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Difficult Moral Questions

by

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How Far May Catholic Hospitals Cooperate with Non-Catholic Providers?

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The following is one of the questions that I am preparing for *Difficult Moral Questions*, which will be the third volume of *The Way of the Lord Jesus*. The response given here will be revised further before the book is published. So, I will welcome readers' letters with criticisms and suggestions for improvement. I also will be glad to receive other difficult moral questions to which readers have been unable to obtain an answer.

Statement of the question:

As you may know, the religious institute of women to which I belong always has been committed to health care. We regard it as an apostolate that continues in our day an essential part of Jesus' own ministry during his earthly life. At present, our U.S. provinces operate hospitals in many places located in several different states.

In times past, we carried on our work autonomously, ignoring most non-Catholic health care providers while allowing some to work in our hospitals or make use of them only under conditions we set. Today, however, mutually agreeable cooperative relationships with those who do not share our faith and ethical views are becoming increasingly necessary for four reasons: the need for efficiency in order to limit the escalating costs of health care; the increasing complexity of health care which requires many forms of cooperation to meet the needs of the people we serve; the demands of payers (the government and insurance companies) that we meet their conditions with respect to benefits and adapt to their arrangements for providing them; and the understandable resistance of non-Catholics (and also of Catholics who do not agree with some of the Church's teachings) to the bishops' "Ethical and Religious Directives." With

the trends of the time, most if not all of our hospitals either will participate in various sorts of mutually agreed upon cooperative relationships or will become increasingly marginalized and ultimately financially nonviable.

Recognizing this need, our superiors have established an interprovincial committee, of which I am a member, to develop guidelines for various types of cooperative arrangements. While difficult to sort out and classify, it appears that the types of arrangements fall into four broad groups (though with some overlap): (1) simple contractual arrangements with other hospitals, diagnostic facilities, individual physicians, and so forth; (2) integrated delivery networks, that is, broad affiliations with other institutions and providers to deliver the complete spectrum of health care in a particular locality; (3) cosponsored health maintenance organizations or similar deliverers of health care to certain groups of insured people; and (4) arrangements assuming responsibility for a purchased portion of the practices of a group of physicians and/or other providers who, at the same time, will remain free to provide the same or other clientele with services in which we feel we cannot participate.

The recent revision of the "Ethical and Religious Directives" (approved by the U.S. bishops on November 17, 1994) and the committee's initial discussions seem to indicate that, so far as the ethical aspects are concerned, two matters will be central. First, while our commitment to our health care apostolate requires that we do whatever is necessary under rapidly changing conditions to continue delivering quality services, we must find ways to maintain our institution's Catholic identity even as we surrender some of our traditional autonomy and legal control. Second, though we will not *sponsor* any forbidden procedures (such as sterilizations and abortions) in our own hospitals, we necessarily will cooperate with those who perform them; therefore, we must clarify the ways in which formal cooperation might arise in the delivery of services under various arrangements, and try to limit our hospitals' involvement to material cooperation.

Though I realize that you probably will not be able to say much on the basis of such a vague description of the problem, I will be grateful for any suggestions you can offer with respect to the ethical aspects of the guidelines we will be developing.

Analysis:

The inquirer seeks fuller answers to two interrelated questions that are touched on only very briefly in the 1994 revision of the "Ethical and Religious Directives." The first question concerns the Catholic identity of Catholic hospitals, and calls for clarifications of the concept of the health care apostolate and the likely impact on that apostolate of entering into and carrying on the sorts of arrangements described. The second question concerns formal and material cooperation. An adequate response to it must explain two things. 1) Formal cooperation is likely to occur not only in carrying on a cooperative arrangement but also, and even especially, in setting it up. 2) Material cooperation also can be wrong, and a Catholic hospital's material cooperation with the provision of

morally unacceptable services is likely to be wrong. Catholic hospitals that avoid wrongful material cooperation and maintain their identity may not be economically viable. Therefore, Catholics committed to health care as an apostolate should look for more suitable ways of carrying it on.

A suitable reply might be along the following lines:

As you say, I cannot provide specific moral advice in response to a general question. However, I will sketch out some considerations that I think the administrators of your hospitals should keep in mind when they consider entering into any cooperative arrangement with non-Catholic providers.

First, your important question about maintaining Catholic identity requires clarification of the concept of the apostolate of health care. In understanding health care as an apostolate, two opposite errors must be avoided: reducing the health care apostolate to the delivery of good care, and regarding Jesus' healing miracles as the basis for the health care apostolate. On the one hand, though providing health care in accord with sound professional requirements serves a human good, committing oneself to health care as an apostolate means, not merely delivering good care, but providing it in ways that embody Christian love and are likely to bear witness to faith. On the other hand, though Jesus miraculously cured some sick people and even raised a few people from the dead, health care as such did not pertain to His ministry. His activities in this regard no doubt were motivated in part by concern about the suffering of the individuals He helped. But His wider, redemptive mission was His overarching concern, and His intention in healing people was to confirm his gospel by signs of the coming of God's kingdom. Had Jesus' commitment been to health care as such, limiting His miracles to those whose faith made them receptive would have been discriminatory; indeed, having the power to cure everyone and raise all the dead, He would have done so. If both errors are excluded, one sees that, just as it would be wrong for those providing health care to compromise its quality in order to promote ulterior religious ends, it will be wrong for your hospitals and destructive of their Catholic identity to compromise witness to faith in setting up arrangements to deliver good care efficiently.

Second, those entering into cooperative arrangements should not take too narrow a view of the actual and potential problem areas, which are by no means limited to sterilization and abortion. Prescribing contraceptives and helping people use them normally involves formal cooperation with contraception, and even material cooperation, especially with forms of contraception whose mode of action sometimes is abortifacient, can be gravely wrong. Genetic counseling with a view to contraception, sterilization, and abortion normally involves formal cooperation in masturbation. In vitro fertilization is morally unacceptable in itself, and procedures such as TOT and GIFT are morally questionable (in my judgment they are morally similar to the simple case of in vitro fertilization). While limiting and withdrawing treatment often are right, both can be methods of suicide or homicide, and both are likely to be abused by coming attempts to ration care on the basis of so-called quality of life, so that the elderly, severely

retarded, and others will be unjustly discriminated against. Active euthanasia also is likely to be legalized, at first by permitting assisted suicide, but eventually by authorizing nonvoluntary euthanasia for many people whose lives are not considered worth maintaining by others concerned.

Third, one cooperates, not only in the delivery of services after an arrangement has been made, but in making an arrangement. Moral norms — though not, of course, norms of health care ethics — can be violated in making the arrangement. Suppose, for instance, a Catholic hospital's administrators work with non-Catholics to create an entity that will provide the full range of services thought to pertain to health care by at least some of the prospective clientele and non-Catholic providers. The negotiators might agree that nothing contrary to the Ethical and Religious Directives will be done in the Catholic hospital or sponsored by it, and might even arrange that providers working in the Catholic hospital will never be called on to refer for excluded services or follow up on them. Of course, to avoid such unacceptable cooperation, the negotiators also will agree on certain conditions that will ensure that non-Catholics who are prepared to provide the excluded services will make them available to clients who desire them. The arrangement seemingly will establish a neat division of responsibility, isolating the Catholic hospital from immoral activities. In agreeing on this way of providing the full range of services, however, the Catholic negotiators will have intended that the excluded services be supplied by others under the conditions agreed upon, and that intention will constitute formal cooperation. Moreover, it will be embodied in the arrangement established; in virtue of it, the Catholic hospital, simply by keeping its commitment to the arrangement and continuing in it, will formally cooperate in providing those services.

Fourth, avoiding formal cooperation in wrongdoing is not enough; even if all the cooperation is material, it may be gravely evil. The possible evils are of several sorts: material cooperation can occasion a sin of formal cooperation; it can be scandalous; materially cooperating with wrongdoing can impair the capacity to give credible witness against it; and it can be unfair to those injured by the wrongdoing.

In providing health care, one who materially cooperates in wrongdoing often will be tempted to cooperate formally in it for three closely related reasons: health care providers ordinarily share the intentions of those they serve; particular services ordinarily must be integrated into a comprehensive pattern of care; and the problem with morally excluded services very often is that a bad means is chosen to attain an appropriate end. For example, if a woman's or family's physical and/or psychological health calls for birth regulation and the woman refuses morally acceptable means, any health care provider sharing responsibility for her care will be tempted not only to refer her to someone who will prescribe other means but to try to ensure that she uses her chosen means regularly and effectively.

Material cooperation with wrongdoing can be scandalous in the strict sense: it can lead people to sin by encouraging them in rationalization and self-deception (which do not free them of guilt) regarding the wrongdoing. Other things being equal, a Catholic institution's material cooperation in immoral activities is much

more likely to be scandalous than an individual Catholic's. Since the institution claims to be distinguished from others by being Catholic, whatever it does is taken by many non-Catholics and even less sophisticated Catholics to be the Church's own act; and its acts are presumed to be fully deliberate and free, not the product of ignorance or weakness.

A Catholic institution's significant, obvious, voluntary cooperation in wrongdoing inevitably will impair or even negate its capacity to provide credible witness. For example, a Catholic institution's partnership in an integrated delivery network for cosponsorship of an HMO that provided, among other things, abortion and in vitro fertilization would strongly suggest that the Catholic Church does not really and firmly reject these evils but only maintains an insincere official opposition to them. For those engaged in health care as an apostolate to impair their witness so greatly would be utterly self-defeating, since, as has been explained, the essence of apostolate is, not only to bring about a human good such as health, but to practice Christian love and bear witness to the gospel's truth, including love for the tiniest of Jesus' sisters and brothers and truth about injustice toward them.

Scandal and impairment of witness have consequences: some individuals will die or suffer lesser injuries that might be prevented if those who profess the sacredness of life and the dignity of persons consistently avoided complicity in wrongful behavior. Accepting these bad consequences is likely to be unfair. To appreciate this potential injustice, one need only consider how most people regard those who cooperated materially in Nazi genocide — the suppliers of poison, the guards, and so on.

You say: "we will not *sponsor* any forbidden procedures (such as sterilizations and abortions) in our own hospitals." In this context, *sponsor* is ambiguous but suggests formal cooperation, whether or not the sponsored procedure is in your own hospital. The phrase, *in our own hospitals*, points to a distinct consideration. Even if formal cooperation is avoided, your hospitals materially cooperate in very significant ways with all procedures performed in them.

In view of these considerations, it seems to me that limited material cooperation is most likely to be morally acceptable in simple contractual arrangements for sharing equipment and physical facilities. I very much doubt that a Catholic hospital can justifiably engage in the material cooperation required by an integrated delivery network or cooperatively operated health maintenance organization. Moreover, the common good of the larger health care community almost certainly will subsume the former Catholic community's common good, since the latter will differ specifically only in ways seriously compromised or even completely suppressed in establishing and carrying on the cooperative arrangement. Thus, the Catholic hospital will merge into the large community and entirely lose its identity.

Fifth, you should not assume that you can continue to operate all your hospitals while entirely avoiding wrongful cooperation. So, since you must avoid wrongful cooperation, you should prepare to give up at least some of your hospitals and eventually, perhaps, all of them. However, very likely your institute has experienced a decline in new members, and by now you probably are able to

staff only a few positions in your hospitals and fill only a few others with Catholics who regard their work as an apostolate. If those members of your institute and other dedicated Catholics were replaced tomorrow with equally competent non-Catholics, people using the hospital probably would note little or no difference in the service they receive.

Sixth, just as individuals maintain their Christian identity by constantly seeking, accepting, and faithfully fulfilling their personal vocations, so groups of Christians forming particular communities maintain their identity as Christian communities only by fidelity to their proper missions. Therefore, institutes such as yours should undertake radical discernment. What are the needs for health care that are now unmet and are likely to remain unmet by others? What gifts equip you for meeting some of those needs?

I suggest that reflection of this sort will not point toward the appropriateness of accepting a subordinate role for your hospitals in a secularized health care system. Instead, it will point toward giving up the hospitals and adopting more suitable means of serving those most in need and least served by that system — the unborn baby whose abortion the system would provide and whose mother needs help to choose an alternative, the individual whose quality of life falls below some arbitrarily set limit, couples who need instruction in natural family planning, people too disorganized to make use of the health care system, the mentally ill who have been “freed” from institutions to wander in the streets, and other victims of ideological fashions.

Institutions such as hospitals are only one means of carrying out a health care apostolate. Like other means, their usefulness is limited, and continuing attachment to them as their usefulness diminishes will entail infidelity to the end they formerly served. In bearing witness, individual Christians are expected when necessary to sacrifice even life itself. Should not your institute be ready to bear witness by giving up its hospitals and finding ways of carrying on its apostolate more appropriate under today's changing conditions?
