FROM THE FIELD

CDF Principles for Collaboration with Non-Catholic Health Care Entities: Ministry Perspectives

Editor's Note: On February 17, 2014, the Congregation for the Doctrine of the Faith, under the signature of Cardinal Mueller, issued a reply (but not an official responsum) to a question that it had received from the USCCB in April, 2013. The question had to do with whether a Catholic health care system could become non-Catholic. While the CDF did not directly respond to the question, seeing it as a concrete application of established moral principles, it did forward to the USCCB a set of seventeen principles to guide the forming of partnerships with non-Catholic organizations. The principles were intended to be of assistance to the bishops of the United States. While awaiting comment on the principles by the USCCB, we include here several reflections on the principles from ethicists in or associated with Catholic health care. Contributors were asked to reflect on 1) Is there anything new in the principles? If yes, what? And what are the implications of that for Catholic health care? 2) If no, then how can this document be helpful in forming partnerships? What effects might it have on forming future partnerships?

It should be noted that the reply of the CDF to the dubium is not a typical "responsum." The principles do not appear on CDF stationary, the format is not that of a typical responsum, they are not signed by the Prefect and the Secretary of the CDF, they are not dated, nor is there any indication that the principles were seen by or approved by the Holy Father.

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Answering the question as to whether *Some Principles for Collaboration with Non-Catholic Entities in the Provision of Healthcare Services* by the Congregation for the Doctrine of the Faith contains anything new depends on to what the document is being compared. When compared internally to previous magisterial statements pertaining to the Principle of Cooperation, it represents a development in the sense that for the first time a delineated set of specific principles pertaining to the institutional application of the traditional Principle of Cooperation in evil is offered.[1] In this regard, there is much that is new in the document. With respect to the wider context of Catholic/other-than-Catholic health care collaboration, its content is more confirmatory than new. However, these facts are important because by confirming recent interpretations and applications of the Principle of Cooperation to collaborative efforts, the CDF *Principles* provide invaluable guidance. This guidance is evident both in what the document says and in what it does not prohibit.[2]

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Specifically, the CDF document confirms that financial viability need not be the only morally legitimate reason to engage in mediate material cooperation. It also confirms the moral legitimacy of Catholic and other-than-Catholic partners being in the same health care system, including a system with a Catholic parent. Moreover, there is no prohibition of Catholic institutions participating in for-profit systems, even if the Catholic subsidiary has no role in the governance of the system. Thus, based on the content of the *Principles*, for-profit status by itself does not seem to constitute illicit cooperation, nor does it preclude the possibility of preserving Catholic identity. It also confirms the moral legitimacy of individuals from Catholic organizations serving on boards of systems that include other-than-Catholic facilities.[3] An examination of the Prologue and some of the principles in the CDF's document will show how these points are confirmed in the document.

The Prologue is important because it confirms that the obligation to collaborate with others in charity and the Principle of Cooperation are distinct but correlative principles. Often times we need to collaborate with others in fulfilling the call to love our neighbor. This is no less true in the ministry of health care. The prologue states that ". . . effective engagement in healthcare often calls for collaboration with non-Catholic healthcare institutions, even establishing joint working arrangements in which the Catholic and non-Catholic entities are full partners. In itself, collaboration in good works is of course, a good thing . . . ." This truth lays the foundation for using improved service to the health care needs of the community as a sufficient reason justifying mediate material cooperation.

The first principle addresses the fundamental question as to whether the traditional Principle of Cooperation may apply to institutions, which is answered in the affirmative. The CDF indicates that institutions do have moral agency and therefore can cooperate in the wrongdoing of others.[4] However, the moral agency exercised by corporations is analogous to the agency of natural persons. Institutions have an identity and character, but this is caused by the decisions of natural persons. Thus, this principle emphasizes the importance of individual decision-making being consistent with Catholic teaching since those decisions determine the moral status of institutional cooperation.

That Catholic institutions do not engage in illicit cooperation simply by participating in a system with other-than-Catholic entities is evident from the fact that the *Principles* only prohibit certain kinds of activity by the Catholic partner, not the participation itself. This implicit recognition is found in most of the principles articulated by the CDF. In the terms of the *Principles*, those decisions of an administrator are prohibited that have a "close connection" to immoral actions, are "involved directly" in or are "proximately connected" to such procedures, that carry an official consent to immoral procedures, or that "enter into" the very essence of the principal act. This prohibition points to the issue of how the nature of the work of administrators factors into a cooperation analysis of partnerships. It shows that the nature of their work does not

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per se involve illicit cooperation, but only specific decisions that have a strict correlation between the content of the decision and the affected principal action (see *Principles*, ns. 1, 3, 4, 9, and 11).

The *Principles* indicate that ownership in a system that includes other-than-Catholic institutions is not by itself morally decisive, but rather the nature of the reserve powers and the decisions that the board members make is. The nature of their work pertains to global matters of the organization such as broad policy, strategic issues, global budgeting, and contractual agreements. Further evidence that a Catholic institution in a mixed system does not constitute illicit cooperation is the fact that the *Principles* allow Catholic institutions to hold "seats" on the boards of such systems, the requirements of civil law notwithstanding (*Principles*, n.11). Moreover, the *Principles* recommend recusal in appropriate situations precisely in order to allow for the continued service of Catholic representatives on system boards while avoiding illicit cooperation (*Principles*, n. 11). This means that recusal is not itself evidence that service on such boards is *per se* illicit, and it means that there is no obligation for the Catholic parties to object in every case of a supposed connection to immoral activity in order to avoid illicit cooperation.

At first glance, Principle 5 could appear to make the real risk of financial viability the only reason for mediate material cooperation, which would exclude the preservation of financial stability as a reason. However, the principle is constructed as a condition. It states that if a financial reason for cooperation is cited, it should not be financial advantage or financial stability for its own sake but grave financial pressure. This does not mean that better service to the needs of the community is excluded as a sufficient reason for material cooperation, nor does it mean that preserving current financial stability is excluded as a reason when market analysis shows that the institution will likely not be able to survive at some point in the near future unless it collaborates.

In order to understand and apply Principle 12 on setting up an independent body to oversee immoral activity, it is important to distinguish between the act of setting up an independent entity to oversee immoral procedures, and acknowledging what the Catholic parties cannot do. Establishing an independent board or committee includes actions such as drawing up its bylaws, legally incorporating the entity, and creating its policies and procedures. None of the activities of setting up the independent boards are included in what a Catholic party does. Furthermore, merely knowing that an other-than-Catholic partner will use the Catholic partner's avoidance of illicit cooperation as an occasion to establish an independent oversight board is not an intention for that entity and its purposes, nor does it constitute an act of helping to set up the entity. Foreseeing a result is not in itself evidence that the result is willed, intended, or desired. The proximate intention of the Catholic parties in this situation is to prevent illicit cooperation.

Although Principle 16 refers to Catholic institutions that are extricating themselves from situations of illicit cooperation, it implicitly recognizes the moral legitimacy of the concept of a Statement of Common

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Value. A SCV is a set of principles that, for an other-than-Catholic entity, adheres as closely as possible to the principles of the natural moral law as it relates to health care. The fact that there are no restrictions regarding contraceptives and direct sterilization in a SCV does not entail an intention for such procedures on the part of the Catholic parties. The intention of the Catholic parties and the other-than-Catholic partner in requiring an SCV is specifically to ensure that the values of the system will adhere as closely as possible to the natural law. Moreover, the Catholic parties do not engage in implicit formal cooperation by deliberately omitting a prohibition against contraceptives and direct sterilization in a SCV, because this omission does not constitute a specific formal condition by which the performance of such activity is made possible. It is the other-than-Catholic parties that supply those conditions.

The CDF's *Principles* provides a helpful guide that is both consistent with the Catholic moral tradition on cooperation and confirms recent interpretation and application of the Principle of Cooperation to Catholic/other-than-Catholic health care collaborations. As such, it provides an important conceptual framework within which new collaborative relationships may be evaluated.

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[1]For example, the document goes beyond making brief (though important) reference to the principle as is found in documents such as *Quaecumque Sterilizatio*, n. 3 (On Sterilization in Catholic Hospitals) or in *The Gospel of Life* (n. 74). For a traditional account of the Principle of Cooperation, see John A. McHugh, O.P., and Charles J. Callan, O.P., *Moral Theology*: *A Complete Course*, rev. ed. (New York: Joseph F. Wagner, 1958).

[2]It is important to note that the term "cooperation" as it functions in the Principle of Cooperation pertains to an identifiable voluntary contribution to the wrongdoing of another and that its meaning is distinct from the meaning of "collaboration," which in the current context refers to a specific joint effort between and among health care providers.

[3]The *Principles* refer to "administrators," board members," board of directors," "directors," and "boards" without clearly distinguishing these terms. For the purposes of this commentary, "administrator" will be used to refer to board members and executives.

[4]For a brief overview of corporate moral agency and cooperation see Peter J. Cataldo, "State-Mandated Immoral Procedures in Catholic Facilities: How is Licit Compliance Possible?" in *Live the Truth*: *The Moral Legacy of John Paul II in Catholic Health Care*, ed. Edward J. Furton (Philadelphia: The National Catholic Bioethics Center, 2006): 258–261.

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The Congregation for the Doctrine of the Faith's (CDF) *Principles for Collaboration with Non-Catholic Entities in the Provision of Health Services* is a response to Cardinal Timothy Dolan's request (April 15, 2013) for assistance regarding the transformation of a Catholic health system into a non-Catholic health system. Of particular concern are the transactions of a Catholic health system with non-Catholic members and organizations that provide procedures that are non-compliant with the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs).

The prologue to the document provides a brief history of Catholic health care throughout the ages with a focus on today's challenging health care environment that is now calling for collaboration with non-

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Catholic health care institutions. Depending on one's perspective, this can be good news—collaboration and good stewardship of resources, or bad news—the "diminution of the prophetic witness to the Faith" and the cause of scandal to the Church.

The CDF's *Principles* are meant to assist bishops and, indirectly, Catholic health care institutions in addressing this complex health care environment so that in such transactions, Catholic health care institutions neither cooperate immorally with procedures that are non-compliant with the ERDs nor cause scandal as a result of their collaboration. Principles #1-4 present the traditional definition of formal cooperation that could share intention or not in cooperating or contributing to the immoral acts.

Principle #5 is new from my perspective. In the past, duress was allowed primarily for individuals and not for Catholic institutions. Principle #5 allows for Catholic health care providers under duress or grave pressure to cooperate under certain conditions:
"In dealing with a Catholic healthcare institution that faces particular concrete circumstances involving its ability to continue its ministry at all, in order for material cooperation in such an institution to be moral, besides meeting the other relevant criteria, the institution must be under grave pressure to cooperate. Considerations of financial advantage or even of financial stability do not constitute sufficiently grave pressure; considerations having to do with the financial viability—that is, the ability of the healthcare institution to survive and to carry out its mission in the face of the complex circumstances that are present locally—do." (Principle #5)

Given the current U.S. health care environment, this is an important development. In addition to concerns regarding financial viability, I would submit that there are also concerns of grave pressure from adverse market forces that could put a Catholic health care institution's viability, while not imminent, in serious jeopardy in the future.

Principles #6-15 underscore the point that the Catholic health care entity cannot govern, manage, perform or contribute to the direct performance nor financially profit from the procedures that are non-compliant with Church teaching. These are basic, elemental moral principles. Furthermore, the Catholic entity cannot set up or help set up an entity that would be engaged in procedures that are inconsistent with Church teaching. Catholic Health Initiatives (CHI) makes it clear from the start of a transaction that if such an entity is to be created, it is up to the future partner to make those arrangements beforehand, without any involvement from CHI.

Principle #17 requires that diocesan bishops be informed of prospective agreements in Catholic institutions. For many systems, this may mean notifying a number of bishops. For those who are public juridic persons, they do not have to get permission, but rather a "nihil obstat."

In conclusion, the CDF's *Principles* seem to be principles that have generally guided transactions between Catholic and other-than-Catholic health care entities. It will remain to be seen how people interpret and apply Principle #5 that could involve grave pressure

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that affects survivability of a Catholic health care provider.

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On February 17th, the Congregation for the Doctrine of the Faith, under the signature of Cardinal Müller, responded to a question, a *dubium*, posed to the Congregation by Cardinal Dolan in the name of the United States Conference of Catholic Bishops (USCCB). The core issue presented to the Congregation pertained to "the transformation of a Catholic system into a non-Catholic system." The question that, in all likelihood, was puzzling to Cardinal Dolan and the other Catholic bishops was the transformation of Catholic Health West into Dignity Health. An even more precise statement of the *dubium* would express the bishops' concern regarding the status of a Catholic health care system that included non-Catholic members, who do not comply with the prohibition of morally unacceptable practices such as sterilization and contraception.

The Congregation's response is out of character compared to other such documents. Cardinal Müller signals as much in his cover letter in which he states that, "it is not possible to respond to the *dubium* in the usual manner." The *dubium*, Cardinal Müller proposes, "concerns more the application of moral principles to concrete situations and less an articulation or clarification of the operative moral principles." But then the reply goes on not to speak about the application of moral principles, but rather proposes 17 new principles that are supposedly relevant to the issue raised by the *dubium,* but says nothing regarding the application of the principles to the case.

The appearance of these 17 principles as the substance of the reply is a cause of wonderment, and even concern, that perhaps they are the introduction of novelty into Church teaching. Where did these principles come from? What is their origin? What is their "sitz im leben" with regard to the life of the Church and tradition? The principles are presented as a list. There is not one footnote or reference to document the teaching associated with these principles, nor are there references to link them to prior Church teaching or the tradition. There are neither references to Scripture nor to the papal magisterium. Where do these principles come from? There is nothing to suggest that the principles are related to the writings of any current or former theologians. There is no indication that the Holy Father reviewed, much less endorsed, the principles. They are new, they are innovations, and, like any innovation in Church teaching, they need to be treated with a high degree of skepticism until their link to the authentic magisterium can be verified. But the mystery remains, from where did these principles come? Is it possible that "the voice is that of Jacob, but the arms are those of Esau?"

The reply to the *dubium* leaves the USCCB in a conundrum. First, it provides no remedy or guidance regarding the application of moral principles to concrete cases. That was the question posed by the USCCB. Second, how, in what ways and on what grounds are the

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bishops to incorporate such novel teaching into their own teaching office? Do they simply accept it because it comes from Rome? Or do they need to question it and determine its origin in Scripture, tradition or the teaching office of the papal magisterium? If individuals outside the episcopal teaching office were to influence the content of documents emanating from the Congregation for the Doctrine of the Faith when responding to questions posed by the USCCB, if this happens to be the case, where does that leave the integrity of the teaching office of the American bishops or why appeal to Rome for guidance?

Finally, what about the principles themselves? It would be tedious to comment on each of them, so for the purposes of this essay, let me focus simply on the first. The issue at stake in this principle is the moral agency of Catholic health care institutions. The principle maintains that the only relevant moral agency is that of CEOs, trustees and other senior leaders. Cooperation is "ultimately about the actions of individual human beings." This position rejects any moral agency attributed to institutions themselves. It posits a negative response to the question: are large complex social institutions such as hospitals and health systems themselves moral agents? An affirmative answer to this question was recently expressed in an article in *Commonweal (Robert Osborn,* "Just War Illusions,*" March 21,2014, p.10):* "The president is as incapable of fundamentally altering the character of an empire as the well-meaning CEO of an oil company is capable of turning the corporation - through token philanthropy and gestures of social consciousness, welcome though these may be - into something other than a competitive, extractive, self-interested, and profit maximizing system."

What is at stake here is crucial for the proper use of the Principle of Cooperation in the present health care delivery environment. A hospital is a complex social organization defined by systems of accreditation and licensure, by the conditions of participation established by CMS, as well as the various medical specialty boards. The essence of a hospital, so to speak, is a social and cultural construct. It can be and do only what its socially constructed nature enables it to be and do. Complex social institutions have no final end; their proper goal or good lies within the common good of a community. If the realities of what hospitals and health systems are, are to be assimilated into theological discourse, then such terms must be construed as general theological categories, i.e., categories shared by theology, but adopted from public discourse. General theological categories need to be distinguished from special theological categories that arise solely within theological discourse and whose meanings are defined by theological discourse. (Bernard Lonergan, *Method in Theology, 285-293).* Only from a theological perspective such as Catholic social teaching can the Principle of Cooperation be applied appropriately to complex social institutions. Only such institutions, not the CEO, trustees or senior leaders, are blessed with Catholic identity.

Perhaps there is a learning that all of us can take away from this response to the *dubium*. In *Evangelii Gaudium* (#16), Pope Francis stated:

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> "Nor do I believe that the papal magisterium should be expected to offer a definitive or complete word on every question which affects the Church and the world. It is not advisable for the Pope to take the place of local bishops in the discernment of every issue which arises in their territory."

The issue posed by the *dubium* is a uniquely American issue. It is an important and more than valid question. But it needs to be discussed, debated and resolved by American theologians, representatives of the Catholic health care systems and members of the American hierarchy. Such a conversation needs to begin with the question the bishops posed to the Congregation, not with the 17 principles.

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It was over 20 years ago when the Catholic Health Association began an internal discussion about the relevance and correct application of the Principle of Cooperation to the emerging practice of Catholic health care institutions entering into various types of business arrangements with other-than-Catholic institutions. In the light of those and other internal discussions, as well as dialogue with the Congregation for the Doctrine of the Faith (CDF), the USCCB and numerous diocesan bishops, the most recent "Responsum" with its attached *Principles* is remarkable for several reasons.

First, the *Principles* affirm that "effective engagement in health care often calls for collaboration with non-Catholic entities even establishing joint working arrangements in which Catholic and non-Catholic entities are full partners." (Preamble) This is quite a shift from the suspicions, if not outright hostility, with which such arrangements were greeted in the 90s. Second, the very nature of the response, that it provides principles rather than concrete or specific conclusions, is a welcome development. *Principles* offer the ministry the "space" needed to explore various forms of business arrangements because, as the text notes, "…each concrete manifestation of a working relationship involving Catholic and non-Catholic healthcare institutions cannot be anticipated." (Preamble)

The *Principles* also are in clear continuity with previous CDF interventions when they affirm that the category of immediate material cooperation, which had been proposed as at times being licit, in fact is formal cooperation. (#2). The text also affirms the long held consensus among many moralists that a Catholic board member cannot vote to affirm ethical guidelines for a wholly owned non-Catholic institution that would permit direct sterilizations (a.k.a. "ERDs Lite") when it says "…this is likely an instance of formal cooperation" (#4) (It should be noted that the use of the word *likely* requires further ethical reflection.)

The *Principles* do raise several points that require further theological reflection and perhaps engagement with the USCCB Committee on Doctrine. In #5 the response seems to severely limit the application of the Principle of Cooperation to situations in which "…the ability of the institution to

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survive and carry out its mission" is at risk. Financial stability or advantage is no longer relevant. Unfortunately there is no explanation for this narrowed range of application. I fear this restrictive understanding of "grave pressure" does not take into account the dynamic transformational nature of the changing landscape of health care delivery in the United States. Catholic health care institutions and systems that wait until their immediate future is at risk (as it would seem the text suggests) most likely will not survive the shift. It is to be hoped that long term survival challenges in today's dynamic market will be understood to constitute "grave pressure".

Another area requiring further reflection is how the *Principles* seek to distance a Catholic entity, and its administrators/board members, from the provision of illicit services. Popularly known as "carve outs" these entities have been a critical aspect of negotiating with non-Catholic institutions and communities. These entities that provide illicit services outside of the Catholic institution have been considered licit if they meet the threefold test of "no governance, no management, no profit" on the part of the Catholic entity. The *Principles* seem to propose a new requirement: "no influence" (#13). Most likely there will be a great deal of discussion about what is meant by "no influence". Some arrangements such as "mirror boards", much like immediate material cooperation, might be found to be a distinction without a basis in fact. The influence in such a situation is so powerful that it is the same as control since the whole logic of having mirror boards is to ensure integrated governance over legally distinct entities. But what about accountable care organizations and other evolving arrangements put together to assume the risk of providing health care for a defined population. Such arrangements will not survive without a bond of shared influence among a range of actors. Is this influence so distant from the object of the moral evil that it is licit?

A final concern is #17. If one follows the usual rules of canonical interpretation, I would suggest there is nothing new here. If a system is entering into an arrangement that will directly impact the character and identity of all of its institutions, then, much like the formation of a PJP, all diocesan bishops involved should be consulted. I say that because of the nature of the *dubium* which occasioned the *Principles*. If, however, the arrangement is specific to one institution in a particular church, and has no impact on the other institutions in the system, it is difficult to understand the canonical standing of any other diocesan bishop on this matter.

Hopefully the discussion and theological reflection that this document is prompting will advance Catholic health care's fidelity to its core mission as well as provide guidance for successfully navigating its significant challenges.

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One could summarize the Congregation for the Doctrine of the Faith's (CDF's) "Some Principles for Collaboration…" by saying that the document addresses the traditional

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Principle of Cooperation (PoC), but articulates it in a new health care context.[1] It expresses important considerations for Catholic health care, which increasingly collaborates within new health care paradigms, such as accountable care organizations and clinically integrated networks. "Some Principles'…" attention and specificity to executive decision-making groups (e.g., boards, administrators) and organizational structures and strategic arrangements (e.g., governance, administration, operations) differentiate it from many other general and applied articulations of the PoC in health care.[2] It mentions executive groups and strategic arrangements in at least 14 of the 17 principles, giving flesh to the *Ethical and Religious Directives' (ERDs)* Part Six introduction encouraging "systematic and objective moral analysis" to new partnership.[3]

This level of PoC structure and process at administrative and board levels may be new to some Catholic health care organizations contemplating prospective transactions. Principles 4, 5, and 11 detail organizational/system structures mainly, while principles 7, 9, 12, and 13 particularize organizational/system processes. (Some crossover may exist, meaning that some principles describe both process and structure.) For the Catholic organization, due diligence in negotiations with other-than-Catholic systems requires art and science (i.e., attention to detail). Examples of "Some Principles'…" specificity are principles 12 and 13. There is moral significance and difference between two kinds of actions. On the one hand, Catholic organizations can communicate that they cannot take part in illicit procedures and presumably agree to an arrangement (i.e. third-party entity or structure) with sufficient moral distance (mediate material cooperation). On the other hand, Catholic organizations cannot 'lead the charge' to form that third-party entity or structure because this exemplifies the intention to perpetuate the immoral procedures by any other name (implicit formal cooperation).[4]

In my view, there are at least three main implications for Catholic health care. First, Catholic health care organizations must be intentional about these PoC deliberations. Some organizations may increase their vigilance. Others may add these considerations to their current level of awareness. Either way, a method of fostering awareness and purpose is to assimilate the principles into organizational resources and procedures. One could accomplish this a few different ways. One is to include experienced human resources – a mission leader, ethicist, moral theologian, and/or consultant with expertise in the PoC – to prospective transaction teams. A second is to add a section to mission discernment or mission-based decision-making processes about executive groups and strategic arrangements while discerning new partnership opportunities. Due diligence considerations and checklists may already include *ERD*-related items (if not, they should). A third is that "Some Principles…" could be transformed into a series of questions, analogous to the PoC "reflective process" questions in "Cooperating with Philanthropic Organizations" by Ron Hamel and Michael Panicola or the Discernment Guide in

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Resources about The Principle of Cooperation by CHA.[5]

Second, this is an opportunity to reflect upon, dialogue, and discuss the *Principles* and the PoC, not only with our bishops and their advisors, but also within our organizations, especially with our leadership and boards. This process begins with reading the *Principles* and then self-reflecting. How do I process this? Group discussions could use hypothetical scenarios, actual past or existing scenarios, as well as current prospective partnerships. Using the example from the previous paragraph, group members may disagree about precisely what actions depict intent (explicit formal cooperation), or intent by any other name (implicit formal cooperation), with wrongdoing in a series of possible responses to a proposed transaction. Such disagreements reflect the tension, even in executive groups and with strategic arrangements, between the PoC's theological foundations of discipleship and integrity.[6] These tensions are unlikely to dissipate and, as such, they are "polarities to manage."[7] Disagreements are also useful because they are formative and may even foster our moral development.[8]

Third, we can rejoice! Applying the *Principles* may be challenging. It also may be an example of the tough work Pope Francis explains in *Evangelii Gaudium*. Our Christian and Catholic witness is to find a way, reunite and bridge-build, and dialogue, even with those who differ from us ideologically and practically.[9] "Some Principles…" *is* itself a sign of the witness and flourishing of Catholic health care now and into the future. Our uses of, applications of, and communication and dialogue about "Some Principles…" *are* likewise.

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[1] Congregation for the Doctrine of the Faith (CDF), "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Healthcare Services" (Vatican: Congregation for the Doctrine of the Faith, February 17, 2014).

[2] See, for instance: Catholic Health Association (CHA), *Report on a Theological Dialogue on the Principle of Cooperation* (St. Louis, MO: Catholic Health Association, 2005); Catholic Health Association (CHA), *Resources about the Principle of Cooperation* (St. Louis, MO: Catholic Health Association, 2013); The National Catholic Bioethics Center, *Walk as Children of Light: The Challenge of Cooperation in a Pluralistic Society*, ed. Edward Furton and Louise Mitchell (Boston, MA: The National Catholic Bioethics Center, 2003); *Cooperation, Complicity and Conscience*, ed. Helen Watt (London, England: The Linacre Centre, 2009); United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 5th Ed. (Washington, D.C.: USCCB Publishing, 2009).

[3] CDF, "Some Principles"; USCCB, *Ethical and Religious Directives*, 15.

[4] CDF, "Some Principles," 3.

[5] CHA, "Resources," 45-46; Ron Hamel and Michael Panicola, "Cooperating with Philanthropic Organizations," *Health Progress* 89, no. 2 (2008): 50-51.

[6] Ron Hamel, "Cooperation: A Principle that Reflects Reality," *Health Progress* 93, no. 5 (2012): 80-81.

[7] Barry Johnson, *Polarity Management: Identifying and Managing Unsolvable Problems* (Amherst, MA: HRD Press, Inc., 1996): 81-82.

[8] Steven Squires, "Interpreting Material Cooperation as a Function of Moral Development to Guide Ministry Formation," copyrighted dissertation, Duquesne University (2012).

[9] Pope Francis, *Evangelii Gaudium (The Joy of the Gospel)* (Washington, D.C.: USCCB, 2013), 50-52, 66, 92-94, 108-124.

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