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## CATHOLIC HEALTH CARE AND THE DIOCESAN BISHOP

REV. JOHN J. COUGHLIN, O.F.M.\*

Over the course of the last decade, the provision of health care in the United States has been undergoing a radical transformation. The days when an insurer, such as Blue Cross and Blue Shield, paid a standard fee to a physician who provided a specified service to an individual patient are passing rapidly.<sup>1</sup> This fee-for-service concept, which characterized American health care from the end of World War II until the 1990s, is being supplanted by a variety of arrangements that fall under the general rubric of "managed care."<sup>2</sup> The fundamental approach of managed care is to provide the patient with all necessary medical services at the lowest cost.<sup>3</sup> The business-

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<sup>1</sup> See JOHN C. GOODMAN, *THE REGULATION OF MEDICAL CARE: IS THE PRICE TOO HIGH?* 72-73 (1980). The author notes that:

Under cash indemnity medical insurance, doctors and patients determine medical fees jointly at the time the medical services are sold, just as if there were no medical insurance. All or part of the medical bill is then paid by the insurance plan, depending on the specifics of the policy. Examples of medical indemnity insurance are Blue Cross and Blue Shield plans.

*Id.*

<sup>2</sup> GEORGE D. POZGAR & NINA SANTUCCI POZGAR, *LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION* 617 (6th ed. 1996) ("Managed care is the process of structuring or restructuring the health care system in terms of financing, purchasing, delivering, measuring, and documenting a broad range of health care services and products.")

<sup>3</sup> See *SOURCE BOOK OF HEALTH INSURANCE DATA: 1996*, 28 (A. F. Minor ed., 1997) ("Managed care plans have the following common elements: arrangements

oriented approach of the for-profit corporate insurer aims to maximize shareholder satisfaction.

Perhaps, the most conspicuous aspect of managed care at the present time is the for-profit Health Maintenance Organization (HMO).<sup>4</sup> Typically, an HMO sells a list of delineated, but not always comprehensive, medical services to patients for a fixed price.<sup>5</sup> The HMO then contracts with primary-care physicians to provide basic medical care.<sup>6</sup> The physicians act as gatekeepers controlling patient access to specialized and expensive technology.<sup>7</sup> Sometimes, the physicians are salaried employees of the HMO.<sup>8</sup> Alternatively, they act as independent contractors, who receive a fixed per-patient payment regardless of the frequency of visits or type of primary care provided.<sup>9</sup> In either case, the relationship between the HMO and the physician acts as an incentive for the individual physician to provide only necessary treatment,<sup>10</sup> and

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with selected providers to furnish a comprehensive set of health care services to members; . . . significant financial incentives for members to use providers and procedures covered by the plan.”); HEALTH CARE CORPORATE LAW: MANAGED CARE 1-5 (Mark A. Hall & William S. Brewbaker III eds., 1996) [hereinafter Hall & Brewbaker] (“Because they retain any leftover money, HMO’s have an incentive to keep people well—thus the term ‘health maintenance.’”).

<sup>4</sup> See POZGAR & POZGAR, *supra* note 2, at 617 (“[HMO’s] are the most highly regulated form of MCOs.”).

<sup>5</sup> See Hall & Brewbaker, *supra* note 3, at 1-6 (“HMOs provide both hospital and medical service coverage to their members in exchange for prepaid fixed monthly fee.”).

<sup>6</sup> See POZGAR & POZGAR, *supra* note 2, at 617 (“Individuals who subscribe to an HMO are often limited to the panel of doctors who have contracted with the HMO to provide services to its subscribers.”); Hall & Brewbaker, *supra* note 3, at 1-5 (“[A]n HMO . . . provides physician services through physicians who are employees of the HMO or who are under contract with the HMO.”).

<sup>7</sup> See Hall & Brewbaker, *supra* note 3, at 1-6 (“By limiting coverage to participating providers who typically are reimbursed on a salaried, capitated or other financial risk-sharing basis, the HMO has a greater ability to control medical costs by negotiating volume discounts from providers and by exercising greater control over providers’ resource utilization.”).

<sup>8</sup> See POZGAR & POZGAR, *supra* note 2, at 617 (“In a staff-model HMO, the physicians would normally be full-time employees of the HMO.”).

<sup>9</sup> See POZGAR & POZGAR, *supra* note 2, at 617 (“An Independent practice association (IPA)-model HMO provides medical care to its subscribers through contracts it establishes with independent physicians.”).

<sup>10</sup> See *supra* note 7 and accompanying text; see also Hall & Brewbaker, *supra* note 3, at 1-7 (“Under some HMOs’ risk-sharing arrangements with providers, financial risk is allocated based on a comparison of actual and projected utilization rates. . . . There is thus a financial incentive to avoid unnecessary tests, hospitalizations, and procedures.”).

thus contain cost. The problem emerges over the definition of what constitutes a "necessary medical service."<sup>11</sup> Depending on the definition supplied by the HMO, a patient could be deprived of comprehensive quality health care.<sup>12</sup>

HMOs also negotiate with hospitals to arrive at a fixed per-patient payment or capitation remuneration.<sup>13</sup> As an aspect of the negotiations, the HMO will frequently require drastic cuts in the hospital's charges for certain services. For example, an HMO might demand that a hospital slice its charge for open-heart surgery, usually a profitable enterprise, which the hospital uses to offset the costs of less profitable services. Additionally, hospitals, which have long been concerned with daily census counts, now feel the pressure to negotiate capitation contracts with HMOs that limit patient days and services.<sup>14</sup> This has a devastating impact on the daily census as the number of empty beds increases. The corresponding decrease in revenue available to hospitals threatens not only the quality of patient care, but also medical research, physician training programs, and investment in cutting-edge medical technology, to mention but a few broad areas.

It should come as no surprise then that the Catholic health care ministry is experiencing the effects of sweeping changes in the ways in which health care is generally provided throughout the United States. These changes, however, may now threaten the very nature and mission of Catholic health care. Consistent with the teaching of Christ, Catholic hospitals have traditionally embraced a mission of providing health care for the society's poor and forgotten.<sup>15</sup> In the New York City metropolitan area, for

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<sup>11</sup> See Hall & Brewbaker, *supra* note 3, at 4-33 ("Because most contracts cover services only where they are 'medically necessary,' the definition of this and similar terms such as 'experimental' is crucial.").

<sup>12</sup> See GOODMAN, *supra* note 1, at 107 ("[I]n an extreme case an HMO has 'a temptation to let a patient die of cardiac arrest rather than place him in the intensive care unit at a cost of \$300 per day.'") (citation omitted).

<sup>13</sup> See Hall & Brewbaker, *supra* note 3, at 4-34 (explaining that hospitals are compensated in different ways, and further stating that hospitals are permitted—for the time being—to be capitated by self-insured employers).

<sup>14</sup> See Catherine G. Vanchiere, *Stalled on the Road to Health Care Reform: An Analysis of the Initial Impediments to the Oregon Demonstration Project*, 10 J. CONTEMP. HEALTH L. & POLY 405, 410 n.35 (1994) (explaining the need for safeguards against the danger that HMO's can inappropriately limit patient services or provide substandard services in order to save money) (citation omitted).

<sup>15</sup> See Mary Johnson, *The Reweaving of Catholic Spiritual and Institutional Life*, 558 ANNALS AM. ACAD. POL. & SOC. SCI. 135, 136 (1998) (stating "Catholics

example, Catholic hospitals served a crucial role from the beginning of the HIV crisis during the 1980s by affording quality health care to persons with AIDS.<sup>16</sup> When many institutions and health care professionals were tempted to eschew the care of AIDS patients, His Eminence John Cardinal O'Connor, the late Archbishop of New York, became a quiet but effective advocate for literally thousands of human beings afflicted with a terrifying and terminal illness.<sup>17</sup> Catholic not-for-profit institutions such as St. Vincent's Medical Center, a major tertiary-care hospital located in Greenwich Village, and St. Clare's Hospital, a specialized facility dedicated to the care of AIDS patients located in the Hell's Kitchen section of the City, answered the call of the Cardinal.<sup>18</sup> If the chief concerns had been cost efficiency and maximized profit, O'Connor's position and the Catholic mission would have been untenable. Church leaders now worry that the mission of the Catholic hospitals may be compromised.<sup>19</sup> Not only the availability of health care to the poor, but the quality of health care in general is bound to suffer in a situation in which financial concern trumps the dignity of each individual human being.

Fulfilling a related aspect of their traditional mission, Catholic hospitals have also served as a beacon of light to society with regard to profound moral issues. In the face of strong political and financial pressures to jettison moral principles, Catholic hospitals have consistently refused to permit the killing of the unborn as well as physician-assisted suicide of the elderly and terminally ill.<sup>20</sup> As part of the effort to afford quality health

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today are exulting in the sense of mission . . . manifested in the tens of thousands of Catholic [hospitals]”).

<sup>16</sup> See Michael Ratner, *How We Closed the Guantanamo HIV Camp: The Intersection of Politics and Litigation*, 11 HARV. HUM. RTS. J. 187, 215 n.88 (1998) (explaining how Catholic hospitals treated Haitian AIDS victims, making a foray into treating people with AIDS).

<sup>17</sup> See Mario M. Cuomo, *Compassion of a Cardinal*, N.Y. TIMES, Jan 20, 2000, at A19 (explaining the Cardinal's efforts to help Manhattan citizens suffering from AIDS).

<sup>18</sup> See Ratner, *supra* note 16, at 215 (explaining Cardinal O'Connor's involvement in treating AIDS victims in early 1990s); Cuomo, *supra* note 17, at A19 (stating “[i]n 1983 . . . the cardinal made St. Clare's Hospital in Manhattan a haven for AIDS victims”).

<sup>19</sup> See *infra* note 20.

<sup>20</sup> See Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1463-71 (1995) (taking an in-depth look at the tension between religious and constitutional issues regarding

care to the poor, the Catholic Bishops of New York State, under the leadership of Cardinal O'Connor, recently established Fidelis Care, a not-for-profit HMO for Medicaid patients.<sup>21</sup> Despite enormous pressure from various government officials, Fidelis limits its maternity coverage to pro-life medical services.<sup>22</sup> Fidelis must compete with for-profit HMOs, which also serve Medicaid recipients.<sup>23</sup> Likewise, Calvary Hospital, located in the Bronx, New York, has long served as a model hospital for the provision of excellent care to persons with terminal cancer. Will Catholic institutions such as Fidelis Care, and Calvary Hospital be left with no alternative but to face financial ruin or cede to the incentive to cut costs even at the expense of the violation of the Catholic teaching about the dignity and sacredness of every human life? It is unfortunately all too realistic to imagine the incentive to euthanize, especially the lives of the poor and powerless, in the current managed-care environment that focuses on cutting costs and returning profits for investors in the market. This grave concern now confronts Catholic hospital administrators, medical professionals, religious sponsors, chaplains, and bishops, who are in some way responsible to safeguard the mission of Catholic health care.

As the courageous example of Cardinal O'Connor demonstrates, the diocesan bishop is entrusted with a profound pastoral responsibility for any health-care ministry undertaken within his diocese.<sup>24</sup> Consistent with the spirit of the Second

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the right to die and physician assisted suicide); see also Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patient Rights*, 51 STAN. L. REV. 1703, 1720–21 (1999) (discussing end-of-life decision-making in Catholic hospitals).

<sup>21</sup> See White, *supra* note 20, at 1738 (defining Fidelis Care as “the Catholic-sponsored HMO serving Medicaid managed care patients in New York”).

<sup>22</sup> The pro-life policy is clearly explained to potential enrollees prior to the choice of Fidelis as the HMO. Under New York regulations, enrollees in Fidelis are also permitted to chose another HMO that provides services such as abortion, sterilization and contraception, which Catholic institutions may not provide. See White, *supra* note 20, at 1740 (describing the Fidelis Care policy regarding family planning which includes refusal to cover abortions, which New York State generally funds for Medicaid recipients, and the fact that these policies are made clear to subscribers at enrollment).

<sup>23</sup> See White, *supra* note 20, at 1740 (explaining how patients requesting family planning services must be provided with a list of Medicaid providers throughout New York State).

<sup>24</sup> See National Conference of Catholic Bishops Administrative Committee, *The Bishop's Pastoral Role in Catholic Health Care Ministry*, 26 ORIGINS 700, 700–04 (1997) [hereinafter NCCB Administrative Committee] (describing Catholic bishops

Vatican Council, this pastoral responsibility is to be fulfilled in an environment marked by collegiality.<sup>25</sup> From a theological perspective, the primary experience of collegiality in the Church locates itself in the College of Bishops. Catholic doctrine holds that the members of the College act as Successors to the Twelve Apostles, who were selected by Christ.<sup>26</sup> In accord with this doctrine, any other experience of collegiality in the Church is only by analogy to that of the College of Bishops. Yet, the analogy serves to inform the exercise of episcopal ministry in relation to all those who individually and communally acknowledge the authority of the diocesan bishop. The historical reality in the United States remains that in many instances, Catholic hospitals have been founded and operated by communities of religious women, whose members have made untold sacrifices for the mission of their respective institution.<sup>27</sup> No bishop would rightfully ignore this enduring historical truth. Thus, in exercising his role, the wise and prudent diocesan bishop will be mindful to function in a collegial, consultative, and cooperative manner, and especially with those women's religious communities and members who have proven their utter dedication to the Church over the course of time.

The theological foundation for a bishop's responsibility is recognized in the teaching of the Second Vatican Council<sup>28</sup> and expressed canonically in the universal law of the Church.<sup>29</sup> Based upon the mandate of Christ, the diocesan bishop exercises the sacred power to teach, govern, and sanctify.<sup>30</sup> As principal

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pastoral role and leadership in sustaining and revitalizing the health care ministry of the church).

<sup>25</sup> See Johnson, *supra* note 15, at 138 (claiming the initiatives of the Second Vatican Council include movement toward communal spirituality among bishops).

<sup>26</sup> See generally Michael D. Belsley, *The Vatican Merger Defense—Should Two Catholic Hospitals Seeking to Merge be Considered a Single Entity for Purposes of Antitrust Merger Analysis*, 90 NW. U. L. REV. 720, 748–49 (1996) (explaining the role of the college of bishops in the church government).

<sup>27</sup> See White, *supra* note 20, at 1741 (noting for example that “Mercy Health Services [was] established by the Religious Sisters of Mercy”).

<sup>28</sup> See *supra* note 26.

<sup>29</sup> See sources cited *infra* note 30.

<sup>30</sup> See *Sacrosanctum Concilium Oecumenicum Vaticanum II: Constitutio Dogmatica de Ecclesia, Lumen Gentium*, 57 ACTA APOSTOLICAE SEDIS 5–89, § 20 (1965) [hereinafter *Lumen Gentium*]; *Sacrosanctum Concilium Oecumenicum Vaticanum II: Decretum De Pastoralis Episcoporum Munere In Ecclesia, Christus Dominus* 58 ACTA APOSTOLICAE SEDIS 673–96 § 11 (1966) [hereinafter *Christus Dominus*]; 1983 CODE c.375, § 2 (in *Codex Iuris Canonici auctoritate Ioannis Pauli*

teacher, he “elicits openness and receptivity to the splendor of the truth,”<sup>31</sup> and remains steadfast that the provision of Catholic healthcare reflects the truth.<sup>32</sup> He exercises his sanctifying ministry on behalf of the entire people of God entrusted to his care, and thus he enables the celebration of the sacraments in health-care settings throughout the diocese as a great sign of unity and bond of charity.<sup>33</sup> Patterned upon the humble service and sacrificial love of Christ, the diocesan bishop governs the particular church to insure the integrity and coordination of all healthcare ministry.<sup>34</sup> Describing the bishop’s sacred power of governance, the Second Vatican Council affirmed that he is set over the particular church, and called for “close collaboration and the coordination of all apostolic works under his direction.”<sup>35</sup> The Church in the United States has adopted the *Ethical and Religious Directives*, which acknowledge the responsibility of the diocesan bishop with regard to the many complex arrangements that Catholic healthcare institutions are considering to sustain their ministry at a time of nationwide significant change.<sup>36</sup> The authority of the bishop’s office does not *per se* endow the office holder with the necessary expertise to understand the complexities of modern health care. Episcopal authority does, however, call for the recognition that the bishop, accepting the proper guidance gained through a genuinely collaborative effort, has been blessed with the grace of his sacred office to discern what course of action will, as a whole, best serve the mission of the Church.<sup>37</sup>

The apostolic activity of religious, in particular, constitutes an important element of that communion, which is the particular

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*Pp. II promulgatus*, 85 ACTA APOSTOLICAE SEDIS 1–317 (1983)), English translations of the *Codex Iuris Canonici* are taken from CODE OF CANON LAW ANNOTATED (E. Caparros et al. eds., 1993).

<sup>31</sup> See NCCB Administrative Committee, *supra* note 24, at 701.

<sup>32</sup> See *Lumen Gentium*, *supra* note 30, at 23; 1983 CODE c.756, § 1; see also Ioannes Paulus Pp. II. *Litterae Encyclicae: Veritatis Splendor*, 85 ACTA APOSTOLICAE SEDIS 1133–1228, § 4 (1994).

<sup>33</sup> See *Sacrosantum Concilium*, 22; 1983 CODE c.837, § 1.

<sup>34</sup> See *Lumen Gentium*, *supra* note 30, at 27; *Christus Dominus*, *supra* note 30, at 17; 1983 CODE c.135, § 1.

<sup>35</sup> See *Lumen Gentium*, *supra* note 30, at 24; *Christus Dominus*, *supra* note 30, at 17.

<sup>36</sup> See National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 24 ORIGINS 449, 460 (1994) (quoting Directives 67 and 68).

<sup>37</sup> See 1983 CODE c.129, § 1.



church with the bishop at its head.<sup>38</sup> While religious enjoy an autonomy of governance with respect to decisions that are internal to the institute, apostolic activity conducted by religious within a diocese falls under the jurisdiction of the bishop.<sup>39</sup> In directing a health-care ministry conducted by religious, the diocesan bishop and the religious superior "must proceed by way of mutual consultation."<sup>40</sup> Ultimately, with respect to the apostolate undertaken within his diocese, "religious are subject to the authority of the bishop, whom they are bound to treat with sincere submission and reverence."<sup>41</sup>

The diocesan bishop's responsibility extends not only to those health-care apostolates conducted by religious, but to all health-care apostolates including those initiated and conducted by the Catholic laity.<sup>42</sup> All "Christ's faithful are bound to show Christian obedience" to their bishop and pastors "who represent Christ" when these sacred pastors teach the faith and prescribe rules of governance.<sup>43</sup> Along with his obligation to coordinate apostolic activity, the diocesan bishop must "be vigilant about the use of the Catholic identity by any individual or group operating within his diocese."<sup>44</sup> Accordingly, an apostolic endeavor may not be called "Catholic" without the permission of the diocesan bishop. Thus, the diocesan bishop is obligated to exercise authority over all health-care apostolates conducted within his diocese. This includes the apostolic activity of both diocesan and pontifical-right religious, as well as that of any private or public juridic person.<sup>45</sup> It would seem to follow from these theological and canonical realities, that a significant modification in the mission, religious identity, ethical practice, and/or the juridic or corporate status of a Catholic health-care provider requires the approval of the diocesan bishop.

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<sup>38</sup> See *Lumen Gentium*, *supra* note 30, at 44; *Christus Dominus*, *supra* note 30, at 35; 1983 CODE c.c.675, 681, § 1.

<sup>39</sup> 1983 CODE c.681.

<sup>40</sup> 1983 CODE c.678, § 3.

<sup>41</sup> 1983 CODE c.c.678 § 1, 681 § 1.

<sup>42</sup> See 1983 CODE c.212 § 1, c.c.216, 394 §§ 1-2.

<sup>43</sup> 1983 CODE c.212 § 1.

<sup>44</sup> NCCB Administrative Committee, *supra* note 24, at 703; See Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159, 210 (1997).

<sup>45</sup> For an explanation of these terms, see 1983 CODE c.c.96-112; see also Ellsworth Kneal, *Physical and Juridic Persons*, in THE CODE OF CANON LAW, A TEXT AND COMMENTARY 70-87 (J. Coriden et al. eds., 1983).

A related matter is raised by the concept of the alienation of ecclesiastical property as envisioned in the *1983 Code of Canon Law*.<sup>46</sup> While the law itself does not delineate the precise meaning of alienation, commentators seem to agree that the concept of alienation must be interpreted broadly to include any action that affects the rights of the Church over ecclesiastical property.<sup>47</sup> For example, alienation would include in addition to sale, *inter alia*, mortgage, merger, lease, easement, option, compromise, types of affiliation, settlement, renting, and leasing.<sup>48</sup> Accordingly, it seems helpful to distinguish between *de jure* and *de facto* alienation. Simple or *de jure* alienation occurs when title or ownership of ecclesiastical property is directly and legally transferred from one party to another.<sup>49</sup> In contrast, recent developments in the healthcare industry raise significant concerns about *de facto* or virtual alienation. Virtual alienation occurs when the rights over, and/or control of, ecclesiastical property are modified by some new venture, partnership, affiliation or relationship, which dissipates or even effectively eliminates ecclesiastical control. Often times, such new arrangements set virtual alienation in motion so that in a matter of time the Church has lost all legal control over the healthcare provider. This type of alienation can take place even while the healthcare provider continues to claim the Catholic identity. The diocesan bishop is obligated by the law to safeguard the conduct of the healthcare apostolate especially when a question of virtual alienation is at issue.<sup>50</sup> In some instances, what could appear to be a positive collaboration could result in *de facto* alienation of church property and the loss of apostolic activity.

As the coordinator of all apostolic activity within his diocese, the diocesan bishop fulfills a service to assess what is right and just both for any particular Catholic health-care institution and also for the whole healthcare ministry of the particular church and the entire ministry throughout the United States.<sup>51</sup> To this

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<sup>46</sup> See 1983 CODE cc.1290–98.

<sup>47</sup> See John J. Myers, *The Temporal Goods of the Church*, in THE CODE OF CANON LAW, A TEXT AND COMMENTARY 879–80 (J. Coriden et al. eds., 1983).

<sup>48</sup> See THE CANON, LAW LETTER AND SPIRIT, A PRACTICAL GUIDE TO THE CODE OF CANON LAW 732–33 (1995).

<sup>49</sup> See 1983 CODE c.1291.

<sup>50</sup> See Singer, *supra* note 44, at 211.

<sup>51</sup> See Singer, *supra* note 44, at 210.

end, it seems advantageous for the diocesan bishop to ensure that a Catholic healthcare provider renders priority to collaboration with other Catholic healthcare providers. Through attentiveness to the long-term effects of the proposal, his action will serve to protect their individual and collective well-being.

In today's national healthcare industry, collaboration among different hospitals and other healthcare providers is often seen as essential to survival, and it routinely crosses diocesan territorial boundaries.<sup>52</sup> It may be detrimental to the common good when a bishop permits or tolerates a collaborative arrangement between a Catholic and non-Catholic provider, which overlooks the possibility for collaboration between Catholic institutions. Likewise, it would seem to detract from the common good when one diocesan bishop permits what another bishop has taken care to prevent. A lack of a uniform policy in the Church may give rise to confusion and scandal. Alternatively, when two or more particular churches unite in a common effort, the bishops' efforts testifies to the catholicity of the whole church.<sup>53</sup>

Consistent with the spirit of Vatican II, the diocesan bishop will ordinarily proceed in a collegial manner in exercise of the power of governance over the diocese. The local bishop ought not to act in a manner that infringes upon the right of religious or any other healthcare provider in the Church to accomplish alienation of their own real property according to the norm of law. He cannot, however, abdicate his responsibility to coordinate all the apostolic activity of the diocese. Nor should he permit any apostolic activity, which claims a Catholic identity to drift from complete fidelity to the teaching and law of the Church. If required to do so for the bond of unity and charity of the *communio* of the Church, he has a moral and legal obligation to intervene in order to ensure the ongoing Catholic identity and nature of all apostolic endeavors and their administration of property. Accordingly, he must also not allow the demise of the Catholic Church's healthcare apostolate through business practices, affiliations, partnerships, mergers, ventures, and any

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<sup>52</sup> See Lawrence E. Singer & Elizabeth J. Lantz, *The Coming Millennium: Enduring Issues Confronting Catholic Health Care*, 8 ANN. HEALTH L. 299, 306 (1999).

<sup>53</sup> See *Lumen Gentium*, *supra* note 30, at 23; *Christus Dominus*, *supra* note 30, at 37.

other relationships that *de facto* eliminate the gospel-centered mission of the Church. Ideally, all those involved in the Catholic healthcare apostolate will be committed to collaborate with the diocesan bishop in a collegial and trustful manner to testify to the Church's profession, adherence to the truth and love of Jesus Christ.

