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Witness, Identity and Common Ground in Collaborative Arrangements: A Partner's Perspective

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INTRODUCTION

The publication of a revised Part Six of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) and the proliferation of collaborative ventures, both within Catholic health care and between Catholic health care and other partners, provide a good opportunity to examine three collaborative arrangements (CAs) between Roman Catholic health care corporations and Seventh-day Adventist health care corporations.[1] As an ordained Seventh-day Adventist minister and ethicist who presently works for a Catholic health care system (Providence St. Joseph Health), as well as serving for a time as an ethics consultant for one of the three CAs (Centura Health[2]), I hope to offer a unique perspective.

These cooperative arrangements between our two faiths are both feasible and necessary in the current American health care industry. The success of Centura Health is an indicator of the high likelihood of success for present and future arrangements even in light of the recent ERD revision. However, I think it is also important to revisit our idea of "success" as these healing ministries of Christ continually morph and respond to the present-day American health care industry and its regulation by the federal government. Could this industry ever change so much that we should seriously consider backing away from some or all of its expressions in our ministries?

PART SIX, ERDs, 2018

First, let's take a brief look at the new Part Six, which is based upon a Vatican document issued in 2014.[3] Ethicists seem to agree that the revision is more confirmatory or clarifying, rather than something entirely new,[4] yet there are some important, if subtle differences.

In his analysis of the revised Part Six, John A. Gallagher, Ph.D., points out a shift toward the church's "prophetic witness" or "witness to Christ" in our present-day world. Gallagher writes:

> These Directives are not primarily about the principle of cooperation nor are they principally about the discernment of moral evils, although these remain elements of an appropriate

> discernment of the church/world, faith/culture tension. The revisions to Part Six of the ERDs are primarily concerned to ensure that prophetic witness, the church's witness to Christ and the new evangelization are vitally engaged in the world and culture through the health care ministry.[5]

He also suggests that there is less stress on scandal and the principles of cooperation or double effect and more on "What the church is and what the church does to frame its engagement with the world and culture." Indeed, Gallagher asserts that in light of this emphasis, "the principle of cooperation has become secondary."[6] If it is the case that the primary concern for CAs revolves around the church's prophetic witness to Christ, how would an analysis of a potential CA with a Seventh-day Adventist health care corporation appear to us? Would discernment about such a deal take a broad, sweeping look at commonalities of commitments to being Christ's witness to world and culture? Or, would it be more concerned for the details of specific ERDs dealing with abortion, end-of-life care, or contraception? Perhaps both analyses are essential.

HOW DO ADVENTISTS AND CATHOLICS GO ABOUT FORMING COLLABORATIVE ARRANGEMENTS?

For the purposes of this article, I reached out to over twenty individuals who were party to the discussions that formed three CAs:

- Centura Health of Colorado: https://www.centura.org/
- AMITA Health of the Chicago area:[7] https://www.AMITAhealth.org/
- Sacred Trust of the Northern California area: This CA is still under review by the Federal Trade Commission and the California State Attorney General.[8]

> "We stayed totally faithful to what needed to be different – our own theologies – yet there was so much good work to be done together that it did not violate our identities."

For Seventh-day Adventist health care corporations, the analysis of a possible CA revolves around two central questions: Is it beneficial to the long-term financial health of the corporation and can it maintain its identity and mission in the process? These questions, in addition to how such arrangements serve society, are also key to Catholic organizations.

These themes are reflected in personal interviews with several involved parties of the Centura and Sacred Trust CAs. On first blush, it seems that the analysis (I won't use the term "discernment" since it is not the term Adventists would use) is somewhat ad hoc, but the reader should realize that Adventism is very young (at 155 years) in comparison with Catholicism. It is important to highlight the fact that as a denomination, Adventism is in a stage of development quite unlike that of Catholicism. One important commonality I have found, however, regards the tension between the clerical branch and the health care

branch for each tradition. I'll say more about this later.

In 1995, in the Denver market, a deal was struck between PorterCare (Adventist) and the Sisters of Charity Health Services, Colorado to form Centura Health. Stephen King (Adventist) and Sister Nancy Hoffman (RCC) were present at the outset. Sister Nancy noted in a 1999 article, "It seemed a most unlikely partnership."[9] But market forces compelled these unlikely partners into considering the unusual:

> They were, indeed, extraordinary times. By the early 1990s, the for-profit hospital giant Columbia/HCA had rolled into Denver, purchased several hospitals, forced closures and buyouts, and captured 35 percent of the market share…[10]

Stephen King highlights the second of the two concerns, namely maintaining Adventist identity and culture (an issue similarly important to the Catholic side of the Centura deal): "We stayed totally faithful to what needed to be different—our own theologies—yet there was so much good work to be done together that it did not violate our identities."[11] What appeared at first to Sister Nancy as an "unlikely partnership," years later had become a "wonderful journey" for which she comments, "When you come down to the true Christian message, you see how similar we are."[12]

Yet, there were and remain significant differences. In a *Spectrum*[13] article, Linda Andrews writes:

> …. there have been some tensions. King explains that the Catholic system is more hierarchical than the Adventist system, so cultural differences began to surface. "There was never a struggle over mission or names," King says, "but our ways of doing business were different. The Adventists have a less centralized system. The Catholic side is more hierarchical."[14]

Pointing to the overall mission and identity concerns of both sides (what Gallagher identified as aiming toward the prophetic witness to Christ in our world and culture), Sister Nancy and Stephen King wrote about their experience together at Centura: "Those of us whose mission and values support the health and well-being of all members of the community have struggled to find innovative ways to continue to provide quality service and patient care to our fellow human beings" they said. Even though they "lived out…[their] faithfulness to sponsors in different ways," they attest to a "reverence" for each other and their traditions as well as a "confidence" in the future.[15]

After a restructuring in 2014, there was a reduction in mission leadership, which gave rise to concerns about whether mission identity and leadership formation would suffer.[16]

For Charles Sandefur, at the time president of the Rocky Mountain Conference of Seventh-day Adventists, the Centura Health deal was a "pivotal moment" for Adventist health care in the United States. As the General Conference of Seventh-day Adventists backed away from legal ownership of Adventist health care corporations in the late 1980s, those corporations began to coalesce into five entities along roughly regional lines. PorterCare in the Denver area didn't naturally fit into any of the

five areas. Realizing they needed help to stay in the health care ministry, they came to the difficult conclusion that they would be better off partnering with the Sisters of Charity.

Many of the Adventist constituents, however, felt it was better to be purchased and get out of the business than to partner with Catholics. But Sandefur and enough others felt that in order to maintain the mission of Adventist health care ministry, it needed to be dragged into the 21st century regardless of the existential angst associated with forming such a collaborative association. Those who opposed the collaborative association represented an intense Adventist, anti-Catholic sub-culture. They were not able to imagine upholding commonalities with a Catholic health care ministry. Thankfully, more thoughtful people prevailed and Centura was launched.

Aside from this socio-political reality, Sandefur noted that from a broad-based emphasis on mission and identity there were two specific concerns regarding the connection with the Sisters of Charity: First, concerns for advancing healthy living principles and maintaining the specialness of Sabbath in Adventist facilities; and then, emerging from identity issues, concern about ownership and branding/naming elements of the deal.

What at first felt more like a "survival mechanism" in a tough market situation has evolved. Now, says Sandefur, such CAs are seen as "positive expressions of Adventist health care mission." The core mission and identity prior to such CAs were occasionally casual and assumptive within Adventist health care, but as we've moved into and through the cooperative ventures, we've had to fine tune our understanding of ourselves and this is good.

In the process of negotiating with interested parties, Sandefur went to Chicago to visit with a select group of bishops from the United States Conference of Catholic Bishops. He felt they were impressed by the Adventist ability to insist upon and find qualified persons of the Adventist faith to place in executive leadership in the health care corporations. For his part, Sandefur walked away from these meetings with a new appreciation for Catholic concern for social justice and for providing health care to the poor and vulnerable of our communities.[17]

For Catholic health care corporations, there were similar market considerations. As American health care industry watchdogs noted at the time, affiliation and collaborative business arrangements swept through the American health care industry. In 1984, Paul Starr explored the development of the American health care corporation in his volume, *The Social Transformation of American Medicine*. Of note, is how American corporations grew to control how health care was offered. His closing chapter, "The Coming of the Corporation," should be standard reading for anyone today who wants to fully understand where we are as faith-based "corporations."[18] Catholic entities aware of the corporatization and affiliations understood the inherent difficulties of maintaining identity that reaches back for two millennia.

In a 1997 article entitled "Catholic Healthcare's Future," Alan M. Zuckerman and Russell C. Coile wrote:

> Even with 550 hospitals, the U.S. Catholic healthcare system is too small and spread too thinly to succeed without partners. Under the demands of competition and capitation, only tightly organized regional and statewide networks have the bargaining strength to deal with HMOs and employer purchasing coalitions…. Catholic sponsors must find mission-compatible business allies, including managed care plans. Catholic health facilities will announce many transactions and linkages, because the alternative of "going-it-alone" isolation is not sustainable. Catholic healthcare providers must pursue strategies of integration, or they may fail to carry out their mission in the twenty-first century.[19]

With appreciation to Dan O'Brien, Ph.D., senior vice president for ethics, discernment, and church relations at Ascension,[20] we have a bit of a window into the moral analysis that went into the development of AMITA Health[21] in the Chicago area. AMITA Health is a joint operating company originally formed by Adventist Midwest Health, part of Adventist Health System in Altamonte Springs, Florida, and Alexian Brothers Health System, a subsidiary of St. Louis, Missouri-based Ascension.

At a general level, the history of Adventism's view toward Roman Catholicism was a concern. Despite the fact that the Adventist Church's official statement takes the effort to "stress the conviction that many Roman Catholics are brothers and sisters in Christ,"[22] Dr. O'Brien's analysis rightly points out that "present day statements are far more palatable" than history would suggest.[23] All told, the Catholic analysis of the potential *AMITA* deal examined nine areas of concern: 1) Commitment to Health and Healing; 2) Adventist Views toward the Catholic Church; 3) Adventist Statement on Values; 4) Sexually Transmitted Diseases; 5) Contraception in Marriage; 6) Abortion; 7) Assisted Reproduction; 8) Care of the Dying; and 9) Employer-Employee Relationships and Unions.

Two areas of concern for Ascension identified under the principle of cooperation with Adventist facilities included policies that allowed a small number of pregnancy interruptions, as well as routine sterilizations. Because the principles of cooperation do not permit the Catholic party to condone or to have oversight for procedures evaluated as intrinsically immoral under Catholic teaching, the proposed Joint Operating Agreement (JOA) explicitly rejected inclusion of the Adventist OB/GYN service lines into the Joint Operating Company (JOC), enabling the moral analysis to conclude that there would be "only remote mediate material cooperation" in the arrangement.

The analysis offered by Ascension anticipated the judgment of the Archbishop of Chicago (then Cardinal George) that "nothing stands in the way" (*nihil obstat*) of the affiliation moving forward "from the perspective of Catholic faith and morals." Indeed, "during exchanges with the Diocese of Joliet" (some facilities fell within this jurisdiction), the Bishop of Joliet indicated that the "Catholic moral theologians or ethicists who direct the development and provision of the various educational and formation programs for the Catholic hospitals within the JOC will need the approval of the Archbishop of Chicago or his delegate."[24] In balance and

given the explicit separations demanded by the JOC, the arrangement was found to be:

…justified by the great goods that will be achieved by the affiliation…. The transaction is clearly intended to strengthen both the Alexian Brothers and Adventist health systems…and strengthen the healing ministry of Jesus Christ in metropolitan Chicago.[25]

HOW DO THE CAs PROTECT THE DENOMINATIONAL CONCERNS OF BOTH SIDES?

Centura Health was very important in the early stages of Catholic-Adventist CAs. In a 1997 article in *Health System Leader* entitled, "Centura Health—Two Faiths in Alliance,"[26] Elaine Zablocki quotes Dean Coddington, the managing director of BBC Research and Consulting, "a national healthcare consulting firm" saying that:

> Centura is promising. They've done something most people didn't think could be accomplished: They've gotten the Catholics and the Adventists to work together, and that's actually a pretty amazing combination if you stop to think about it.[27]

At the time of the formation of Centura, Terry White, the first Centura executive vice president, said of the arrangement, "We were inventing the wheel. Now hospitals in other parts of the country are using our documents as models."[28]

Quoting Leland Kaiser, Ph.D. (president of the consulting firm Kaiser and Associates) in her summation, Zablocki writes:

> Across the country you find hospitals with religious backgrounds—Adventist, Catholic, Lutheran, Baptist, Methodist—but all with a built-in desire to serve and a spiritual orientation. What really brought these two hospitals together was, first, that it made good business sense, but second, that their shared spirituality was more important than their religious differences. What's happening in Denver is very important, because I think you're going to see it across the United States.[29]

Kaiser's words could not have been more prescient. Twenty years later we read in the news on almost a weekly basis about major corporate health care deals. One wonders how many corporations will remain ten years hence. Indeed, if CA deals are good for some of our corporations, why would we not pursue such arrangements to the logical end and create one massive faith-based, not-for-profit corporation with branded branches all over the country? If our denominational concerns are well managed, what would be the argument against such a broad affiliation? Perhaps there are legal ramifications I am unaware of, but if focus remains on market strength with mission protections what would stop us from joining forces?

For both sides, maintaining focus on Christ's healing ministry in our local communities is paramount. O'Brien's analysis for Ascension from the Catholic perspective is revealing. In addition to the nine points of his Moral Analysis noted above, Ascension, upholds "System Policy #1." Meant to establish a baseline from which all other matters emerge, Policy #1 makes clear what is important to their work:

> It is the policy of Ascension to function as and to fully express its identity as a ministry of the Catholic Church consistent with Church teaching—including the *Ethical and Religious Directives for Catholic Health Care Services*…and our Mission, Vision, and Values, in accord with the guidance of the Ascension Sponsor, which is the Ministerial Public Juridic Person accountable to the institutional Church (Holy See).[30]

The seven principles that form the core of the expression of Policy #1 are as follows:

> 1) Solidarity with Those Who Live in Poverty; 2) Holistic Care; 3) Respect for Human Life; 4) Stewardship; 5) Participatory Community of Work and Mutual Respect; 6) Act as a Ministry of the Church; and 7) Fidelity.

Although, a cursory look at Catholic health care in the U.S. might give the impression that abortion, contraception, and serving the poor and vulnerable would summarize their concerns, this is not the whole story. We run a similar risk when looking at the key elements within Adventist health care mission and identity.

Similar to what Ascension developed as "System Policy #1," AdventHealth outlined what matters most to them as they engage others within the American health care industry.[31] The document, "Mission and the Management of an AdventHealth Facility,"[32] has three main sections: "Where We Came From, Who We Are, and How We Manage." The purpose of the document is to "identify, describe and provide rationale for essential principles regarding the mission and culture of AdventHealth." It is explicitly designed to be used "in the process of negotiating mergers, acquisitions and joint operating agreements with external partners." There are six substantive sections meant to express "historic, ecclesiastic, moral, and ethical foundations for health care delivered by AdventHealth": 1) Social Responsibility; 2) Pastoral/Spiritual Care); 3) Seventh-day Adventist Church and Beliefs; 4) Clinical Care; and 5) Business Relationships.

Meredith Jobe, JD serves as general counsel for Adventist Health, the Adventist side of Sacred Trust (should it receive necessary governmental approvals). In general, he noted that "We are more alike than otherwise, in our mission of providing health care to our communities." He expressed appreciation for the intense concern for society's poor and vulnerable from the Providence St. Joseph side of the CA. Additionally, he says Adventist Health would like to learn more about the efforts PSJH puts into mission education and leadership development. Jobe also noted Catholic concerns for end-of-life care (particularly as it relates to legislation for physician-assisted suicide), abortion and the role bishops play in providing oversight on these issues.

Of special concern for Adventist Health in the maintenance of its mission is the ability to protect positions of leadership in the new venture. Preference for Adventist persons in senior management and executive leadership is a clear concern and is not limited to positions of mission roles. Jobe echoed what Charles Sandefur said in my interview with him, namely, the protection of Sabbath observance and

healthy living principles must be maintained in the CA deals.

The one official document that best summarizes Adventist concerns for its health care mission is entitled, "Operating Principles for Healthcare Institutions."[33] Approved in 1988, these principles are best summarized as follows:

- Whole person care, to include preventative medicine and health education to the community;
- Concern for the "unique Christian witness of Seventh-day Adventists," namely, the Seventh-day Sabbath, vegetarian diet free of stimulants, and no alcohol or tobacco;
- Human life, dignity, and relationships;
- Functioning as a part of the local community;
- Competent staff who seek to uplift Christ to those served;
- Financial responsibility in concert with the *Working Policy of the General Conference of Seventh-day Adventists.*

While this document does not approximate the ERDs, it does help establish a broad sense of agreement and collegial involvement between the General Conference of Seventh-Day Adventists and Adventist health care corporations. Like Catholicism, the Adventist Church does not legally own "Adventist" health care corporations, but there remains a very strong bond between the Church administration and the health care corporations.

Regarding this bond, it helps to recognize the difference between Catholic and Adventist ethos. For Catholicism, the local bishop has authoritative oversight of all Church ministries operating within his diocesan jurisdiction. The diocesan bishop, for example, has the power to withdraw his recognition of the Catholic identity of a hospital located within his diocese if he determines its administrators are seriously failing in their accountabilities to operate the hospital in accord with church teaching. Such a scenario is unlikely to occur within Adventism.

The Protestant ethos is strong within Adventism (at least in North America) and there is a rather wide latitude in the relationship between Adventist health care systems and the General Conference of Seventh-day Adventists (which provides worldwide leadership) than you would find in Catholicism. If the General Conference were to consider and reject a health care corporation's Adventist identity, it would likely be vigorously defended by Church leadership at the national and regional levels and likely be intensely argued in an American court rather than simply accepted by the system.

On a local level, even if a Conference President (the rough equivalent of an Archbishop) proclaimed a hospital as no longer Adventist, it would have no practical impact because the denomination's governance structure gives Adventist systems more autonomy from the local Conference. Indeed, it is hard to imagine such a scenario because the trust and relationships developed between church administrators and health care administrators is important and presently robust. Perhaps it is a strength of the Adventist system that allows for a more trusting relationship with local clergy. The fear of oversight and control that occasionally presents in the Catholic context is almost completely absent in the Adventist context.

Nevertheless, there is an ongoing tension in the relationship between church officials and health care administrators in both traditions. The revised 2018 edition of the ERDs is an indicator of the felt need for high level involvement and assertive oversight by Catholic Church bishops, particularly in matters relating to church teaching on morality and on the administration of sacraments. Similarly, within Adventism the General Conference ethos is to protect the fundamental beliefs of the church.

On the other hand, health care ministry, whether Adventist or Catholic, responds to a public in need. Serving those in need inclines us toward compassion and empathy even if we occasionally do not fully understand or support the morality behind the requests they make. For instance, caring for transgender persons is a challenge to both faith groups. Catholicism and Adventism both are challenged by philosophical and theological accounts of human nature that are not binary (male or female or no gender at all). Yet, our health care systems must (and do) care for persons who walk through our doors. Science and culture are pushing us, once again, and challenging our historical theological understandings. The tension that this places between health care administrators and caregivers and church administration is obvious to those of us who work on the inside.

A FEW FINAL QUESTIONS

First, how will we sustain attention to theology and ethics in these CA structures? A good bit of analysis goes into the formation of the entity up front, but what of the day-to-day work of leadership and spiritual formation, theology and ethics, in the structures that follow? Are there elements of the deal that demand a structure for attending to the faith and moral concerns of both sides? How will each CA, each facility, allocate staffing and finances for these concerns? Will there be dedicated, informed theologians and/or ethicists in the system office? Will such persons be on staff in each facility or regional offices?

The Joint Commission,[34] the accrediting entity for U.S. hospitals, requires only a mechanism of some sort to deal with ethical issues in a hospital. Will Catholic and Adventist health care corporations go above and beyond this simple requirement? In a world where billable services rule the day, mission leaders, theologians and ethicists usually do not bring in any income for these CAs. Both chaplain services and clinical ethics consult services are expenses for the facilities we operate. When budgets get tight, which service gets funded? Some ministries depend on spiritual care departments for ethics consult services. Are chaplains with a modicum of ethics training and other responsibilities prepared to take ethics consult calls? I could highlight this question with detailed knowledge of both Catholic and Adventist corporations and hospitals who do not pay for trained clinical ethicists but place the burden of hospital case consult services on chaplains or spiritual care personnel. It raises serious questions of integrity if we undertake theological, ethical, and legal analysis of these deals at the outset but fail to pay for persons who will give ongoing attention to the daily reality of clinical ethics education and consultation needs.

Second, what does "success" mean for our faith-based systems? Both Catholic and Adventist Church administrative bodies understand and account for financial deliberations as part of the moral discernment

necessary for operating in today's American health care industry. Both sides note in their analysis the harsh reality of market forces in health care. So, how do we measure success? Do we fail if we do not meet a certain percentage EBIDA (earnings before interest, depreciation, and amortization? Do we fail in our prophetic witness to Christ if one or more of our facilities or full corporations must close their doors? Do we fail if we have to file for bankruptcy or sell out to a larger system because our finances simply will not allow us to keep our doors open? Have we failed, in such a scenario, to offer our community the healing ministry of Christ?

What are we willing to do in terms of corporate deals and arrangements to stay in the health care business as a ministry of Christ? Is there a danger in secular America that compels Catholics or Adventists to back away from the industry? Is the growth of American for-profit health care changing the paradigm in such a way that it threatens not-for-profit, faith-based health care corporations? If so, what are we willing to concede? As we often ask in PSJH, "What would the Sisters do" in such a scenario? Would they, would we, ever shut down or sell our ministries to avoid compromise? And on the Adventist side, did the "Heath Message"[35] vision of our Adventist Pioneers even imagine such radical reality in light of responding to the signs of the times?

The call to be attentive to the "signs of the time" is precious to Adventism and is also central to the Sisters of Providence expression to their mission as they transitioned to a Public Juridic Person.[36]

> We have no fixed blueprint for how to express the role and responsibilities of Providence Ministries other than by reading the signs of the time, trusting in Providence, and embracing our Baptismal call to follow Christ.[37]

What would success and responding to the signs of the time look like for our ministries in a time of environmental crisis that points to health care as a significant source of pollution?[38] When the Pope himself is calling for adjusting our economic and institutional imbalance out of concern for our planet and the poor,[39] what is an appropriate way for our health care systems to adjust our views of corporate growth? One international economist, Kate Raworth, Ph.D.[40] rightly notes that we in the West are "structurally addicted to growth."[41] What is whole person care in a system that pays surgeons obscene amounts of money for quick fixes to unsustainable lifestyles? Does keeping our doors open, responding to the times, mean that we slavishly demand of ourselves a certain percentage EBIDA?

In America's capitalistic health care industry, where built-in injustices marginalize so many members of society, what does it mean to offer *preferential option for the poor*,[42] to minister for the poor and vulnerable? Ironically, Catholic and Adventist health care are two of the more successful players in the American health care industry. How do we rationalize being part of an unjust system while stating that we serve the poor and vulnerable? Darlene Fozard Weaver, Ph.D. summarizes my point well:

> In short, once we understand human dignity not only as a stipulation of inherent moral worth but as a practice of inclusive regard, health care ethics, health care practices, and health care

> systems appear as both culprits in sinful dynamics of misrecognition of dignity and as vehicles for restoring dignity to its full expression.[43]

CONCLUSION

These are not easy questions. We are making progress in moving health care out into the community, expanding the reach and methods of health care beyond the walls of hospitals. Our systems are making the changes necessary to respond to a new environment and to achieve greater sustainability.

American health care will not get any easier for faith-based systems, but we should celebrate our progress and our collaboration and trust that we will be better off facing the future together with reverence for each other as we together advance the prophetic witness and healing ministry of Christ.

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Creating Dialogue

1. How would you weigh the moral concerns between a Catholic health facility and a partner of a different faith?
2. How can the common good guide the ethical discernment of health care business questions?
3. Do you see the broader community involved in disucssions of partnerships?
4. What values should guide the development of joint partnerships?

ENDNOTES

[1] Available at: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf . This, almost 100-year-old, document serves as the formal guidance document for ministries of the Catholic Church in the United States that serve in the healthcare context.

[2] https://www.centura.org/

[3] *The Vatican Congregation for the Doctrine of the Faith* (*CDF*), *Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services* Available at: https://www.ncbcenter.org/files/4914/4916/4379/Q14.2_Verbatim_CDF_Principles.pdf. In an analysis of the *CDF* document, Peter Cataldo, PhD notes "there is much that is new" in this document in that it offers "for the first time a delineated set of specific principles pertaining to the institutional application of the traditional Principle of Cooperation." He also notes that with regard to Catholic and "other-than-Catholic" healthcare cooperative arrangements "its content is more confirmatory than new." "CDF Principles for Collaboration with Non-Catholic Health Care Entities: Ministry Perspectives," *Health Care Ethics, USA*. 2014, pp. 24-29; p. 24. Available at: https://www.chausa.org/docs/default-source/hceusa/cdf-principles-for-collaboration.pdf

[4] In a webinar sponsored by the Catholic Health Association of the United States, both Fr. Charles Bouchard and Dan O'Brien, PhD noted that there is nothing particularly new or challenging about the revisions to Part Six, itself. "These revisions are mainly a question of clarification," states Fr. Bouchard. See "Understanding the Revision to Part Six of the ERDs," is available to CHA members at: https://www.chausa.org/online-learning/viewer/understanding-the-revision-to-part-six-of-the-erds

[5] Ibid., pg. 33.

[6] Ibid., pg. 31.

[7] My interaction with personnel at *AMITA* was limited for this article. In kindly correspondence Deborah S. Fullerton, Vice President and Chief Marketing Officer let me know that they had recently experienced the arrival of two new mission officers. On the Catholic side, Mary Paul, a VP for Mission Integration at *Ascension* is serving on an interim basis and on the Adventist side, Ismael Gama is now caring for mission services.

[8] For further information go to: https://oag.ca.gov/charities/nonprofithosp#notice2

[9] Andrews, Linda. "Centura Health: Two Faiths, One Mission." *Spectrum*. Vol.27;3: pp. 53-57.

[10] Ibid., pg. 53.

[11] Ibid., pg. 57.

[12] Ibid.

[13] "*Spectrum* is an independent publication of Adventist Forum:" https://spectrummagazine.org/about

[14] Andrews, pg. 55.

[15] King, Stephen B. and Sr. Nancy Hoffman. "An Unlikely Reverence: The Story of Centura Health A Partnership Between Seventh-day Adventists and Roman Catholics. UPDATE. Vol.16;3 (November 2000). A publication of the Loma Linda University Center for Christian Bioethics.

[16] In the first iteration of the Mission leadership within *Centura*, King and Hoffman were the two Senior Vice Presidents in the corporate headquarters working with Vice Presidents in three operating groups in their respective territories. In 2014 *Centura* restructured, reducing from three to two operating groups as well as from two Senior VPs to one Senior VP. From author's personal correspondence.

[17] I appreciate Charles Sandefur's willingness to discuss his memories and analysis of the establishment of *Centura Health*.

[18] Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books.

[19] Zuckerman, Allan M. and Russell C. Coile. "Catholic Healthcare's Future." *Health Progress,* Nov-Dec, 1997*: pp. 23-35.*

[20] https://ascension.org/

[21] https://www.AMITAhealth.org/

[22] https://www.adventist.org/en/information/official-statements/statements/article/go/-/how-seventh-day-adventists-view-roman-catholicism/

[23] "Moral Analysis: Proposed Joint Operating Agreement Between Ascension Health and Adventist Health System." Dan O'Brien, principal author.

[24] O'Brien moral analysis, p. 29.

[25] Ibid.

[26] Zablocki, Elaine. "Centura Health—Two Faiths in Alliance." *Health System Leader*, Jan. 1997, pp. 17-26.

[27] Ibid., pg. 25.

[28] Ibid.

[29] Ibid., pg. 26.

[30] Provided in personal correspondence with Dan O'Brien, PhD. For a description of a "Public Juridic Person" see: http://www.vatican.va/archive/ENG1104/_PD.HTM

[31] AdventHealth is the parent company of the Adventist side of both AMITA and Centura Health. I'm grateful to Ted Hamilton, Chief Mission Integration Officer, for his assistance in helping me understand their approach to these CAs.

[32] Provided to me via personal correspondence. Interested persons may call 407.357.2458 for more information.

[33] Available at: https://www.adventist.org/en/information/official-statements/statements/article/go/-/operating-principles-for-health-care-institutions/

[34] https://www.jointcommission.org/

[35] Two articles may be helpful to the reader to understand the "health message" in Adventism: https://www.ministrymagazine.org/archive/2017/03/healthmessage . And another one from the official Adventist website: https://www.adventist.org/en/vitality/health/

[36] http://www.vatican.va/archive/ENG1104/_PD.HTM

[37]http://in.providence.org/or/departments/missionintegration/Documents/OR%20Region%20Hopes%20and%20Aspirations%20for%20Providence%20Ministries.pdf

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[39] Pope Francis, *Laudato Si—On Care for our Common Home*. United States Conference of Catholic Bishops, 2015.

[40] Kate Raworth, PhD is a professor at Oxford and Cambridge Universities. https://www.cisl.cam.ac.uk/directory/kate-raworth

[41] See the transcript of a recent TED talk from Dr. Raworth: https://www.npr.org/2018/12/07/674117856/kate-raworth-how-can-we-create-a-thriving-economy-for-ourselves-and-the-planet
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Sex and Senior Living: Ethical Questions for Catholic Housing and Long-Term Care

Fr. Charles Bouchard, O.P., S.T.D.

Most senior living facilities, whether independent, assisted living or skilled nursing, have by now encountered questions about how to manage intimate or sexual relationships among residents. The simplest case is the elder couple who meet in assisted or nursing care and begin to develop a relationship or even fall in love. This raises issues of competence, safety and consent. But there are other cases as well. Together they suggest a number of ethical questions regarding the proper balance between patients' rights and our obligations to church teaching. I raise these questions only to help clarify the tasks that lie ahead as we encounter changing cultural attitudes toward sexuality and aging.

WHAT ARE THE ETHICAL QUESTIONS?

There are at least three questions involved. First, "Is a Catholic senior living facility *cooperating illicitly* in immoral activity if a) it allows physical or sexual intimacy among assisted living or nursing home residents who are not married; b) it admits as residents unmarried couples who wish to share an apartment; c) it admits divorced and re-married couples whose previous marriage has not been annulled, or d) it admits couples that have entered into a civil same-sex marriage?" Second, are we requiring inappropriate cooperation of associates, if we ask them to assist patients with certain needs related to sexual intimacy; and third, do we *cause scandal* by admitting couples who will engage in such activities even if there is no significant moral cooperation. Let us address cooperation first.

> We should encourage companionship and friendship for senior residents. But Catholic institutions cannot ignore our tradition on sexual morality and the virtue of chastity.

WHAT CONSTITUTES UNACCEPTABLE COOPERATION?

In considering this question of *physical or sexual intimacy among unmarried residents,* we must balance the requirements of our moral tradition with the patients' right to physical and sexual expression, which is guaranteed in some states

by law. These laws are based on a "right to privacy" and on the assumption that the state does not have an interest in limiting intimate expression unless it is non-consensual or involves a minor. It is these two principles that led to the abolition of laws prohibiting adultery or sex among two persons of the same sex. Even if such activities are legally sanctioned, Catholic institutions may not consider them as moral if they take place between unmarried persons. Do we insist on compliance or can we can *tolerate*[1] these activities and relationships in our facilities as long as the residents have the moral competency to enter into the relationship, the relationship is fully consensual, does not take place in a public area where it invades the privacy of others, and does not pose safety risks to either of the residents? (You may laugh at this last qualification but there have been cases of frisky seniors falling out of bed and incurring injury.)

Another situation is that of *unmarried but cohabitating residents*. One instance would be the case of friends, siblings or other family members who either have shared or wish to share an apartment and for whom there is no indication of any sexual or romantic involvement. This does not pose a problem unless the facility's mission is focused in such a way that it would allow no unmarried couples at all. This might be the case, for example, if a facility is dedicated to "promoting married life for seniors" and if such a mission would be legal from the stand point of equal access and non-discrimination.[2]

A more complex case involves an unmarried, romantically involved couple whom we suspect will engage in sexual activity. Do we act on our suspicion, or do we refrain from asking questions and overlook suspected behavior because our mission is to provide housing, which we consider to be a basic human right?

Even more complex is the case of a *couple in a second marriage when at least one of them has been divorced but has not received an annulment; and the case of a same-sex couple that has been married in a civil ceremony.*[3] From a canonical perspective these marriages are essentially similar because neither of them is recognized as valid by the church. As far as the church is concerned, they are not married at all and would be, as we used to say "living in sin."[4] In cases such as these, does the facility consider marital status as irrelevant to their mission of providing appropriate housing and health care and therefore does not ask about marital status? What if the facility learns about the couple's marital status by disclosure or some other means? Do we then become complicit in the illicit and invalid act of marriage?

If we rule out illicit cooperation[5] in the act of getting married, a second issue is whether the facility cooperates in the ongoing sexual activity that may take place as part of the couple's relationship.

Formal cooperation involves sharing the intention of a wrongdoer. If someone were to rent to an unmarried couple a one-night "honeymoon suite" complete with videos, champagne and various pleasure aids, it seems the intent is to further or promote the (illicit) sexual union. However, a senior living center that rents an apartment with bare walls and no furniture is in the business of providing a safe, secure and age-appropriate residence for senior citizens. The residence is not sharing in, encouraging, or providing any essential requirement for sexual activity. They are renting to the couple as persons, not as sexual

partners. So if there is any level of cooperation here at all, it is minimal (mediate material) and morally justifiable long as there is proportionate reason for it. I believe it is likely that the fundamental importance of adequate housing, especially for the elderly, provides a proportionate reason to consider applications from persons in either of these groups despite the possibility that they might engage in extra-marital sex or in other activities that may be immoral. However, this is a question that requires further discussion.

ASSOCIATE INVOLVEMENT

There is a related question about cooperation on a micro level when it involves specific tasks that staff, particularly CNAs, are asked to do. For instance, what if a staff member is asked to assist a resident in getting dressed, or in getting into bed (maybe with the assistance of a mechanical lift as one administrator suggested to me) in preparation for what appears to be an intimate encounter, or to provide peri care afterwards? Some employees may feel uncomfortable or unprepared to do this. Paula Span raises this question and wonders whether CNAs are capable of assessing these requests, or if they should even be asked to do so.[6] She notes that while many residences have no policies to deal with sexual behavior, others "train staff to ask people about their relationships – how they feel, whether they are comfortable," to determine if the relationships are safe and mutual. How much can we ask of associates without violating their consciences?

If associates have a religious or moral objection to patient behavior, do we excuse them from any kind of participation if possible, just as we would do in other situations that cause moral distress? Should we provide training to help staff understand the importance of emotional and physical intimacy for the elderly? If we encourage them to respect patient self-determination and to be cautious about judging or assuming they know what level of intimacy has or is about to take place, are we promoting moral indifference?

WHAT ABOUT SCANDAL?

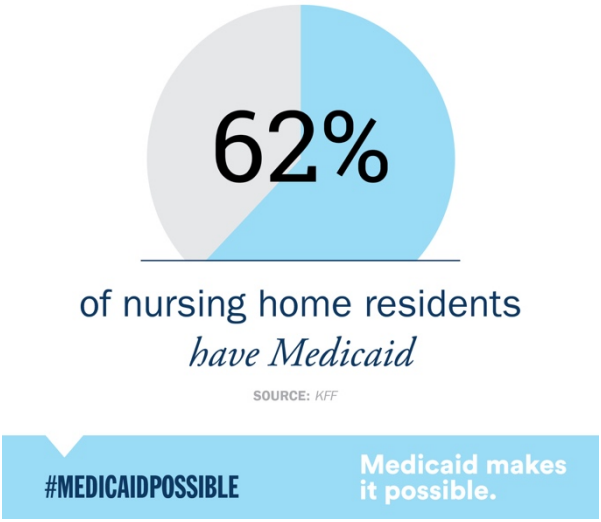
Let's assume that there is no formal and no significant material cooperation involved in renting to or caring for same-sex or divorced and re-married couples. The last question we must deal with is the issue of scandal. Scandal may be defined as an act, behavior, attitude or even proximity to evil that leads others to do evil, causes confusion or weakens their faith.[7] The word "scandal" appears repeatedly in church documents that deal with joint ventures and partnerships in health care. While renting an apartment surely has less potential for scandal than a collaborative arrangement between two large health care systems, it is nonetheless a concern.

Scandal may be given to other residents or to outsiders who are aware that some of the residents are not married or are in marriages the church does not recognize. Sometimes scandal is the result of a *deliberate* attempt to lead another to do wrong; but often it is the result of a cooperator getting too close, or appearing to get too close, to the wrongdoing of another so that they *unintentionally* lead others astray, causing confusion and giving the impression that we approve of an immoral act.

Is there a risk of giving scandal by *appearing* to condone illicit marriage or sex outside of marriage even if technically, from the perspective of moral cooperation, we do not?

The Revised Part Six of the *Ethical and Religious Directives for Catholic Health Care* notes that we must carefully evaluate the danger of scandal in each case. It notes that we can sometimes avoid or mitigate the risk of scandal by providing an explanation, for example, by emphasizing our mission is to protect human dignity and contribute to the common good by providing quality housing or long-term health care to those in need of it. We could explain that we do this as Catholics out of our faith commitment, but we do so without regard to social or personal status. Just as we do not ask patients when their last confession was when they come to the emergency room, we do not base admission to our residential facilities on presumed immoral behavior. Treating a criminal in an emergency room does not mean we condone his criminal acts, but that we are responding to human suffering.

Meeting these basic human needs is an obligation in justice generally, but it is particularly important for vulnerable seniors who are devalued by a society obsessed with youth and beauty. The elderly are sometimes perceived as non-contributing, inefficient members of a society that highly values economic success. Providing a safe, welcoming place for them enables them to flourish and to experience God's grace in old age. Is it appropriate to exclude those who may not be living a fully virtuous life?



CONCLUSION

The good of human accompaniment is important to all of us and becomes even more important as we age and begin to experience diminishment, increasing physical limitations and isolation. In fact, human companionship is perhaps the most important part of quality senior life. We should encourage companionship and friendship for senior residents. But Catholic institutions cannot ignore our tradition on sexual morality and the virtue of chastity. These are, to be sure, matters that should be addressed first with a pastor or spiritual director, but in many cases our residents or patients do not have access to spiritual advice, or they may not feel any need for it.

The administrators of our Catholic residential facilities must also be mindful of organizational ethics. This is not just about the virtue of patients, or even providers, but of the organization itself. How do we model Gospel values of respect for human dignity? How do

operationalize our teachings on morality and virtue? How do we show that there is a difference between Catholic elder care and elder care offered by others?

I fear that this short analysis provides far more questions than answers. I present them not to foreclose dialogue, but to open a discussion about responding to basic human needs in a rapidly changing society. I am confident our tradition has the resources to respond with integrity.

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Creating Dialogue

1. Describe various ethical questions you have encountered in Catholic senior housing and long-term care facilities regarding the sexual behavior of residents.
2. What responsibility does management have to employees and associates of these facilities who have religious or moral objections to patient behavior?
3. How do we balance the basic human need for housing and the human dignity of patients in the context of church teaching and social practice?

ENDNOTES

[1] "Toleration" is used here as a technical moral term that means to allow, for some good reason, a sinful action by another, without approving of it.

[2] There are federal rules prohibiting discrimination in housing which are found in the Fair Housing Act of 1968 (The Fair Housing Act [FHA], 42 U.S. Code § § 3601-3619 and 3631). The FHA prohibits discrimination in housing based on seven factors: race, color, religion, national origin, sex, disability, and familial status. It does not currently prohibit discrimination based on sexual orientation or marital status, but many states and municipalities do. This analysis is concerned primarily with the ethical argument derived from Catholic moral teaching. Local laws must also be considered, but we would not want to allocate housing unjustly even if it is legally permitted.

[3] See "A Retirement Community Turned Away These Married Women," which recounts the story of two women who were married, who were refused admission to a non-denomination but faith-based retirement community in St. Louis. The couple filed suit claiming alleging sex discrimination in violation of the federal Fair Housing Act and the Missouri Human Rights Act. *The New York Times*, August 17, 2018 https://www.nytimes.com/2018/08/17/health/lgbt-discrimination-retirement.html

[4] "The remarriage of persons divorced from a living, lawful spouse contravenes the plan and law of God as taught by Christ." See Catechism of the Catholic Church, #1665. In 2003, the Congregation for the Doctrine of the Faith made it clear that gay marriage was not marriage in any sense and was in no sense to be condoned. See *Considerations Regarding Proposals to Give Legal Recognition to Unions Between Homosexual Persons*.

[5] Cooperation is a technical term that refers to various levels of participation in the wrongdoing of another. The ERDs (*Ethical and Religious Directives for Catholic Health Care*) describe *formal* cooperation as "an action, either by its very nature of by the form it takes, can be defined as a direct participation in an immoral act, or a sharing in the immoral intention of the person committing it." The cooperation is only *material* if the one cooperating "contributes to the immoral activity in a way that is causally related but not essential to the moral act." The ERDs also note that several factors go into to determining the level of cooperation, including "how important the goods to be preserved or the harms avoided by cooperating." *Ethical and Religious Directives for Catholic Health Care*, Sixth Edition, Part Six, Introduction.

[6] Paula Span, "Sex in Assisted Living: Intimacy Without Privacy," *New York Times* (June 10, 2014). The author mentions the Hebrew Home in Riverdale, the Bronx, which has had a sexual rights policy for older adults since 1995.

[7] The Catechism of the Catholic Church defines scandal as "an attitude or behavior which leads another to do evil" (CCC, n. 2284) and says "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (CCC, n. 2287).

Ethics and Medical Standards of Care: Hysterectomy, Tubal Ligation or Salpingectomy?

Sr. Patricia Talone, RSM, Ph.D.
Amy Warner, D.O., M.A.

Editor's Note: The issue of foreseen future pregnancies that may be hazardous to mother, child or both have been an ethical challenge for ethicists and clinicians alike. The ERDs do not allow direct sterilizations even to avoid future complications. The recent "Response to a Question on the Liceity of a Hysterectomy in Certain Cases" (10 December 2018) from the Congregation for the Doctrine of the Faith (CDF), says that in cases where the uterus is irreversibly incapable of sustaining a pregnancy, a hysterectomy is licit. However, that causes conflicts with medical standards of practice which always prefer treatments that are less invasive and less risky. In this article, Sr. Patricia Talone, RSM, Ph.D., and Dr. Amy Warner present and discuss two cases that highlight the tension between ethical standards and medical standards. A further discussion of some questions that arise from the CDF responsum *follows.*

ALISON

Alison, a 29-year-old woman in her 26th week of pregnancy was in town for the day, shopping with her mother. She began cramping and leaking fluid and went immediately to the hospital where she learned her water had broken. She received regular prenatal care in her hometown an hour away, and recounted her complicated pregnancy history, including three previous cesarean sections. The first was performed due to the breech presentation of her baby. During surgery her doctors diagnosed her with a bicornuate uterus resulting in an abnormally shaped cavity. Her uterus, she was told, is divided by a muscular wall which limited the ability of her baby to change position.

Her next delivery, two years later, was also breech and she underwent a second cesarean delivery. This delivery had been complicated by placenta accreta, a condition in which the placental tissue abnormally grows into the wall of the uterus, most often around the previous uterine incision. Removal of the placenta can lead to profound hemorrhage and require hysterectomy at the time of delivery. Her physicians removed the placenta and saved her uterus, but they warned her of the risk of future pregnancies. They advised her to use effective contraception, giving her uterus time to recover fully prior to attempting another pregnancy. She was using oral contraceptives when she conceived four months later.

During this pregnancy her placenta had implanted away from her previous uterine scar and the accreta had not recurred. However, at 36 weeks, they discovered the scar on her uterus left by previous surgeries had ruptured. Fetal membranes and part of the umbilical cord were protruding through the uterine wall into the abdominal cavity. She reported no pain, bleeding, or contractions prior to this and the baby was delivered safely.

The separated area of the incision was not bleeding uncontrollably, so the doctors removed the damaged scar tissue and repaired the uterus rather than undertaking a hysterectomy with its additional risks of bleeding and damage to other pelvic organs. After careful consideration and reflection, she and her husband chose etonogestrel, a long-acting reversible contraceptive that she understood to be as least as effective as surgical sterilization.

Within days she began having terrible mood swings and a few weeks later she was almost completely bed-ridden with depression. When these side effects didn't subside, she started an antidepressant medication, but after several months her symptoms still had not improved. She finally made the decision to have the implant removed and resume oral contraceptives, this time combined with condoms.

This worked well for nearly three years, but again she became pregnant. There was no evidence of placenta accreta or surgical scar rupture. Alison planned for another cesarean delivery, this time with bilateral tubal ligation at the time of delivery.

Unexpectedly, her membranes ruptured. When she learned that the Catholic facility would not be able to perform a tubal ligation after delivery, she requested transfer to her hometown hospital. Just as the transfer began, nursing called for emergency assistance as Alison was in excruciating pain and hemorrhaging vaginally. Her son was delivered in surgery 16 minutes later in critical condition. He survived, but the staff reported that if this event had happened outside the hospital, it probably would have been fatal for both mother and child.

Her surgeon believed that she will not be able to carry another pregnancy to term, and possibly not even to viability, and requested permission to proceed with a salpingectomy. He recommended this over hysterectomy because, even though her bleeding was currently controlled, she had already lost a considerable amount of blood. She bled into the tissues surrounding the uterus, distorting the anatomy making a hysterectomy difficult, lengthy, and risky.

JEN

Jen is a 38-year-old patient pregnant for the sixth time. Her first two children did not survive due to premature delivery at 22- and 23-weeks' gestation because of cervical incompetence, a condition in which the cervix fails to support a growing pregnancy, often resulting in premature delivery with little or no warning. Her physicians believe her cervical incompetence is due to a series of LEEP procedures she had in her early twenties to treat abnormalities found on her Pap smear.

With her next pregnancy, she had a cervical cerclage placed. This surgical suturing of her cervix was an effort to support her dysfunctional cervix and allow her to carry a pregnancy. The pregnancy went well until 25 weeks' gestation when she began hemorrhaging due to failure of the cerclage. Her daughter was delivered by cesarean and survived but was challenged with physical and mental disabilities. Jen and her husband then lost a child at 17 weeks, before a cerclage was placed. With her fifth pregnancy, her physician had cautioned her that placement of the suture had been difficult as she had little remaining cervical tissue and this was badly damaged by the failure of the previous cerclage. He added weekly progesterone injections to her care in the hopes of delaying delivery. At 24-weeks, her cerclage again failed. The son she delivered died a few hours after birth.

All of this took an emotional and financial toll on Jen and her family. Her daughter needed a great deal of support and expensive care. Her husband, an oil field worker, was often away for long periods of time and her family was unable to offer much support. "We could never place our daughter in a situation in which she faced certain serious harm or death," she said, "and we can't knowingly do this to our unborn child either." In view of the risks, she chose a long acting contraceptive implant.

The implant was in place when Jen conceived a sixth time. Her physician again started progesterone injections and placed a cerclage, but has warned her to prepare for a likely preterm delivery. She asked for a tubal ligation if her delivery is caesarean section. The doctor agreed and wanted to deliver at the Catholic hospital because the facility had the needed neonatal intensive care services and because after the birth, she lived almost an hour away from the closest hospital.

COMMENT

These two cases are not common, but they represent very real clinical scenarios. But there are other factors, as well. They show how a woman's risk may be exponentially increased by factors such as geographic location and access to care. What might be considered reasonable risk for a woman living within easy access of specialized obstetric services and neonatal intensive care may be catastrophic for a woman in an isolated rural community.

The American College of Obstetricians and Gynecologists reaffirmed in April 2018 their position calling for transparency regarding institutional policy, so that a patient may seek transfer of care early in her pregnancy if she desires an elective procedure that is not routinely provided.[1] However, transfer to another provider is not always possible and it may not represent the best or most compassionate care for mother or baby, especially if alternate facilities lack needed medical and surgical subspecialties including neonatal intensive care. Transferring a child with a foreseeable need for intensive care services, or mother with a complicated medical condition away from a long-established relationship with a specialist physician, places both patients at unnecessary risk.

Hysterectomy at the time of cesarean, even in controlled situations, carries significant risk of harm including hemorrhage, injuries to other organs, and additional operating time. Additionally, removal of the uterus in its entirety disrupts the ligaments of the pelvis resulting in loss of support for the bladder,

vagina, and rectum. The creates an increased long-term risk of bowel and bladder complications including incontinence.

It is important to note that the uterus develops embryologically from the fusion of the two paramesonephric ducts which fuse in the midline to form the uterine body and fundus. The free ends of these ducts remain as appendages forming the uterine, or fallopian, tubes.[2] Anatomically, the uterus and the uterine tubes may be understood as one organism. In this case, especially when therapeutic choices are limited, removal of a *portion of the uterus, the uterine tubes,* by a complete or partial salpingectomy rather than the uterus in its entirety, may represent the best surgical option.

The quandary for the physician is this: If the outcome of the procedures is identical and the indications are the same, how does one justify choosing the ethically acceptable alternative – a hysterectomy – if it places mother or baby at risk of additional or unnecessary harm?

In these complex cases in which both clinical and social circumstances result in scenarios in which a viable birth is increasingly unlikely, both ethics and good medicine suggest the less invasive procedure and the avoidance of future pregnancies is not just an option, but the best course.

In our experience, physicians face these cases frequently and generally describe them as medically-indicated sterilizations. They believed, as we do, that each situation is unique and complex and must be judged in a wholistic sense, respecting the clinical and familial realities of each patient. These circumstances are frequently tragic and raise serious challenges for the families involved in them as well as moral quandaries for physicians and other health-care professionals serving them. We are convinced that those who minister in Catholic health care can and must engage in serious scientific and theological study and dialogue about cases like these.

Moralists have grappled with these problems for many years, from the mid-seventies when Mercy Health System, Detroit, opened a dialogue about the possibility of performing sterilizations for serious medical reasons. Clinicians, theologians and bishops continued in this dialogue (with no real resolution) until the publication of the Congregation for the Doctrine of the Faith's promulgation of *Quaecumque Sterilizatio* (July 31, 1993). This brief document forbade direct sterilization even if it was performed for a subjectively good intention.[3]

How then to address this problem? Because church teaching maintains that sterilization is intrinsically evil, the principles of double effect, toleration of evil and the lesser of two evils do not apply.[4] *The Ethical and Religious Directives for Catholic Health Care Services* (Directive 53) clearly states that "direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." Cancer of the uterus is an example of such a pathology; whereas a potential pregnancy is hypothetical and not a present pathology.

Yet when confronted with cases like those we have described, committed physicians, nurses and ethicists often reflect that a literal application of this interpretation seems "too

burdensome for most people."[4] Furthermore, for clinicians, it doesn't pass the "common sense" test. A hysterectomy is a more extensive and sometimes dangerous operation, requiring longer recuperation time for the woman than does a tubal ligation. Acknowledging the teaching that direct sterilization is not permitted because it is intrinsically evil (some moralists use the term "disordered") and aware *Quaecumque* rules out the use of subjectively "right intention," it seems that analysis of the moral liceity of a procedure may benefit by revisiting an objective/subjective analysis. That is, respecting the objective teaching that sterilization is immoral (or disordered) but recognizing that in some limited, subjective situations, it may be the only pastoral solution to prevent an even graver evil, abortion. It is also important to note that today we deal with medical conditions whose long-term consequences – such as a womb that is unable to carry a future pregnancy to term – are known to us in a way they never were in the past. This strains our traditional reasoning, which assessed liceity primarily on the basis of immediate, rather than probable long-term effects.

Two examples of an application regarding a related topic, contraception, occurred in the past 60 years. The first involves the distribution of the contraceptive "pill" to religious women in the Belgian Congo during the horrendous years of the Congo Crisis from 1960-65. Roman Catholic sisters had become the targets of rape by Congolese rebels outraged by years of poverty and foreign rule in their country. Three respected and recognized Catholic theologians offered slightly different arguments, but concurred that sisters in the Congo missions could legitimately take the pill to prevent pregnancy in the case of rape. They argued that the sisters' intention in using the pill was to protect themselves from pregnancy as the result of unjust aggression. The theologians, Msgr. Pietro Palazzini, Secretary of the Sacred Congregation (later bishop), Professor Franz Hurth, SJ, of the Pontifical Gregorian University, and Msgr. Ferdinando Lambruschini of the Pontifical Lateran University were internationally respected scholars.[5] None of the three refuted the church's objective teaching against contraception but observed that elements like circumstances and intention factored into the subjective analysis of the painful situation.[6] Even though their opinion did not represent official magisterial teaching, it did bear the weight of three "auctores probati", and as far as we know was never challenged or overruled by church authorities.

Forty years later in an interview with a German journalist, Pope Benedict XIV commented upon the use of condoms to prevent the transmission of HIV. His nuanced remarks were touted by some commentators as a change in church teaching regarding contraception. However, reading the Pope's statement in its entirety, one recognizes that the Pontiff upheld the teaching about the immorality of contraception, while subjectively recognizing the importance of the intention of the one acting. Responding to a question from the journalist, The Holy Father said "[the Church] of course does not regard it [condom use] as a real or moral solution, but, in this or that case, there can be nonetheless in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality."[7]

The church's moral tradition, born in response to its sacramental teaching and practice,

especially regarding the Sacrament of Reconciliation, instructs confessors and anyone endeavoring to judge the morality of a given case to examine three things. First, one must look at the moral act itself determining the moral good or evil of the act. Then one must consider the intention of the one acting, and finally the circumstances in which the moral agent finds him or herself. This approach regards the moral agent holistically, recognizing that people perform actions in specific situations often facing "damned if you do, and damned if you don't" kinds of circumstances.

While moral wisdom traditionally cautions that a good intention may not justify an evil action, intention does matter in the total moral analysis of a situation. Thomas Aquinas emphasized the significance of intentionality in the *Summa* (I-II, Q. 12, a. 1-5). In this section, he noted that some moral actions are extremely complex and thus, the moral agent may have more than one intention or goal in acting.[8] Thomas provides an example that involves taking medicine to attain health. He says, "I am determined to take this medicine because I am determined to get well." There are two purposes: the first is to take medicine, the second, ultimate goal is to get well. In speaking of intention, Thomas is writing for confessors, and it seems that the role of the skillful confessor or counselor is, in conversation with the agent, to determine the agent's primary intention.

In our two tragic examples, we meet women whose lives and marriages have been open to new life. Alison is in her fourth pregnancy, Jen in her sixth. We have met many women like them. We have never heard one state, "I want to be rendered sterile" but rather, "I want to live to care for and raise my children. I want to carry out the responsibility I was given at their births." Additionally, in speaking with countless physicians, we met few whose goal is rendering a woman sterile. Obstetricians and perinatologists commit themselves to help women and their babies achieve the maximum medical outcome by bringing forth healthy new lives.

The varied circumstances of our ministries are important too, especially for our hospitals in rural, underserved areas.[9] Pius XII, in his November 24, 1957 allocution on the Prolongation of Life, noted that means to prolong life may "vary according to circumstances of persons, places, times, and culture."[10] What is ordinary means to preserve life in a Western, metropolitan area would not necessarily apply in the Amazon jungle of Brazil. Jen, like many other women lives in a rural area. Given her tenuous physical condition, forcing her to travel beyond a local hospital might cause her physical harm or even death. And, it certainly may cause moral distress to physicians whose primary intention is to prolong the woman's life and who commit themselves to use their professional expertise to save lives.

In sum, we do not believe that the 1975 and 1993 definitions and pronouncements of the CDF take adequate account of the complexity of obstetrical cases nor the advances in perinatal medicine and diagnosis since then. We also believe that our cases and our analysis fall short of a comprehensive response. However, it seems from the church's response in limited contraception cases like the "pill" in the Belgian Congo or condom use with sexually-active persons with HIV, that our rich, moral tradition possesses the pastoral wisdom to enable patients and physicians to remain true to the church's teaching while at the same time

making complex medical decisions. It is our fervent hope that Catholic health care, committed to life from conception to natural death, can again openly examine these cases and come to a conclusion that is both medically and morally sound.

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ENDNOTES

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[2] Thomas W. Sadler, *Langman's Medical Embryology,* 13th edition, (Philadelphia: Wolters, Kluwer Health, 2015) 266. Sadler's view is affirmed in Moore's *The Developing Human: Clinically Oriented Embryology,* 10th edition (Elsevier, 2015) and Schoenwolf, *Larsen's Human Embryology*, 5th edition (Elsevier, 2014).
[3] Congregation for the Doctrine of the Faith, "Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters." July 31, 1993. The full history of the 1975 case is recorded in Richard McCormick's *Notes on Moral Theology 1981-84* (Lanham, MD., University Press of America, 1984) 187.
[4] Pope Pius XII. "The Prolongation of Life." November 24, 1957. Granted, the Pope was speaking about use of ordinary/extraordinary means to prolong life. But the pastoral concern expressed in his statement roots the moral tradition in the real lives of the faithful.
[5] A full account of their reasoning is found in "Una Donna Domanda: Come Negarsi Alla Violenza," *Studi Cattolici* 5(1961) 63-71.
[6] This line of reasoning reappeared again in 1993 when Father Giacomo Perico, writing in *Civiltà Cattolica* argued that contraception for Bosnian women during the Serbo-Croatian war was a means of legitimate self-defense against an unjust aggressor. Reported in the *Chicago Tribune*, March 5, 1993.
[7] Quoted in Alan Holdren. *CNA/EWTN News*. "Analysis: What the Pope really said about Condoms." November 22, 2010.
[8] Aquinas, *Summa Theologica*, I-II, q. 12, a.3 states that "[one] can intend several things at the same time, for…intention can go out to both the eventual end and the intermediate end." *Summa Theologiae*, Thomas Gilby, OP, ed., vol. 17, *Psychology of Human Acts* (Blackfriars/McGraw Hill, New York, 1970) 114-121.
[9] Catholic hospitals serve one in six patients throughout the United States, and 26.6% of Catholic hospitals are rural. The Catholic Health Association reported in 2018 that 133 of its member hospitals are critical access hospitals.
[10] Pope Pius XII. Ibid.

A New Look at Liceity of Hysterectomy in Certain Cases

Initial Observations by CHA Member Ethicists on the Vatican Document

Shortly after this document appeared we solicited comments from some of our system ethicists. We combined them with our own observations and grouped them under three categories. We hope that these initial thoughts will stimulate more reflection on the meaning and importance of this document. We will be happy to publish other comments in our next issue.
-C.B. and N.B.H.

On December 10, 2018, the Congregation for the Doctrine of the Faith issued a new document on the liceity of hysterectomy in certain cases.[1]

This document is a response to questions about certain "extreme cases" in which the uterus is in an irreversible condition such that a pregnancy will result in a spontaneous abortion before the fetus is able to arrive at a viable state.

OBSERVATIONS AND QUESTIONS

The questions behind the *dubium* and the CDF response are complicated. It seems that the document makes some new distinctions. It also raises some new questions. We have solicited comments from a number of ethicists and have integrated their comments into this essay under three general categories: questions about methodology, clinical questions and questions about language and meaning. They are intended to facilitate dialogue and to help achieve consensus on the correct interpretation.

METHODOLOGICAL QUESTIONS

The new document responds to three questions: a) Is it licit to remove a damaged or diseased uterus in order to counter "an immediate serious threat" to the mother, even if it results in permanent sterility? b) Is it licit to remove a uterus that is not in itself a "present risk to the life and health of the woman," but in order to prevent a "possible future danger" deriving from conception? c) Is it licit to substitute tubal ligation, "also called 'uterine isolation' for the hysterectomy," because it is simpler and less serious, and because the resulting sterility might be reversed?

For two of the questions, the new document affirms teaching found in the 1993 Response of

the CDF to "Questions Proposed Concerning 'Uterine Isolation' and Related Matters."[2] Regarding (a), it uses traditional double effect reasoning to affirm that it is licit to perform a hysterectomy to remedy an immediate threat such as endometriosis or uterine cancer. Regarding (c), it affirms that a tubal ligation, even if described in terms of uterine isolation, is still "intrinsically illicit as an end and a means."

With (b), however, it takes a methodological turn and allows a hysterectomy when the uterus is deemed to be incapable of bringing a pregnancy to term. In this case, hysterectomy does not "regard"[3] sterilization and is entirely different than the "uterine isolation" question to which they responded in July of 1993.

However, this still seems to beg the question: If a hysterectomy in the cases referred to is not equivalent to a direct sterilization, what is its purpose? As one ethicist asks: "What would be the purpose of removing the uterus in this instance? It's not cancerous or diseased, so it's not threatening her health or the life of the fetus. There aren't fibroids so it's not a pre-cancerous condition and it isn't causing her pain or suffering. It's just sitting there and would be fine if left alone." The purpose seems to be to prevent future pregnancy which in all likelihood could not come to term.

Principle of Double Effect: The new document continues to tolerate sterilization as an unintended effect of a therapeutic action (e.g., to treat uterine cancer or endometriosis) on the basis of the principle of double effect because the two effects – therapy for the disease and loss of fertility – are inseparable. Yet it allows a hysterectomy because of an existing, virtual sterility due to the condition of the uterus. In this case, however, the two effects are not inseparably connected. The removal of the uterus, which is not undertaken with a therapeutic intent, is done *in order to* prevent a future pregnancy.

The document suggests that hysterectomy is permissible because the uterus is damaged or diseased beyond repair and is therefore "unable to fulfill [its] procreative function." Since the uterus is unable to fill this role, procreation is impossible so the hysterectomy is not "against procreation."

However, it also says "we are not dealing with a defective, or risky functioning of the reproductive organs." Does this mean that hysterectomy is not allowed if the uterus is defective or functioning badly in a way that may harm the mother, but only if it is so thoroughly compromised that it is a risk to the fetus?

How certain is certain? The document does not indicate exactly what might constitute the extreme cases in which a hysterectomy is permissible, but it does acknowledge the need for a clinical judgment and requires "the highest degree of certainty" that the uterus cannot support a pregnancy to term.

There are two issues here. First, physicians agree that "certainty" is difficult to come by in most medical matters. One ethicist noted the necessarily prudential nature of this judgment: "There are conditions in which this judgment might attempt to be applied, such as repeated damage from C-sections, congenital malformations (bicornate uterus), anti-phospholipid antibodies, etc. All of these could conceivably (pardon the pun) result in multiple miscarriages, without being able to declare with the highest degree of medical certainty that such a result would be inevitable in an

individual case, and it must perforce occur prior to viability. The present responsum requires and assumes the presence of all these conditions. However, all medical prognostication is really just an exercise in probabilities – **certainty** is extremely hard to come by, and rarely possible." Second, it is unclear whether the "highest" certainty called for is the same as "moral certainty" which has been the traditional criterion for action in cases of doubt or if it is a more rigorous standard.

The role of circumstances. Another issue is the relevance of circumstances. Traditional moral reasoning allows circumstances a determinative role in the moral quality of the action only when the action does not involve intrinsic evil. However, Dr. Amy Warner and Sr. Patricia Talone suggest the complex circumstances of time, geography, finances and personal issues that are part of clinical judgments are very important to good medicine especially when the issue is a sustained medical event like pregnancy. Shouldn't the ability to pre-empt complications and travel distance from medical resources figure into the equation if we are virtually certain of future outcome?

CLINICAL QUESTIONS

The most important clinical issue is the disparity between medical standards of care[4] which call for the most effective, safest, and least invasive treatment possible, and the requirements of our moral tradition. At the moment, our understanding of pre-emptive sterilizations as intrinsically illicit runs counter to best practice because it is often the safest and least invasive option.

Another issue is anatomical. Both documents speak as if the uterus and fallopian tubes are totally separate organs such that it is permissible to remove one but not the other. Medical embryology suggests they develop as one. As Talone and Warner say elsewhere in this issue:

> Fallopian tubes, also called uterine tubes are not distinct from, but a part of the uterus. It is important to note that the uterus develops embryologically from the fusion of the two paramesonephric ducts which fuse in the midline to form the uterine body and fundus. The free ends of these ducts remain as appendages forming the uterine, or fallopian, tubes.[5]

This is a very important point. If the uterus and the fallopian tubes are both part of a single organ, then doesn't it seem more logical (and clinically sound) to remove as little of the organ as possible? Wouldn't that suggest a partial or total salpingectomy rather than a hysterectomy if they both accomplish the same purpose?

Clinical circumstances. We have already noted the methodological importance of circumstances. They are also important in clinical judgments. Warner and Talone note specifically clinical circumstances like the patient's condition, blood pressure, medication side effects, as well as time, place, and available resources. These circumstances often determine the appropriateness of one course of treatment over another. Is there not a way that we can take greater account of circumstance from a moral perspective as well?

LANGUAGE AND TERMINOLOGY QUESTIONS

The document notes that the "malice of sterilization" (here referring to a tubal ligation or "uterine isolation") is rooted in the "refusal of children" and is "an act against the *bonum prolis*." The removal of a uterus which is unable to bring a pregnancy is not a refusal of children the document maintains, because no complete pregnancy is possible. However, it does not seem that a salpingectomy in the same situation is necessarily a refusal of children, either. In fact, in the cases described by Warner and Talone, the couple may sincerely WANT more children, but deem it impossible or too risky.

There is also some question about whether this new document redefines procreation. Our traditional understanding is based upon a presumption that a unique human person exists from the moment of conception. Even though it is physically impossible for the egg and sperm to unite and result in a new organism in the absence of a uterus, the document's understanding of "procreation" seems to imply that procreation involves ovulation, fertilization, implantation, gestation and delivery. If that is so, it seems to give full protection only to children that are born. Even though fertilization is impossible without a uterus, since the sperm must travel through the uterus to fertilize the egg in the uterine tube, doesn't the fact that conception could take place if the uterus were left in place indicate that the intent is to prevent conception?

Others have raised similar questions. Jeanne Smits says the document "rests on skewed definitions of the words 'procreation' and 'sterilization. '" The classic definition of procreation, Smits says, "is here destroyed by a stroke of the pen."[6]

The Couple to Couple League raises similar questions, saying "this reasoning on the part of the CDF is somewhat surprising." Both groups suggest that the document confuses, rather than clarifies, the matter. Dr. Philip Schepens, a former member of the Pontifical Academy for Life, says the Response is "unnecessary and at the same time unnecessarily creates confusion."[7]

One final point about language is that the document does not use the terms "intrinsic evil" or "intrinsically immoral," terms that have appeared in other documents, including the *Ethical and Religious Directives*.[8] Instead they speak of "intrinsically illicit" and "morally illicit." These terms may be equivalent to "evil" and "immoral," but some of us wonder whether the shade of difference is significant. Is the choice of language lowering stakes in some way?[9]

This document is important because it takes explicit account of advances in medical science that enable us to diagnose causes and anticipate outcomes in a way that was not possible in the past. Until modern times, there was little understanding of what caused miscarriages or failure to conceive in the first place. Can our moral reasoning find a way to acknowledge these advances?

Overall, the document seems to open the door to further discussion, but it also raises as many questions as it answers. It seems to ignore important clinical facts, such as the connection between the uterus and the uterine tubes, and in our view does not give adequate attention to

our responsibility to prevent foreseeable future harms to mother and child.

ENDNOTES

[1] Congregation for the Doctrine of the Faith, "Response to a Question on the Liceity of a Hysterectomy in Certain Cases," December 10, 2018.

[2] "Responses to Questions Proposed Concerning Uterine Isolation and Related Matters," July 31, 1994. http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_31071994_uterine-isolation_en.html See also "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (*Quaecumque Sterilizatio*) March 13, 1975.

[3] "Regard" is not common English usage in this case. The Italian phrase is "perche non si tratta di sterilizzazione" and the French is "il ne s'agit pas de stérillisation" both of which have a clearer connotation of "has nothing to do with." If the intent is to distinguish the case they cite from sterilization, a better choice would have been "does not constitute" or "does not involve" sterilization.

[4] While standards of care are often used to assess allegations of medical malpractice, they are also guidelines for the best treatment, given current evidence. See Brian K. Cooke, Elizabeth Worsham and Gary M. Reisfield, "The Elusive Standard of Care," *Journal of the American Academy of Psychiatry and the Law Online* (September 2017) 45 (3) 358-364.

[5] Thomas W. Sadler, *Langman's Medical Embryology,* 13th edition, (Philadelphia: Wolters, Kluwer Health, 2015) 266. Sadler's view is affirmed in Moore's *The Developing Human: Clinically Oriented Embryology,* 10th edition (Elsevier, 2015) and Schoenwolf, *Larsen's Human Embryology*, 5th edition (Elsevier, 2014).

[6] Jeanne Smits is the editor of the right-wing French periodical Présent and a frequent critic of Pope Francis. "Do the Vatican's New Guidelines on Hysterectomy Open a Door to Contraception and Abortion?" *LifeSite News* (January 18, 2019). The document, she says, employs "strange reasoning indeed, insofar as the removal of the uterus is well and truly performed in order to 'impeded the functioning of the reproductive organs…deliberately preventing that from happening in itself constitutes sterilization." She also says that "the response "if read logically, appears to consider a conceived child who is not viable as not being the fruit of the true procreation." (https://lifesitenews.com/opinion/do-vaticans-new-guidelines-on-hysterectomy-open-a-door-to-contraception-and-abortion). Accessed January 27, 2019. (On January 30, the website said the article "no longer exists or has moved.")

[7] Forest Hempden, "What the New Vatican Document says About Hysterectomy," Couple to Couple League, January 3, 2019. (https://ccli.org/2019/01/01/what-the-new-vatican-document-says-about-hysterectomy/). Accessed January 27, 2019.

[8] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, 6th ed. (Washington DC: USCCB, 2018).*

[9] In sacramental theology, there is a significant difference between "illicit" and "invalid." The former connotes a violation of law, doing something not allowed, but still sacramentally valid. The latter means that, to use a mechanical analogy, just doesn't work because of some inherent defect, such as inappropriate matter (e.g., attempting to consecrate a bottle of chocolate milk instead of a chalice of wine). Is the use of illicit here rather than immoral analagous to the sacramental use, where licit is a matter of law, and valid refers to sacramental effectiveness?

Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, associate director, supervised the contributions of Brandon Hall (J.D. anticipated 2019) and Valerie De Wandel (J.D./Ph.D. expected 2020).

LOBBYIST DOCUMENTS REVEAL HEALTH CARE INDUSTRY BATTLE PLAN AGAINST "MEDICARE FOR ALL"

Preceding the 2018 election, leading pharmaceutical, insurance, and hospital lobbyists formed the "Partnership for America's Health Care Future," to dissuade lawmakers of both political parties from supporting expansion of Medicare, in particular the Medicare for All effort. Despite growing attention and interest in the idea, private healthcare lobbyists feel "confident" that they can thwart any federal expansion of Medicare, given the political makeup and climate, and by focusing on research that indicates that any support for the Medicare for All option dissipates when beneficiaries find out that Medicare for All would likely require ending employer-based coverage, tax increases, and increased governmental control. Proponents of the Medicare for All concept, however, assert that "the smear of socialized medicine has been used a thousand times and has lost its bite," pointing to California Governor Gavin Newsome's recent proposal in California as evidence. Proponents counter-attack solution is seemingly simple: educate the public on the realities. Proponents assert that once a single payer option is more widely understand "as a program that covers everyone, that doesn't impose copays and deductibles, and that has more comprehensive benefits than existing plans," support will only continue to grow. Lee Fang, Nick Surgey, *The Intercept,* November 20, 2018
https://theintercept.com/2018/11/20/medicare-for-all-healthcare-industry/

UNDER TRUMP, NUMBER OF UNINSURED KIDS ROSE FOR FIRST TIME THIS DECADE

According to a Georgetown University report, the number of children without health insurance rose by almost 300,000 in the United States. Although the statistics indicate that the percentage of uninsured children rose by merely .3 percent, normally the uninsured rate maintains stability through times of economic growth. One of the reasons for the rise in uninsured children is the fact that the Trump administration has stopped funding to those seeking coverage and to those helping people sign up for coverage. Further, many health care providers, such as OLE Health, that serve immigrants have seen patients disenroll from health care, due to fear of deportation. Some states, however, did make progress in lowering the uninsured rate of children, including South Dakota, Utah and Texas. Georgia, Massachusetts, Ohio, South Carolina, and Tennessee also increased their insured children. Phil Galewitz, *Kaiser Health News*, November 29, 2018

https://khn.org/news/under-trump-number-of-uninsured-kids-rose-for-first-time-this-decade/

TRUMP ADMINISTRATION DETAILS HEALTH-LAW WAIVERS FOR STATES

Recently, the Trump administration has identified different ways states can waive parts of the Affordable Care Act. According to Centers for Medicare and Medicaid Services, there are four different template indicating how states may implement waivers. In response, Health and Human Services Secretary Alex Azar released a statement that, "The specific examples laid out today show how state governments can work with HHS to create more choices and greater flexibility in their health insurance markets, helping to bring down costs and expand access to care." Democrats, and other supporters of the ACA, argue these templates will only allow for inadequate coverage, a result of the current administration working to undue the central tenets of the ACA. Supporters of the ACA argue that legal challenges could be brought against the waivers provided. Although these waivers may encourage states to use differing methods in implementing health care, some states may keep the current system while others may entirely defer from the system. Stephanie Armour, *Wall Street Journal*, November 29, 2018
https://www.wsj.com/articles/trump-administration-details-health-law-waivers-for-states-1543512557

HEALTH LAW COULD BE HARD TO KNOCK DOWN DESPITE JUDGE'S RULING

Appointed to the Federal District Court in Fort Worth, Judge Reed O' Connor ruled that the Affordable Care Act was unconstitutional, based on the law's requirement that the majority of American citizens have health coverage or must pay a tax penalty. Although the tax penalty was taken away by Congress, the rest of the law was left in place per the legal doctrine of severability. Although Judge O' Connor cited such congressional intent, he ignored the 2017 congressional action. Ad thus failed to analyze the most recent congressional perspective. While this argument continues, efforts to protect the ACA also continue. The Supreme Court may decide to hear the case, if the case moves forward and is heard by the United States Court of Appeals for the Fifth Circuit this spring and the Fifth Circuit overturns Judge O'Connor's ruling. Those five justices who upheld the ACA in the notable 2012 decision still serve on the U.S. Supreme Court. Jan Hoffman, Robert Pear, and Adam Liptak, *The New York Times,* December 15, 2018
https://www.nytimes.com/2018/12/15/health/texas-aca-ruling-unconstitutional.html

DRUGMAKERS MAY BE DELAYING PRICE HIKES TO AVOID SPOTLIGHT

According to health care services analyst Robert Jones, "The lower magnitude of brand price increases could present modest downside risk to wholesaler earnings." This was a response to a delay in prince increase of branded medicines, with the average list price increase being half of what it was in 2018.

Raymond James analyst Elliot Wilbur indicated that the majority of major drugmakers are using a "wait-and-see approach" due to more cautious approach by the major drugmakers to avoid the regulation spotlight. Cristin Flanagan, Riley Ray Griffin, *Bloomberg Law,* Jan. 2, 2019 https://www.bloomberglaw.com/product/blaw/document/XC7GEPBC000000?bc=W1siU2VhcmNoIFJlc3VsdHMiLCIvcHJvZHVjdC9ibGF3L3NlYXJjaC9yZXN1bHRzL2NiYzc3M2EzYWZlMTAxNjE5NGU5MWFhMTNiMDdmNzdkIl1d--ee5fb2888c66317f7037995240d6bfcf623204cb&guid=ba6514ff-b4c0-4fc8-81a4-7bd596c5e683&search32=gpgugOSnIb0qJ_M1EbDhDw%3D%3DfNwewZYf67ItN9D-P5LJyiTaXt3-IUrM9504KPGgL9H6t5bqurwGEvF6jYwsfA_ib8lEz_XdADLZotBftBzME1EVMZvVdOU2M8FSmw8nJPXfrKo5rJa7_GAbTnYhPAnh

NEW MAINE GOVERNOR ORDERS MEDICAID EXPANSION

After over a year of non-compliance with the a 2017 ballot initiative that expanded Medicaid in Maine under former Governor Paul LePage, new Governor, Janet Mills signed an executive order in her first week that implements the expansion, thereby expanding access to care in Maine. This means that an estimated 70,000 low income adults in Maine are expected to be eligible for coverage. But while the executive order has gotten the proverbial ball rolling, full implementation still faces a few more necessary tasks. CMS still must approve Maine's state plan amendment to implement the expansion, and the state legislature still has to approve the requisite funding of the state's 10 percent share of the cost. Both are expected to be completed fairly quickly. Harris Meyer, *Modern Healthcare,* January 3, 2019 https://www.modernhealthcare.com/article/20190103/NEWS/190109956

DNA TESTING? YOU MIGHT WANT TO WAIT FOR MORE LEGAL PROTECTION

The genetic testing industry is expected to flourish, but altogether raises a major concern that existing laws may not be fully comparable with protecting the privacy of genetic information. Currently, according to Joel Winston of the Pittsburgh-based Winston Law Firm LLC, "There are a lot of gray areas and companies are taking advantage of it." A major concern lies with de-identification. Although data can be de-identified, current technology has made it easier to re-identify the data, introducing a concern for the use in racial profiling, according to Alexandra Cavazos of Loeb & Loeb LLP. Although there are laws that do apply, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Genetic Information Nondiscrimination Act (GINA), they define genetic and personal information as two separate things. Thus, the overarching argument is that the "law always lags behind the technology", according to Jessica B. Lee of Loeb & Loeb LLP. Another concern is the lack of blanket privacy protections, since genetic information, once leaving the individual source, is not under any sort of privacy protection. Thus, greater issues such as familial impact can arise from such technological advances of DNA testing. Dana A. Elfin, *Bloomberg Law*, Jan. 7, 2019 https://www.bloomberglaw.com/product/blaw/document/X8KOPB3C000000?bc=W1siU2VhcmNoIFJlc3VsdHMiLCIvcHJvZHVjdC9ibGF3L3NlYXJjaC9yZXN1bHRzLzQ5ZTdhYT

IxMDM4MGM1YzQyOWYyMTAyNjVhOWNjNTYwIl1d--d7315180b5aab749c3c3c2b3e76e5b0ef96fcb2b&guid=dcb562ad-1f3f-4fdc-938c-761c5bb646b6&search32=n7RxfP4FmM8VF0_v6OphWg%3D%3DYDskOL738EphcfEbc79lofHFXTsxgipiBVBxUMRUcxdAhfxq14iBgC118QX0kZfltjPDxc7E_mTzMh0sfV3-fqq_paMtAA7hFy25XnNzRzJc5_KTnR7gdAGPM3-HXHT5

HOW HELPING PATIENTS GET GOOD CARE AT HOME HELPS RURAL HOSPITALS SURVIVE

As rural hospital closures continue to plague parts of the U.S., the remaining rural hospitals are stuck balancing the need for revenue with the fear of being penalized for repeat patient visits and admissions. However, those rural hospitals are seemingly entering a new era of hospital management, one in which hospitals and home health agencies are now collaborating rather than strictly competing. And these newfound "community partnerships" are rapidly growing in healthcare markets across the country. But this trend is not without its downsides, too, as the rural hospitals are finding out: a lack of readmissions, while potentially saving on penalties from the government, means a reduction in overall admissions, too, a balance that is difficult to navigate. Blake Farmer, *Nashville Public Radio/Kaiser Health News,* January 8, 2019
https://khn.org/news/how-helping-patients-get-good-care-at-home-helps-rural-hospitals-survive/

TO GET MENTAL HEALTH HELP FOR A CHILD, DESPERATE PARENTS RELINQUISH CUSTODY

In what can only be described as heart-wrenching decisions, parents—even those with private health insurance and/or Medicaid coverage for the child (if a child from foster care)—are increasingly being forced to pay high out-of-pocket costs for severe mental health treatments or relinquish custody of the children to the state, which is obligated to pay for the necessary services and treatments. While two-thirds of states do not keep track of the number of relinquished custodies specifically to get children mental health services, a 2001 Government Accountability Office (GAO) study found that families in 19 states relinquished approximately 13,000 children. The lack of available information has prompted new studies to be conducted, as mental health advocates blame "decades of inadequate funding for in-home and community-based services across the country. Further, even when facility beds are available, some are unwilling or unable to take a child who has severe mental health conditions. And even with laws in place and successful lawsuits compelling such coverage, it appears that currently, there is little-to-no enforcement of these laws, leaving children—especially those coming from foster care—without access to the treatment they need and are supposed to be legally afforded. Christine Herman, *Kaiser Health News*, January 9, 2019
https://khn.org/news/to-get-mental-health-help-for-a-child-desperate-parents-relinquish-custody/

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