A Three-Pronged Approach to Ecclesial Relations for Catholic Health Care Facilities

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The *Code of Canon Law*, the Second Vatican Council, and the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* from the United States Conference of Catholic Bishops all affirm the pastoral responsibility of the local bishop for all Catholic health care ministries within his diocese.[1] And while the importance of the need for mutual cooperation between a Catholic medical facility and the local bishop is officially acknowledged, in practice the relationship between the two is often tenuous, strained, or practically non-existent. After all, diocesan bishops are not experts in health care and medical treatments. Plus, many Catholic medical facilities either hire ethicists or work within systems that provide ethics consultation to ensure fidelity to the ERDs and Catholic moral teaching. Given this two-fold reality, maintaining a pro-forma relationship with the bishop would appear adequate. Indeed, in the past while serving on the ethics committee for a Catholic hospital, it seemed to me that hospital administrators only spoke with the diocesan bishop's office when there were major ethical problems that had occurred. And while such major issues did not arise often, when they did, such discussions were almost always "after the fact" and were more concerned with damage control than building the "mutual cooperation" mentioned before.

Can Catholic health care do better than this? Further, rather than being an added burden or nuisance, would not a more integrated relationship between Catholic medical facilities and the local diocese strengthen Catholic health care ministry as a whole?

I believe the answer to both questions is a definitive yes, and can be illustrated by the current situation in the relationship between the Diocese of Kansas City-St. Joseph and our two Catholic hospitals, St. Joseph Medical Center and St. Mary's Medical Center. Both hospitals have a long history in the Kansas City area. The Sisters of St. Joseph of Carondelet came to our city in the late 1800s to establish schools for the growing population. But they soon realized that there was also a need for better health care services in the region, especially for the city's poor. They eventually established St. Joseph Hospital in 1874. The Sisters of St. Mary were invited to Kansas City

to take over the operation of the city's German Hospital. After much local encouragement they opened their own hospital, St. Mary's, in 1909. The two orders of Sisters officially merged their hospital operations in 1997 and formed Carondelet Health, which was eventually bought by Ascension Health in 2002. Thus, our hospitals have more than a century of health care ministry to the people of Kansas City. However, in 2012 Ascension began seeking a buyer for the two facilities. In 2015 they were sold to Prime Healthcare, Inc., a for-profit company based in California.[2]

The sale to a for-profit company caused great concern among Catholics in the Kansas City area, who feared that the legacy of the two orders of Sisters was about to come to an end. But the representatives of Prime Healthcare, Inc., recognized the value of the historic missions of the two hospitals, and as part of the sale entered into a formal covenant agreement with the Diocese of Kansas City-St. Joseph, which we refer to as the Catholic Traditions Agreement. The most important aspect of the agreement is that Prime affirmed they would maintain the Catholic identity of the hospitals and abide by the ERDs in all of their operations. But what has become an even more interesting outcome of the Catholic Traditions Agreement has been the method that was set up to verify that the hospitals are operating as Catholic facilities. It was especially important for the diocese to ensure that if the hospitals were going to retain their names, continue the legacy of their founding Sisters, and be recognized as Catholic facilities, there would need to be a clear and ongoing method of assessing their fidelity to the covenant agreement. In short, a merely adequate ecclesial relationship between the diocese and the hospitals would not suffice. The method that was created involves a three-pronged approach centered on the establishment of a new Office of Catholic Health Care within the diocese to oversee the Catholic identity of the hospitals, and serve as the primary liaison between the facilities and the bishop's office.

Here are the basics of this three-pronged approach. First, as a visible sign of their Catholic identity, the hospitals agreed to maintain a Director for Mission Integration. The director is hired by the hospitals, but the bishop has the right to approve of their candidate, who must be a Catholic in good standing with the Church with training and experience in Catholic health care ministry. As a "director," this person participates in senior-level administrative meetings and has a seat on the governing board of each hospital. The director also has access to the surgical logs and reviews them daily to ensure what procedures are being performed every day in each facility. Finally, the director covers an anonymous "hotline" that has been established for both staff and patients to report concerns affecting our Catholic identity. In effect, the Director of Mission Integration is an "inside person" overseeing the Catholic culture of the facilities, while working closely with the Director of Catholic Health Care for the diocese who represents the second prong of this approach.

The Office of Catholic Health Care was established as a condition of the sale and is funded by the hospitals. The rationale is that Catholic health care represents a unique and

important niche within the American health care market, providing a strategic marketing advantage and brand recognition as it were for any owners. And so, an investment by the hospitals towards maintaining their Catholic identity was warranted. However, in our approach, the director of this office is hired by the diocese and serves as part of the Chancery staff. The director must be a Catholic in good standing with the Church, and have expertise in Catholic moral teaching, health care ethics, and the ERDs. The Director of Catholic Health Care serves as the primary liaison between the Director of Mission Integration within the hospitals and the diocese, and has regular meetings with both sides. The director also sits on the ethics committee for the hospitals, as well as the governing board as a representative of the bishop. And although the Director of Catholic Health Care works with the Director of Mission Integration, there is also direct two-way communication with the CEOs, CMOs, and CNOs of both hospitals that creates the spirit of mutual cooperation that lies at the heart of ecclesial relations with Catholic health care facilities. In effect, the Director of Catholic Health Care is an "outside person" working with the hospitals and providing an objective perspective and helpful input regarding their Catholic identity.

The third and final prong of this approach is the Vicar General – Vicar for Clergy of the diocese. Since the Director of Catholic Health Care works at the Chancery, there is direct and open communication with the Vicar General, who in turn keeps the bishop informed of all matters related to the Catholic identity of the hospitals. The Vicar General also sits on the ethics committee for the hospitals, and so is directly involved in discussions of Catholic identity in those meetings with hospital personnel as well. The Director for Catholic Health Care also meets regularly with the Vicar General and the bishop. In effect, the Vicar General is the "inside person" for the diocese with direct access to the bishop. With this approach, the Director of Mission Integration in the hospitals, the Director of Catholic Health Care for the diocese, and the Vicar General representing the bishop, have direct, open, and continual communication. And given that the Director of Catholic Health Care operates with both the hospitals and the bishop's office, the lines of communication are seamless. This has allowed us to be proactive regarding areas of concern for the hospitals' Catholic identity, preventing many potential problems from ever arising. And in those few cases in which issues have arisen retroactively, the lines of communication allow us to address such matters in a timely fashion and avoid scandal. In sum, this three-pronged approach offers a truly integrated method of ecclesial relations that benefits the facilities through the direct and active support of the diocese for our local Catholic hospitals, while also benefiting the diocese by keeping the bishop continuously informed of their activities and providing open means of communication from his office to hospital administrators. This mutual understanding and support have strengthened the Catholic health care ministry in Kansas City, preserving and promoting the legacy of our founding Sisters. ✣

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ENDNOTES

1. For a summary of the relevant Codes, teachings of Vatican II, and the ERDs, see John J. Coughlin, "Catholic Health Care and the Diocesan Bishop," 40 *Cath. Law*. 85 (2000-2001). Available at: https://scholarship.law.nd.edu/law_faculty_scholarship/69, and Barbara Anne Cusack, JCD, "The Role of the Diocesan Bishop in Relation to Catholic Health Care," *Health Progress,* July-August 2006, pp.64-65.
2. Historical information provided by Marty Denzer, "St. Joseph's and St. Mary's Are Catholic Hospitals in Action," *The Catholic Key*, 9/11/2015, available online at: https://catholickey.org/2015/09/11/st-josephs-and-st-marys-are-catholic-hospitals-in-action/.