### The Linacre Quarterly

Volume 63 Number 2

Article 14

May 1996

## Ethical Quandary Forming Hospital Partnerships

Russell E. Smith

Follow this and additional works at: http://epublications.marquette.edu/lnq

#### Recommended Citation

Smith, Russell E. (1996) "Ethical Quandary Forming Hospital Partnerships," *The Linacre Quarterly*: Vol. 63: No. 2, Article 14. Available at: http://epublications.marquette.edu/lnq/vol63/iss2/14

# Ethical Quandary Forming Hospital Partnerships

by

The Reverend Russell E. Smith, S.T.D.

The text of a talk delivered to the annual Bishop's Workshop in Dallas, the author addresses concerns of Prof. Germain Grisez (Linacre Quarterly, Nov. 1995) and Fr. Richard McCormick, writing in Origins last year.

In the past three years, one of the most common consultation requests submitted to the Pope John Center has been for assistance in the ethical assessment of proposed hospital partnerships between Catholic and non-Catholic providers. When preparing for a lecture on the application of the principles of cooperation to health care alliances last year for this workshop, there were virtually no contemporary sources to turn to. Theologians had not yet gotten articles published on the topic, although many of us were actively engaged in working with Catholic health care sponsors and administrators on this precise question. Religious congregations generally had "in house" documents used as guides for their institutions' boards and administrators to use for compatibility studies and approval protocols. In the last twelve months, however, a number of articles have appeared.

Among them, there are two very thoughtful and thought provoking articles from two distinguished Catholic ethicists. The first, by Father Richard McCormick, entitled "The Catholic Hospital Today: Mission Impossible?," focusses on the broad spectrum of changes in the delivery of health care and the practice of medicine which have dramatically altered both the culture of the hospital and the culture of the doctor/patient relationship.\(^1\) McCormick describes eight characteristics which form a context of health care different than that present in the first half of this century: viz., the depersonalization which results from medical technology and efficiency, the secularization of the medical profession (understood as "increasing preoccupation with factors that are peripheral to and distractive from holistic health care [like] competition, liability, government controls, finances), a contrast emerging in the medical ethos from

focus on the ethics of individual clinical decisions to concern for broader social and economic concerns, the market-driven health care system, the death-denying technological imperative resulting in overtreatment, continued fascination with high tech rescue medicine, an increasingly disembodied understanding of health and disease, and the need for fewer acute care hospitals. As a result of these developments, he says, "We see a Catholic hospital questioning its identity . . . There is a gap between institutional purpose and aim, and personal conviction and involvement" on the part of Catholics involved in this work. He summarizes this as follows: "We see people who have jobs, not great causes. I think this may well have happened to many Catholic hospitals. They were organized around the 'greatest story ever told.' The Catholic hospital exists, therefore, to be Jesus' love for the other in the health care setting. It has the daily vocation of telling every patient — especially the poor — and every employee how great they are, because Jesus told us how great we are and in the process empowered us. Yet I suspect this raison d'etre has become practically dysfunction. If that is the case, then the heart of the Catholic health care culture is gone. The mission has become "mission impossible." Father McCormick ends his talk with the question of whether the "soul" of Catholic hospitals can be saved in light of the necessary elements of Catholic identity and a health care setting hostile to those elements.

The second distinguished Catholic ethicist, Professor Germain Grisez, answers Father McCormick's question in the negative.<sup>3</sup> Professor Grisez focusses his attention precisely on the principles of cooperation. He maintains that much of the involvement of Catholic institutions in the evolution of health care delivery is formal cooperation and that which is material cooperation should not be permitted either. This position will be addressed later, but I mention it here as one concrete answer to the fundamental question articulated by Father McCormick which contrasts sharply with the opinion of Catholic sponsors, the Church's pastoral leadership and the Catholic Health Association (CHA).

CHA has collaborated with the National Coalition on Catholic Health Care Ministry to produce a workbook which is actually a dossier of items to provide assistance to everyone studying the question of the Church's continued involvement in health care. It is a collection of articles, charts, suggested models and graphs aimed at explaining how and why Catholic sponsors can remain in this ministry. This Coalition answers "yes" to Father McCormick's question. In this talk I would like to add to this conversation by examining the "no" and "yes" sides of the answer by reviewing the conclusions of my talk on cooperation in

"duress," "scandal" and "immediate material cooperation;" and by addressing a few aspects of general application to health care alliances and our relationships with physicians.

health care alliances of last year; clarifying some ambiguous concepts by defining

#### The Principles of Cooperation.

The first intervention of the Magisterium in the field of morals occurred in 1679 when Pope Innocent XI — through the agency of the Inquisition — condemned sixty five theses of moral doctrine as being laxist. Number 51 is a

laxist rendering of the sinfulness of a certain kind of cooperation: the case of a servant carrying a ladder or opening the window of his master to facilitate the master's rape of woman.<sup>5</sup> While this example sounds archaic and I would never suggest that you use this as an example at a hospital board meeting unless you like being laughed at, we will return to it later in this presentation.

It would take almost a century to articulate a coherent understanding of cooperation that was considered neither lax nor rigorist. This development would be fundamentally the work of St. Alphonsus Liguori. He made the principles of cooperation acceptable by introducing the distinction between formal and material cooperation (the former never acceptable and certain forms of the latter could possibly be acceptable, and by a consideration of scandal as a serious invitation to sin. Cooperation in the ethically significant sense is defined as the participation of one agent in activity of another agent to produce a particular effect or joint activity. This becomes ethically problematical when the action of the primary agent is morally wrong.

Last year, the distinctions of the principles of cooperation were delineated and can be referred to in the Proceedings. The fundamental distinction is that of formal and material cooperation. Formal cooperation involves willing participation in an intrinsically evil act. Material cooperation is either immediate or mediate. We will discuss immediate material cooperation later in the talk, but mediate material cooperation is proximate or remote, free or necessary. Mediate material cooperation can be justified if there is a significant reason to engage in the proposed course of action and if scandal can be avoided.

Needless to say, a determination that a proposed partnership is mediate material cooperation is not the same as saying such a proposal is prudent. There may be local, particular factors which complicate such an enterprise which the principles, baldly stated, would be blind to. In general, however, there are four basic theological and pastoral concerns that must be addressed. First, the extent and type of cooperation entailed in the partnership should be fleshed out. Second, cooperation with partners who perform some activities we deem morally inappropriate must derive from some "serious reason." The pressures of health care delivery evolution can be this serious reason. Third, the potential for scandal - and the potential for notoriety — have to be looked at. And fourth, the canonical questions of sponsorship and alienation of property require serious attention. This is particularly acute today because our experience of the relationship of "ownership," "control" amd "sponsorship" is changing. In some cases, for example, it has been suggested that the "sponsor" sell its hospsital (relinquishing "ownership") but that the "sponsor" can retain "control" of the hospital through contractual agreements which would respect those essential ingredients of reserved powers that canonical stewards must exercise to maintain Catholic identity such as establishment of philosophy and mission, the further disposition of the assets, closure of the hospital, etc.

There are five basic principles the Pope John Center is using as guidelines in moral evaluations of partnerhsips:

1. Cooperation must be mediate material, never formal or immediate material.

- 2. We can only do together what all partners agree to be appropriate. This means that while the alliance or collaborative effort need not be Catholic, it must nevertheless observe the ERDs as respecting the "corporate conscience" of the Catholic partner.
  - 3. Morally illicit procedures cannot be provided on the Catholic campus.
- 4. Any morally illicit procedure(s) provided on campuses of non-Catholic alliance partners must be excluded from the new alliance corporation through separate incorporation and separate billing mechanisms.
- 5. All publicity should be straightforward regarding: (a) the need to form an alliance for survival of the apostolate; (b) the good achieved by "rationalizing" health care (the cost-driving reality of competition); (c) the exclusion of immoral procedures from the partnership (while these services will still be available on the campuses of some partner[s]); and (d) the necessity of this publicity appearing also in the promotional literature of the Catholic hospital.

Let us return to Professor Grisez' "no" to health care alliances. He says, "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." He thinks that the creation of an integrated delivery network or HMO constitutes formal cooperation because "[i]n agreeing on this way of providing a full range of services, ... 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." This is a serious charge. Professor Grisez is implying that the "moral object" of collaboration includes an at least implicit intention of providing prohibited services. He goes on to say, "[m]aterial 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."8

However, there seems to be another way to understand this collaboration. In my opinion, the negotiation involves the intention of the Catholic partner to continue to provide health care within the reconfigured arena and that deliberation about prohibited services is aimed precisely at removing the Catholic partner from involvement with prohibited services. It is tantamount to saying "We are only going to do together what all partners agree is appropriate and anything deemed inappropriate must be the private project of that proponent." This involves the "carve-outs" that give so much meaning and enjoyment to the lives of hospital attorneys. This entails a form of collaboration with other providers by which the Catholic partner is removed entirely from any contact with prohibited services, thereby arguably rendering cooperation with those services virtually nil.

The term "prohibited services" covers a lot of ground, and a spectrum of

ethical seriousness from tubal ligation to abortion (and perhaps euthanasia), none of which can be offered by Catholic providers because of their intrinsically evil nature. But we must not lose sight of the fact that the difference in the respective degrees of seriousness is vast. That is why compatibility studies focus more on sterilization than abortion. Notorious abortion providers are generally exluded from consideration of collaboration early on. And when there is such serious consideration, many more alarms have to be addressed than when abortion is off the table. The NCCB recognizes this distinction in its commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals of 1975 and the ERDs. The "serious reason" allowing material cooperation in the case of providers of contraceptive services is not of the same magnitude as that in the case of providers of abortion services.

Having said this, there is one other very important point that Professor Grisez mentions: "A Catholic institution's significant, obvious, voluntary cooperation in wrongdoing inevitably will impair or even negate its capacity to provide credible witness . . . For those engaged in health care as an apostolate to impair their witness so greatly would be utterly self-defeating, since . . . 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 tinest of Jesus' sisters and brothers and truth about injustice toward them."

Certainly if involvement in prohibited procedures is formal, this contradiction is an actuality. Evil can never be done even for the sake of otherwise doing great good. Even if cooperation is material, such a contradiction could be implied or perceived. This is the issue of scandal which will be addressed below. However, it seems that cooperation need not be formal for the reasons mentioned above. And it must be stated that even if cooperation remains material, collaboration may be counter indicated for reasons of insurmountable scandal or other pastoral concerns. But these concerns lie in the realm of prudential decision, not moral principle.

#### Three Troublesome Ambiguities

At this juncture, I would like to address briefly three concepts that are used often whose meaning is implied rather than specified: scandal, immediate material cooperation and duress.

#### Scandal

St. Alphonsus taught that mediate material cooperation could be justified if there is a "serious reason" to cooperate and if scandal could be avoided. Scandal is defined by St. Thomas as "any word or deed not fully upright which is the occasion of sin to another." Father Ludvic Bender says "active scandal is unbecoming conduct in act, word, or omission which is the occasion of spiritual harm to another. Sometimes actions, not evil in themselves, have nevertheless the appearance of evil and as such may lead to sin." This latter situation is the real possibility when partnerships are mediate material cooperation. The public

perception of the Catholic hospital's cooperation may be such that it appears that the Catholic partner is compromising or contradicting the professed teachings of the Church.

This type of scandal occurs in the board room as well as in the community. It is very difficult to explain the principles of cooperation in a way that holds the attention of one's listeners. The fundamental touchstone of these principles is the objective moral order which one is not free to violate. But living in a fallen world, the morally upright person will encounter the intentional evil of others, and unless one withdraws from all involvement in the world (sectarianism), one must cooperate in ways that do not involve evil intentions or intrinsically evil acts. The careful distinctions that have a certain clarity on the blackboard of the theology department lose their focus in the minds of practical Anglo-Saxons. We are often accused — explicitly or implicitly — of winking and nodding, of rationalizing, or in religious language, of phariseeism. This can only be avoided by constant living contact between the articulation of the principles of cooperation and the first principle of morality, "do good and avoid evil."

The scandal that must be avoided then, can be defined as "the proposal or execution of a course of action which either is or has the potential of being perceived as constituting a contradiction or compromise of the Church's teaching with the effect that the Catholic partner is or appears to be doing evil, giving bad example, making evil appear to be good or upright, and/or suggesting that others can embark upon this evil with impunity."

#### Immediate Material Cooperation

Immediate material cooperation has been a focus of some attention in the literature of the last year. And this topic is perhaps the most important thing I can address in this talk. In the dossier of items entitled *Catholic Health Ministry in Transition*, it is repeatedly asserted that immediate material cooperation is permissible for a proportionate reason. I cannot be more emphatic that this is a gratuitous assertion which contradicts the theological teaching regarding the principles of cooperation from the time of St. Alphonsus. The impermissibility of immediate material cooperation in the tradition is noted by Father Charles Curran in his article on the history of the principles.<sup>11</sup> To assert now that such cooperation is possible "for a proportionate reason" is novel and unproven.

It is said that the "proportionate reason" justifying immediate material cooperation is duress (which will be examined next). But this too is untraditional since duress mitigates the subjective guilt of the cooperator rendering the cooperator something of a hostage by compromising freedom of action. Whereas, immediate material cooperation was understood as the free action of the cooperator which while not intrinsically evil, has intimate involvement in the evil of the principal agent. Recall the example condemned by the Inquisition in 1679. Here the Church taught that the servant's action of carrying a ladder for his master to climb into a woman's room was to be considered morally wrong. Note: the Church had no need to condemn the action of the master because everyone recognized its intrinsic evil. The action of the servant was morally indifferent —

prescinding from the circumstances. However, the morally indifferent act was corrupted by its intimate association with the crime of the principal agent. What was condemned in 1679 was immediate material cooperation.

It was the verdict of the Magisterium that intimate involvement with the immoral acts of others can corrupt even morally indifferent acts of cooperation. One cannot directly contribute even in a material way to the evil acts of others. The clerk in the liquor store is engaged in proximate material cooperation with a particular client's alcoholism, but the bartender is engaged in immediate material cooperation. It is therefore important to focus on the distinction between immediate and mediate material cooperation, not on that between formal and immediate material cooperation. Again, duress implies loss of control and therefore a crippling of the voluntary.

Immediate material cooperation, then, is the performance of a morally good or indifferent action which is inherently and intimately bound to the performance of an evil action on the part of the principal agent, in such a way that the evil action of the principal agent stands as a defining or morally significant circumstance of the cooperator's action which corrupts its moral species such that it is rendered impermissible.

#### Duress

Duress is a vague, and therefore, broadly understood concept. Webster's Third New International Dictionary defines duress as: "restraint or check by force . . . Stringent compulsion by threat of danger, hardship, or retribution . . . Compulsion or constraint by which a person is illegally forced to do or forbear some act by actual imprisonment or physical violence to the person or by threat of such violence, the violence or threat being such as to inspire a person of ordinary firmness with fear of serious injury to the person, reputation or fortune."

The element of duress was addressed in the Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals of 1975. There, one reads: "Material cooperation will be justified only in situations where the hospital because of some kind of duress or pressure cannot reasonably exercise the autonomy it has." "Direct sterilization is a grave evil. The allowance of material cooperation in extraordinary cases is based on the danger of an even more serious evil, e.g., the closing of the hospital could be under certain circumstance a more serious evil." Also, it states: "In making judgments about the morality of cooperation each case must be decided on its own merits. Since hospital situations, and even individual cases, differ so much. it would not be prudent to apply automatically a decision made in one hospital, or even in one case, to another."

Here, one discerns the nature of the duress which the National Conference of Catholic Bishops (NCCB) (and the Congregation for the Doctrine of the Faith) have in mind. Authors who write about duress stress the fact that duress should not "be exaggerated to justify cooperation in wrongdoing;" therefore, an analysis and expounding of the relevant Church documents on this point would seem to be helpful. In light of the dictionary's definition of duress and the ecclesiastical documents' description of elements of licit responses to duress, it seems that the

following elements are considered essential: First, duress arises from a situation of coercion or compulsion against a certain party. Duress implies threat and force to such a degree that the victim of this duress has a reasonable loss of will in light of the situation. This element of fear or threat removes this from the realm of the purely voluntary in an ethically significant sense, and therefore, from the realm of the principles of cooperation as they were conceived in the tradition. Here one crosses the threshold of impediments of human (moral) acts whereas the principles of cooperation as they are delineated in the textbooks remain in the arena of the voluntary. Duress implies significant characteristics of the hostage who may perform acts identical to that of the hostage taker, but whose involvement in the act of the principal agent are purely instrumental, not voluntary. That is why this is not immediate material cooperation in the way the tradition has understood it.

Second, the NCCB understands such duress to be rare, that is "episodic" to the extent that the reasons allowing for the involvement of Catholic providers in the business of sterilization cannot be articulated in the form of a policy that could be shared among hospitals nor even between one case and another in the same facility. "Since hospital situations, and even individual cases, differ so much, it would not be prudent to apply automatically a decision made in one hospital, or even in one case, to another." This episodic character which the documents speak of is important to ponder and to consider in light of what hospital administrators and sponsors are describing as "systematic duress" understood generally as market pressure or physician demands. There seems to be some disparity between the documents' understanding of duress as a relatively rare occurrence of horrific proportions and some administrators' beliefs that duress is a pressure of ever increasing force which is inherent in the very matrix of health care which demands a uniformity of provision of services, the non-compliance therewith entails gradual strangulation and eventual closure by withdrawal of professionals and their referrals. As evidence of this, administrators of Catholic hospitals point to dwindling OB/GYN admissions and foresee a decline in pediatrics as this specialty will be treating children through the age of 18, with all the challenges of adolescence.

From a different direction, there may be some relief in this disparity of understanding from the philosophical community. Among these dons, duress has both episodic and systemtic characteristics. Indeed, it is compulsion to perform certain actions which one would otherwise be unwilling to perform, but is coerced to do through threat of injury, death or other damage which has been sanctioned and mandated by legal authority of the State. Here, for examaple, one finds that certain States require all HMOs operative within their jurisdiction to provide contraceptive services by force of law. Catholic sponsors can embark upon engagement in ownership or partnership with HMOs only by "providing for the non-provision" of contraceptive services on our part through the creation of third party underwriters and the like that do what we would not involve ourselves in. (This is what Professor Grisez calls formal cooperation and what many consider phariseeism on our part.)

Until there is a meeting of the minds on the nature of duress regarding its

systemtic expression, an operative definition may be formulated as follows: Duress is an exceptional (episodic) compulsion to perform certain non-death-dealing procedures which are not permitted by the ERDs, so strong as to render the Catholic provider constrained to comply or suffer grave catastrophic loss to the mission. Duress does not strictly fall under the principles of cooperation, but rather under the non-voluntary principles of compliance under force.

While Catholic hospitals must insist on their sovereign rights of ownership and conscience, it is theoretically possible to imagine scenarios of legalized (ergo, systemic) formalities which produce structures of permanent or persistent duress habitually inhibiting the freedom of hospital administration in certain areas. However, such systemic duress would impel the Catholic sponsor to consider both negotiated dispensation from the requirements of law and/or the possibility of modification of the apostolate.

An example of systemic duress is the legal impediment of the Church to engage in religious instruction in some countries. The duress is systemic inasmuch as the law impedes the Church from engaging in the activity by threat of legal sanction and perhaps suppression ("the more serious evil" mentioned in the NCCB's reply.) However, this example is analogous because the non-provision of religious instruction is a legal impediment to engaging in a certain action, whereas in the hospital setting, what is being addressed is that duress which would force one to engage in the *performance* of an act considered immoral. There is a great difference between being prohibited from doing a good thing, and being forced to do something evil. Also, the moral reflex responds differently to the two scenarios: with regret in both, but with a hope in patient endurance when impeded from being free to teach the faith, and with a sense of anger resulting from a certain defilement having been forced into being an instrument of evil in the case of engaging in an act we believe to be evil.

#### **Two Problematical Applications**

In conclusion, I would like to mention two items of concern to sponsors, administrators and bishops. The first is regards the shape and direction of health care delivery evolution through the creation of Integrated Delivery Networks. One of the most vexing questions is what is the evolution going to lead us to in five, ten, fifteen years? Today, individual hospitals are joining together to form Management Corporations which are being giving broad and deep powers of control over the various hospitals in the Network to "rationalize" care. In general, the individual hospitals remain owned by the respective sponsors (Catholic or non-Catholic), each retains its own board of directors and each sponsor remains the sole member of the hospitals corporation. It is foreseen that these Management Corporations are themselves becoming the center of health care delivery and gravitate toward the assumption of ever increasing authority over the hospitals. It is argued that for efficiency, the Management Corporation should become a Holding Company which itself becomes the sole corporate member of the hospitals. (The members of the Holding Company are the collective sponsors

of the hospitals.) Note that in this schema, the Catholic sponsor is no longer the sole member of their apostolate's corporation: The question is: if actual control of the hospital in the areas we regard as the domain of reserved powers can be given to the religious sponsors through contractual arrangement with the Holding Company, is this enough to constitute *sponsorship* (not defined in the Code of Canon Law), in the face of the cessation of *ownership*? It seems to me that if the assets of the hospital are sold to a (non-Catholic) holding company, there is certainly alienation of property. But the next question is if the Religious Congregation can retain *control* of the elements of reserved powers, can this hospital still be considered to be Catholic? What constitutes Catholic sponsorship: ownership, control or both?

Second, with relation to purchase of physicians' practices. The writing of prescriptions for oral contraceptives is increasingly problematical. In my encounters with physicians and religious sponsors throughout the country, it has been my experience that there is emerging consensus that professionals' practice cannot be "owned" in the usual sense of the work. They are not technicians nor mere instruments of a corporation. Their professional persona is larger than their "employment contract." If they prescribe oral contraceptives, it cannot be done as an agent of their employer, but as a private professional. This means that it must be written on their own (not St. Swithun's) prescription pad which means they are solely liable for their action and its outcome.

#### Conclusion

Can the soul of Catholic health care be saved? Certainly, its body is changing rapidly. As Charles Osgood says, "as I get older, I realize my body is playing by different rules." This is true of health care. But I hope that the changes in the body signal a development in maturity rather than being symptomatic of terminal illness. Let us hope that these changes are the dawn of mid-life rather than the departure of the soul at death.

#### References

- Richard McCormick, S.J. "The Catholic Hospital Today: Mission Impossible?" Origins Vol. 24, no. 39 [March 16, 1995] 648-653.
  - 2. Ibid. 649.
- 3. Germain Grisez. "Difficult Moral Questions: How Far May Catholic Hospitals Cooperate with Non-Catholic Providers?" *Linacre Quarterly*. Vol. 62, no. 4 67-72.
- Catholic Health Ministry in Transition: A Handbook for Responsible Leadership. Silver Spring, MD.: National Coalition on Catholic Health Care Ministry. 1995.
- 5. DS 2151. See Russell E. Smith. "The Principles of Cooperation and their Application to the Present State of Health Care Evolution." *The Splendor of Truth and Health Care: Proceedings of the Fourteenth Workshop for Bishops.* Braintree, MA.: Pope John Center. 1995. 217-231.
  - 6. Grisez, op. cit. 71.
  - 7. ibid. 70.
  - 8. ibid. 68f.
  - 9. ibid. 71.
- 10. Ludovico Bender, O.P. "Scandal." *Dictionary of Moral Theology*, ed. Pietro Palazzini. Westminster, MD.: The Newman Press. 1962. 1096. See Smith, op. cit. 224.
- Charles Curran. "Cooperation in a Pluralistic Society." Ongoing Revision in Moral Theology. Notre Dame: Fides/Claretian. 1975. 210-228.
- James Fr. Keenan, SJ and Thomas R. Kopfensteiner. "The Principle of Cooperation." Health Progress. April 1995. 26.