

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

Mark F. Carr, M.Div., Ph.D.

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 Health²), 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/>

"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."

- 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

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 Health²¹ 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.



Mark F. Carr, M.Div., Ph.D.

Director of Ethics

Providence Health and Services

Alaska Region

Anchorage, Alaska

Mark.carr@providence.org

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 discussions 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/nonprofitosp#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.AMTAhealth.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%20or%20Providence%20Ministries.pdf>

³⁸ Eckelman, M. J. and Jodi Sherman, Shama Agmad, editor.

“Environmental Impacts of the U.S. Health Care System and Effects on Public Health.” *PLoS One*. 2016; 11(6): e0157014. See also a book by Jessica Pierce and Andrew Jameton who raised concern for this issue over 17 years ago in *The Ethics of Environmentally Responsible Health Care*. Oxford University Press; New York, 2004.

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>

⁴² See the following article by Thomas A. Nairn, OFM, PhD for a good description of the “preferential option for the poor” in healthcare: <https://journalofethics.ama-assn.org/article/roman-catholic-ethics-and-preferential-option-poor/2007-05>

⁴³ Weaver, Darlene Fozard. “Christian Anthropology and Health Care.” *Health Care Ethics*, USA, Fall, 2018. Available online: <https://www.chausa.org/publications/health-care-ethics-usa/archives/issues/fall-2018/christian-anthropology-and-health-care>