSN - Medical Safety Net	7/1/15
SJMC	County of Orange	Paternity Opportunity Program	9/9/14
SJO	County of Orange	Indigent and Trauma Care	7/1/14
SJO	County of Orange	Designated ER Services	7/1/13
SJO	County of Orange	MSN - Medical Safety Net	7/1/15
PVH	Sonoma County Department of Health Services,	MOU between Healthcare & Emergency Organizations to coordinate services in disaster situations	10/1/06
PVH	County of Sonoma Department of Health Service	MOU for Vaccinations	7/1/07
PVH	Sonoma County Office of Education	Facility Use Agreement	7/1/13
PVH	County of Sonoma	Receiving Hospital Agreement (EMS)	7/1/15
PVH	County of Sonoma	Receiving Hospital Agreement (EMS)	7/1/15

Attachment A

SJHS – City/County Contract List

List of Contracts Between City/County and SJHS Affiliated Hospitals			
Hospital	**City / County**	**Services Covered**	**Original Eff. Date**
SRM and PVH	County of Sonoma	Mental Health Services Agreement No. 2015-0023-A00	4/15/15
SRMH	Sonoma County Indian Health Project (SCIHP)	Medi-Cal	8/1/14
SRMH	Sonoma County Department of Health Services,	MOU between Healthcare & Emergency to coordinate services in disaster situations	5/15/06
SRMH	County of Sonoma Department of Health Service	MOU for Vaccinations	7/1/07
SRMH	County of Sonoma	Level II Trauma Center Designation	5/1/10
SRMH	Sonoma County Office of Education	Facility Use Agreement	7/1/13
SRMH	County of Sonoma	EMS Base Hospital Agreement	7/1/15
SRMH	County of Sonoma	STEMI Receiving Center Agreement	7/1/15

Key:

RMH = Redwood Memorial Hospital
SJE = St. Joseph Hospital, Eureka
QVMC = Queen of the Valley Medical Center
SRMH = Santa Rosa Memorial Hospital
Hoag = Hoag Hospital – Newport Beach / Irvine
MH = Mission Hospital – Mission Viejo / Laguna Beach
SJMC = St. Jude Medical Center
SJO = St. Joseph Hospital of Orange
PVH = Petaluma Valley Hospital

Attachment A
PH&S – City/County Contract List

List of Contracts Between City/County and PH&S Affiliated Hospitals			
Ministry	**City / County**	**Services Covered**	**Original Eff. Date**
San Pedro			
PHS-So. Cal dba Providence Little Co. of Mary Med. Ctr San Pedro	County of Los Angeles	Psychiatric Inpatient Hospital Services to Medi-Cal Beneficiaries eligible for such services under the Medi-Cal Fee-For-Service program	7/1/15
Providence Little Co. of Mary Ctr (San Pedro)	Los Angeles County Dept of Health Services Emergency Medical Services Agency	SART Center Confirmation Agreement	4/20/15
Torrance			
Little Company of Mary Hospital (Torrance)	County of Los Angeles	Hospital and Medical Care Agreement (CHIP-Formula Hospital Funds)	6/30/08
Little Company of Mary Medical Center (Torrance)	County of Los Angeles	Memorandum of Understanding re Child Support Services	9/24/14-10/31/18
Providence Little Company of Mary-Torrance	County of Los Angeles	Agreement for Participation in Hospital Preparedness Program	1/1/13-6/30/18
Providence Little Company of Mary Medical Center San Pedro	Los Angeles County Children and Families First Proposition 10 Commission (AKA First 5 LA)	Grant Agreement	1/1/15-6/30/16
Providence Little Company of Mary Torrance	County of Los Angeles	Agreement for Paramedic Base Hospital Services	1/1/13-6/30/17
St. John's			
Sisters of Charity of Leavenworth Health System, Inc. re Saint John's Hospital and Health Center	City of Santa Monica	Development Agreement and Amendment Re Construction for Improvements	10/4/11
Providence Saint John's Health Center	County of Los Angeles	Department of Mental Health (mental health services)	7/1/15
Providence Saint John's Child and Family Development Center	City of Santa Monica Mental Health Services	Will Rogers Learning Development Center/ Child Youth Development Project	7/1/15-6/30/16
Providence Saint John's Health Center	City of Santa Monica	Human Services Grants Program Short Term Grant Agreement	7/1/15-9/30/15

Attachment A
PH&S – City/County Contract List

List of Contracts Between City/County and PH&S Affiliated Hospitals			
Ministry	**City / County**	**Services Covered**	**Original Eff. Date**
Providence Saint John's Health Center	County of Los Angeles	Los Angeles County Children and Families First Proposition 10 Commission (A KA First LA) Grant Agreement re Partnerships for Family Initiative	1/1/15-6/30/16
Holy Cross			
Providence Holy Cross Medical Center	Los Angeles County Department of Health Services Emergency Medical Services Agency	ASC Confirmation Agreement re Stroke Center	6/10/10-5/9/12
Providence Holy Cross Medical Center	Los Angeles County Department of Health Services Emergency Medical Services Agency	ASC Confirmation Agreement re ST-Elevation Myocardial Infarction Receiving Center	9/1/13-8/31/16
Providence Holy Cross Medical Center	Los Angeles County	Paramedic Base Hospital Services Agreement	1/1/13-6/30/17
Providence Health System So. CA. dba Providence Holy Cross Medical Center	Los Angeles County	Trauma Center Service Agreement, as amended	7/1/08-12/31/15
St. Joseph's			
Providence Saint Joseph Medical Center	County of Los Angeles	Hospital Preparedness Program Agreement, as amended.	1/1/13-6/30/17
Providence Saint Joseph Medical Center	Los Angeles County Department of Health Services Emergency Medical Services Agency	ASC Confirmation Agreement	10/19/09-3/22/10
Providence Saint Joseph Medical Center	Los Angeles County Department of Health Services Emergency Medical Services Agency	EDAP Confirmation Agreement	12/5/11-12/4/14
Providence Health System-Southern Calfornia DBA Providence Saint Joseph Medical Center	County of Los Angeles	Agreement for Paramedic Base Hospital Services	1/1/13-6/30/17
Providence Saint Joseph Medical Center	Los Angeles County Department of Health Services Emergency Medical Services Agency	SRC Confirmation Agreement	6/1/13-3/31/16

Attachment A
PH&S – City/County Contract List

List of Contracts Between City/County and PH&S Affiliated Hospitals			
Ministry	**City / County**	**Services Covered**	**Original Eff. Date**
Tarzana			
Encino Tarzana Regional Medical Center-Tarzana	County of Los Angeles – Department of Health Services Emergency Medical Services Agency	Hospital and Medical Care Agreement (CHIP-Formula Hospital Funds)	7/1/06-6/30/07
Providence Health and Services DBA Providence Tarzan Medical Center	County of Los Angeles	Expanded Agreement re Hospital Bioterrorism Preparedness	1/1/01-12/31/-12
Providence Tarzana Medical Center	County of Los Angeles, Child Support Services Department	Intra-County Plan of Cooperation re guidelines for an effective social security program	10/1/09
Providence Tarzana Medical center	Los Angeles County Department of Health Services Emergency Medical Services Agency	Stroke Center Confirmation Agreement re Caring for Stroke Population of LA County	4/1/10-5/31/12
Providence Tarzana Medical Center	Los Angeles County Emergency Department	Approved for Pediatrics (EDAP) Confirmation Agreement	12/5/11-12/5/14
Providence Tarzana Medical Center	Los Angeles County Department of Health Services- Emergency Medical Services Agency	SRC Confirmation Agreement re Approved ST-Elevation Myocardial Infarction Receiving Center (SRC)	4/1/10/3/31/12
Providence Tarzana Medical Center	County of Los Angeles Department of Public Health, Acute Communicable Disease Control Program	Confidential Data Use Agreement	7/22/09

ANALYSIS OF ST. JOSEPH HOSPITAL-EUREKA'S SERVICE AREA

Service Area Definition

Based upon St. Joseph Hospital-Eureka's 2014 inpatient discharges, St. Joseph Hospital-Eureka's service area is comprised of 40 ZIP Codes from which 91% of its inpatient discharges originated. Approximately 50% of St. Joseph Hospital-Eureka's discharges originated from the top two ZIP Codes located in Eureka. In 2014, St. Joseph Hospital-Eureka's market share in the service area was approximately 48% based on total area discharges.

SERVICE AREA PATIENT ORIGIN MARKET SHARE BY ZIP CODE: 2014

ZIP Codes	Community	Total Discharges	% of Discharges	Cumulative % of Discharges	Total Area Discharges	Market Share
95501	Eureka	1,758	27.4%	27.4%	2,661	66.1%
95503	Eureka	1,425	22.2%	49.6%	2,016	70.7%
95519	Mckinleyville	490	7.6%	57.2%	1,380	35.5%
95540	Fortuna	401	6.2%	63.5%	1,320	30.4%
95521	Arcata	307	4.8%	68.3%	1,043	29.4%
95502	Eureka	265	4.1%	72.4%	373	71.0%
95546	Hoopa	189	2.9%	75.3%	471	40.1%
95562	Rio Dell	107	1.7%	77.0%	348	30.7%
95573	Willow Creek	81	1.3%	78.3%	226	35.8%
95536	Ferndale	77	1.2%	79.5%	224	34.4%
95524	Bayside	70	1.1%	80.6%	152	46.1%
95560	Redway	67	1.0%	81.6%	203	33.0%
95570	Trinidad	58	0.9%	82.5%	175	33.1%
95551	Loleta	56	0.9%	83.4%	161	34.8%
95542	Garberville	55	0.9%	84.2%	206	26.7%
95525	Blue Lake	47	0.7%	85.0%	134	35.1%
95537	Fields Landing	35	0.5%	85.5%	45	77.8%
95547	Hydesville	34	0.5%	86.1%	108	31.5%
95564	Samoa	32	0.5%	86.6%	47	68.1%
95549	Kneeland	29	0.5%	87.0%	46	63.0%
95518	Arcata	27	0.4%	87.4%	100	27.0%
95589	Whitethorn	26	0.4%	87.8%	88	29.5%
95553	Miranda	24	0.4%	88.2%	59	40.7%
95528	Carlotta	22	0.3%	88.5%	88	25.0%
95565	Scotia	21	0.3%	88.9%	94	22.3%
95554	Myers Flat	21	0.3%	89.2%	67	31.3%
95563	Salyer	18	0.3%	89.5%	61	29.5%
95555	Orick	18	0.3%	89.8%	49	36.7%
95534	Cutten	15	0.2%	90.0%	23	65.2%
95526	Bridgeville	13	0.2%	90.2%	58	22.4%
95556	Orleans	13	0.2%	90.4%	37	35.1%
95514	Blocksburg	12	0.2%	90.6%	29	41.4%
95559	Phillipsville	7	0.1%	90.7%	24	29.2%
95545	Honeydew	6	0.1%	90.8%	14	42.9%
95569	Redcrest	6	0.1%	90.9%	16	37.5%
95511	Alderpoint	6	0.1%	91.0%	31	19.4%
95558	Petrolia	5	0.1%	91.1%	18	27.8%
95571	Weott	5	0.1%	91.1%	22	22.7%
95532	Crescent City	2	0.0%	91.2%	12	16.7%
95550	Korbel	2	0.0%	91.2%	11	18.2%
Subtotal		5,852	91.2%	91.2%	12,240	47.8%
Other ZIPs		565	8.8%	100%		
Total		6,417	100%			

Note: Excludes normal newborns

Source: OSHPD Patient Discharge Database

Exhibit 2

Exhibit 3

ROB BONTA
Attorney General of California
NELI PALMA
Senior Assistant Attorney General
KARLI EISENBERG (SBN 281923)
Supervising Deputy Attorney General
MARTINE D'AGOSTINO (SBN 256777)
DAVID HOUSKA (SBN 295918)
KATELYN WALLACE (SBN 319370)
Deputy Attorneys General
455 Golden Gate Ave., Ste. 11000
San Francisco, CA 94102
Telephone: (415) 510-3374
E-mail: David.Houska@doj.ca.gov
Attorneys for the People of the State of California

DANIEL M. GLASSMAN (SBN 179302)
PAUL W. SWEENEY JR. (SBN 112511)
TAYLOR YAMAHATA (SBN 347192)
K&L GATES LLP
1 PARK Plaza, 12th Floor
Irvine, CA 92614
Telephone: (949) 253-0900
E-mail: Dan.Glassman@klgates.com
Attorneys for St. Joseph Health Northern California, LLC

[Exempt from filing fees pursuant to Government Code § 6103]

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF HUMBOLDT

THE PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff,

v.

ST. JOSEPH HEALTH NORTHERN CALIFORNIA, LLC AND DOES 1-10,

Defendants.

Case No. CV2401832

STIPULATION AND ~~[PROPOSED]~~ ORDER

Action Filed: September 30, 2024

STIPULATION OF THE PARTIES

Plaintiff, the People of the State of California, by and through Attorney General Rob Bonta (the People), and Defendant St. Joseph Health Northern California LLC (SJH) (the People and SJH collectively the Parties) hereby agree and stipulate as follows:

WHEREAS, the People filed this Action on September 30, 2024, and served SJH on October 1, 2024;

WHEREAS, the People generally allege, among other things, that Providence St. Joseph Hospital (Providence Hospital) in Eureka, California, operated by SJH, fails to provide adequate emergency services and care to pregnant patients in danger of "loss of life, or serious injury or illness." The People further allege that Providence Hospital's conduct violates California's Emergency Services Law (ESL), the Unruh Civil Rights Act, and the Unfair Competition Law;

WHEREAS, SJH denies these allegations and the other allegations set forth in the Complaint filed by the People;

WHEREAS, when the People filed the Complaint, the People also moved for a preliminary injunction to require Providence Hospital to comply with the terms of the ESL (the Motion);

WHEREAS, the People originally noticed the hearing on the Motion for October 25, 2024;

WHEREAS, SJH's response to the Motion was originally due on October 14, 2024 and the People's reply was originally due on October 18, 2024;

WHEREAS, the People filed a notice of supplemental factual authority and declaration on October 10, 2024;

WHEREAS, the Parties submitted a Stipulation and [Proposed] Order to the Court on October 15, 2024, requesting to reset the hearing date on the Motion to November 15, 2024, to reset the deadline for SJH's response to the Motion to October 28, 2024, and to reset the deadline for the People's reply to November 8, 2024;

WHEREAS, the Stipulation and Order was signed by the Court on October 21, 2024;

WHEREAS, the labor and delivery unit of Mad River Community Hospital is currently set to close on October 31, 2024, after which Providence Hospital will operate the only labor and delivery unit in Humboldt County;

WHEREAS, the Parties mutually desire to ensure that pregnant patients receive adequate treatment for emergency medical conditions, based on the professional judgment of the treating physician;

WHEREAS, the Parties have initiated discussions regarding the settlement of this case;

WHEREAS, SJH, without admitting any liability and consistent with its high standards for safe, quality, compassionate care; commits to fully comply with its own existing policies which are consistent with California's ESL with respect to pregnant patients experiencing emergency medical conditions; and

WHEREAS, the Parties' stipulation does not constitute a waiver of the People's allegations.

NOW THEREFORE, the Parties stipulate and agree that:

1) The hearing on the Motion, and all corresponding briefing deadlines, shall be taken off calendar; and

2) SJH, without admitting any liability related to the claims asserted in this Action, and consistent with its high standards for safe, quality, compassionate care; and the People, without waiving any allegation regarding SJH's prior conduct as detailed in the Complaint, agrees to fully comply with California's ESL, Health & Safety Code section 1317, *et. seq.* with respect to pregnant patients experiencing emergency medical conditions. Providence Hospital specifically agrees to:

   a) Continue to allow its physicians to terminate a patient's pregnancy (via induced labor, a Dilation and Evacuation procedure, or any other procedure that the relevant personnel are licensed and qualified to perform and for which Providence Hospital has the physical facilities to accommodate) whenever the treating physician(s) determine in their professional judgment that failing to immediately terminate the pregnancy would be reasonably expected to:

i. Place the patient's health in serious jeopardy;

ii. Result in serious impairment to the patient's bodily functions; or

iii. Result in serious dysfunction of any bodily organ or part of the patient.

b) Follow the ESL's pre-transfer treatment requirements. In particular, Providence Hospital agrees that it will not transfer a pregnant patient without first providing emergency services and care that the patient's treating physician(s) determine in their professional judgment are medically necessary (including where applicable terminating a pregnancy) such that there is a reasonable medical probability that the transfer or the delay caused by the transfer will not result in a material deterioration in the medical condition in, or jeopardy to, the patient's medical condition or expected chances for recovery.

c) Follow the policy and protocol requirements of the ESL enumerated in Health & Safety Code section 1317.2 and all applicable protocols and regulations for transfers prescribed by the California Department of Public Health.

3) SJH agrees that, within seven days of the issuance of this Order, the Providence Hospital shall provide written notice of this Order, and all obligations under it, to all of Providence Hospital's medical staff and each and every physician with privileges at Providence Hospital.

4) The court shall have jurisdiction to enforce the terms of this stipulation.

[SIGNATURES ON THE FOLLOWING PAGE]

IT IS SO STIPULATED.

Dated: October 28, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
KARLI EISENBERG
Supervising Deputy Attorney General

/S/ David Houska
DAVID HOUSKA
Deputy Attorney General

K&L GATES LLP

By: */S/ Daniel Glassman*
Daniel M. Glassman
Paul W. Sweeney Jr.
Taylor Yamahata

Attorneys for Defendant
St. Joseph Health Northern California, LLC

[PROPOSED] ORDER

Pursuant to the Stipulation of the Parties, the Court having considered the matter, and good cause appearing, it is **ORDERED** that:

1) The hearing on the People of the State of California's Motion for Preliminary Injunction, and all corresponding briefing deadlines, shall be taken off calendar.

2) The hospital known as Providence St. Joseph Hospital (Providence Hospital), operated by Defendant St. Joseph Health Northern California, LLC, without admitting any liability, must fully comply with California's Emergency Services Law (ESL), Health & Safety Code section 1317, *et. seq.* with respect to pregnant patients experiencing emergency medical conditions. Providence Hospital must specifically:

   a) Allow its physicians to terminate a patient's pregnancy (via induced labor, a Dilation and Evacuation procedure, or any other procedure that the relevant personnel are licensed and qualified to perform and for which Providence Hospital has the physical facilities to accommodate) whenever the treating physicians determine in their professional judgment that failing to immediately terminate the pregnancy would be reasonably expected to:

      i. Place the patient's health in serious jeopardy;

      ii. Result in serious impairment to the patient's bodily functions; or

      iii. Result in serious dysfunction of any bodily organ or part of the patient.

   b) Follow the ESL's pre-transfer treatment requirements. In particular, Providence Hospital may not transfer a pregnant patient without first providing emergency services and care (including where applicable terminating a pregnancy) such that there is a reasonable medical probability that the transfer or the delay caused by the transfer will not result in a material deterioration in the medical condition in, or jeopardy to, the patient's medical condition or expected chances for recovery.

   c) Follow the policy and protocol requirements of the ESL enumerated in Health & Safety Code section 1317.2. In particular, Providence Hospital may not "discharge" patients with instructions to self-transport to another facility and

Providence Hospital must comply will all applicable protocols and regulations for transfers prescribed by the California Department of Public Health.

3) Within seven days of the issuance of this Order, Providence Hospital shall provide written notice of this Order, and all obligations under it, to all of Providence Hospital's medical staff and each and every physician with privileges at Providence Hospital.

4) Nothing in this Order changes the ordinary requirements for obtaining informed consent from a patient or their medical proxy before performing a medical procedure. Nothing in this Order compels Providence Hospital to perform any treatment if a patient (or their medical proxy where appropriate) declines such treatment after being fully advised of the possible risks and benefits.

5) The Court shall have jurisdiction to enforce the terms of this stipulation.

IT IS SO ORDERED.

Date: OCT 29 2024

Signed: TIMOTHY A. CANNING
Judge of the Superior Court

Exhibit 4

ROB BONTA

Attorney General

Attorney General Bonta: Draconian Hospital Policies that Deny Emergency Abortion Care Have No Place in California

Monday, September 30, 2024

Contact: (916) 210-6000, agpressoffice@doj.ca.gov

Sues Providence St. Joseph Hospital for Denying Patient Emergency Abortion Care

Lawsuit alleges hospital in violation of multiple laws including California's Emergency Services Law (the state level analogue to the federal EMTALA statute)

SACRAMENTO — California Attorney General Rob Bonta today announced a lawsuit against Providence St. Joseph Hospital (Providence) in Eureka, California. In the lawsuit, filed in Humboldt County Superior Court, the Attorney General alleges Providence violated multiple California laws due to its refusal to provide emergency abortion care to people experiencing obstetric emergencies. One particular patient, Anna Nusslock, had her water break when she was 15 weeks pregnant with twins on February 23, 2024. Despite the immediate threat to her life and health, and despite the fact her

pregnancy was no longer viable, Providence refused to treat her. She had to travel to a small critical access hospital called Mad River, 12 miles away, where she was actively hemorrhaging by the time she was on the operating table. In addition to filing the complaint, the Attorney General is moving immediately for a preliminary injunction to ensure that patients like Anna will receive timely emergency healthcare services at Providence, including abortion care.

“California is the beacon of hope for so many Americans across this country trying to access abortion services since the Dobbs decision. It is damning that here in California, where abortion care is a constitutional right, we have a hospital implementing a policy that’s reminiscent of heartbeat laws in extremist red states,” **said Attorney General Bonta**. “With today’s lawsuit, I want to make this clear for all Californians: abortion care is healthcare. You have the right to access timely and safe abortion services. At the California Department of Justice, we will use the full force of this office to hold accountable those who, like Providence, are breaking the law.”

In February 2024, Anna Nusslock was fifteen weeks pregnant with twins when she visited Providence in pain and severely bleeding after her water prematurely broke. At Providence, the doctor diagnosed Nusslock with Previable Premature Pre-labor Rupture of Membranes (Previable PPROM) and confirmed her twins would not survive. Her diagnosis also meant that without abortion care, she was at increased risk of permanent harm or death from infection and hemorrhage. Nevertheless, Providence informed her that hospital policy prohibited them from providing this emergency care as long as one of her twins had a “detectable heartbeat.” Only once there was an immediate risk to Nusslock’s life—which is to say, a more immediate risk than she already faced—would the hospital give her the treatment she needed.

Instead of providing Nusslock emergency medical abortion care required by state law, Providence discharged her with instructions to drive to a small community hospital nearly 12 miles away. On the way out the door, Providence handed Nusslock a bucket and towels “in case something happens in the car.”

Providence’s policy bars doctors from providing life-saving or stabilizing emergency treatment when doing so would terminate a pregnancy, even when the pregnancy is not viable. Not only does this violate California law, this policy discriminates against pregnant patients as the hospital chooses the decision for them.

Today’s complaint alleges Providence violated California’s Emergency Services Law (the state level analogue to the federal EMTALA statute), the Unruh Civil Rights Act, and the Unfair Competition Law. Additionally, the Attorney General moved for a preliminary injunction, seeking a court order to guarantee that patients receive prompt emergency medical care including abortion care. This is especially critical because the hospital—Mad River Community Hospital—where Anna eventually received her abortion will be closing its labor and delivery (L&D) unit this October. In a month, Providence will be left as the only hospital with an L&D unit in all of Humboldt County. The next person in Anna’s situation will face an agonizing choice of risking a multi-hour drive to another hospital or waiting until they are close enough to death for Providence to intervene.

This lawsuit enforces the crucial right to emergency abortion care under California state law, while the scope of federal protections for such care under the Emergency Medical Treatment and Labor Act (EMTALA) remain uncertain. Under EMTALA, every hospital in the United States that operates an emergency department and participates in Medicare is required to provide stabilizing treatment to all patients with an emergency medical condition. When the U.S. Supreme Court upended decades of legal precedent establishing a constitutional right to an abortion in *Dobbs v. Jackson Women’s Health Organization*, EMTALA should have provided a critical backstop, guaranteeing that no

matter what state a pregnant patient was in, they would receive the emergency care, including abortion care, they needed. But this past summer in *Idaho v. U.S.*, the U.S. Supreme Court declined to confirm that EMTALA requires hospitals to provide necessary abortion care to pregnant patients experiencing access medical emergencies irrespective of any conflicting state law. With EMTALA in limbo, states like California have to rely on their own state laws to protect pregnant patients.

California Attorney General Bonta remains committed to ensuring that California continues to be a safe haven for those seeking essential reproductive healthcare including abortion care. For more on his actions, and for key resources to assist you in obtaining reproductive healthcare, visit https://oag.ca.gov/reprorights.

If you are looking for information specific to abortions, the California Abortion Access website provides a safe space to find resources and guidance. The privacy of those who visit this website is protected, and their information is not saved or tracked.

California law requires hospitals to provide emergency abortion care. Click here to learn more.

If you were denied an abortion you needed in a medical emergency, or if you were denied any other emergency medical care, you can contact abortion.access@doj.ca.gov.

A copy of today's filed complaint and preliminary injunction can be found here and here.

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