

HEALTHCARE AND SOCIAL RESPONSIBILITY

The Revised Directives Clarify the Catholic Position

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CHA and the Center for Health Care Ethics at the St. Louis University Health Sciences Center are collaborating to publish a series of articles on the Ethical and Religious Directives for Catholic Health Care Services. This article is the second in the series, written by Sr. deBlois, CHA's senior associate for ethics, and Fr. O'Rourke, director of the Center for Health Care Ethics.

In our day, the Church emphasizes responsibility for social justice. The popes of this century have devoted much of their attention, theological analysis, and teachings to social problems and possible solutions to them. Of course, substantive issues of social justice affect people of all religions and nations. A concern for social justice thus forces the Church "to step outside herself" and, by applying the teaching of Christ, serve as a light and a leaven to help all people and nations create a more compassionate and fair society. The Bishops' Synod of 1971 summed up the reason for the Church's intense concern for matters of social justice: "Action on behalf of justice and participation in the transformation of the world fully appear to be a constitutive dimension of the preaching of the gospel, or in other words, of the Church's mission for the redemption of the human race, and its liberation from every oppressive situation."¹

With the significance of social justice in mind, the writers of the new *Ethical and Religious Directives for Catholic Health Care Services*

(ERD)² place great emphasis on it. Focusing on the responsibilities for social justice, Part 1 of the ERD places the Catholic healthcare mission in the heart of our pluralistic society: "Their embrace of Christ's healing mission has led institutionally based Catholic health care services to become an integral part of the nation's health care system." The organizations devoted to providing healthcare in the name of the Church thus have two goals:

- To remain faithful to their mission of healing carried out in the name of Christ
- To offer healthcare to the community at large as a means of providing for the common good of the community

The healing mission is not confined to advancing sectarian religious purposes. True, the members of the Church exercise charity and fulfill their baptismal commitment by engaging in the apostolate of Catholic healthcare. But, in the words of the Second Vatican Council, their engagement in the mission of healing is designed primarily "to improve the whole range of the

Summary

The Catholic Church participates in the U.S. healthcare system by reason of its contribution to the common good of society. To facilitate this, the *Ethical and Religious Directives for Catholic Health Care Services* set forth certain normative principles. Catholic healthcare is dedicated to promoting human dignity and the sacredness of life; it has an "option for the poor"; it seeks the common good, cooperating with other providers toward that end; it prohibits abortion, in vitro fertilization, contraceptive sterilization, and assisted suicide procedures in free-standing Catholic healthcare institutions.

This article focuses on the directives in Parts 1 and 6 of the ERD. Directive 2 calls for mutual respect among care givers. Directive 3 discusses

ways to care for people "at the margins of society." Directive 4 describes the medical research permitted in Catholic facilities, and Directives 5 and 9 suggest how such facilities can best perpetuate their Catholic identity.

Directive 7 mandates that Catholic facilities treat employees justly. Directive 8 says that such facilities must observe canon law in transferring sponsorship or in founding, closing, or selling an institution. Directive 68 suggests that the bishop be involved in a proposed partnership that may infringe upon Catholic identity. Directive 70 urges Catholic facilities to avoid scandal, and Directive 69 warns that some forms of cooperation are unethical even when scandal is not present.

temporal order."² As the council indicated, the spiritual and temporal orders are closely connected and should never be conceived as diverse or contradictory. Yet it is significant to realize that the efforts of the Church in the field of healthcare pertain primarily to the temporal order and are carried out in conjunction with other people committed to supplying the goods and services intimately related to the common good.

Insisting on the Church's right to participate fully as an equal partner in the provision of healthcare in our pluralistic society is important. Catholic healthcare providers must make sure their efforts are not marginalized because they do not provide all "legal healthcare services." They must insist that their work is motivated by their desire and ability to provide good healthcare, not from a desire to promote sectarian objectives. The measure of "good" healthcare is not necessarily that allowable by law. If that were so, Nazi concentration camp atrocities would have been reckoned as good healthcare because those atrocities were in accord with the laws of Nazi Germany. The real measure of good healthcare is the physiological function of persons, insofar as it disposes for integrated social and cultural functions.³

Catholic healthcare fills this need well, even though it does not provide every procedure classified as legal. The Church's right to contribute to the common good by providing healthcare services has been recognized from the very beginning of our country. Thomas Jefferson in 1804 assured the Ursuline nuns of New Orleans that their work with orphans furthered "the wholesome purposes of society"—in other words, the common good.⁵ When the Medicare and Medicaid programs became federal law in the mid-1960s, the Social Security Administration declared that Catholic healthcare facilities could receive funds for the care of patients covered by these programs because Catholic hospitals are not "integrated auxiliaries" of the Church.⁶

In sum, the Church participates in the U.S. healthcare system by reason of its contribution to the common good of society, not by reason of special exemption or privilege.

PRINCIPLES

To facilitate the participation of Catholic healthcare services in the nation's healthcare system in a way that meets the aforementioned goals, the *ERD* set forth five normative principles:

Sacredness of Life Catholic healthcare is dedicated to promoting human dignity and the sacredness of life, from the moment of conception until death. Derived from this principle is the right to

life and the right to protect it through adequate healthcare. In the bishops' view, this first principle is not a religious principle; that is, it is not derived primarily and fundamentally from the teaching of Christ, though it is certainly in accord with that teaching. The principle is based on human experience and human reason.

Clearly, many adhere to this principle even though they have no church affiliation. The fact that our first principle of healthcare is shared by many who are not Catholic establishes a firm foundation for our participation in the provision of healthcare in the United States.

The Option for the Poor The second principle, to have "an option for the poor," is derived primarily from the teaching and tradition of the Church. Indeed the *ERD* refer to caring for the poor as "a biblical mandate." This does not mean that those who do not accept biblical teaching—for example, those in the humanistic tradition—do not also have a concern for the poor. But it does imply that the motivation that should prompt Christians—the love for the poor displayed by Christ—may be lacking in those acting out of the humanistic tradition. In the United States, for example, there are government programs designed to help the poor, but they hardly bespeak love for them. At present, there are approximately 40 million people without adequate access to healthcare. Efforts to change our national system of providing healthcare are certainly part of our Catholic identity. Cost shifting, the principle means of providing healthcare for the poor in the past, is being eliminated or at least discouraged by managed care programs. Noninstitutional programs, such as those carried out in the home or parish, may turn out to be one of the more effective ways the Catholic healthcare ministry can help the poor.

The Common Good The third and fourth principles may be combined by stating that the Catholic healthcare ministry seeks to contribute to the common good through responsible stewardship. Responsible stewardship promotes the good health of all in the community. This can be best accomplished, the *ERD* maintain, through dialogue and cooperation with others and in accord with the principle of subsidiarity and other moral principles. In recommending dialogue and cooperation, the bishops have endorsed the effort to provide healthcare for all by cooperating with other providers. Cooperation is mentioned again in the *ERD*'s Part 6, which discusses the moral guidelines for forming new partnerships designed to exercise responsible stewardship. Because Parts 1 and 6 are closely related, Part 6 being an application of Part 1's fourth



normative principle, we shall treat both parts in this article.

Prohibited Procedures

The fifth and final principle concerns physicians and prospective patients who request medical or surgical procedures "contrary to the moral teaching of the Church."

Abortion, in vitro fertilization, contraceptive sterilization, and assisted suicide procedures are explicitly prohibited by the *ERD* and will

not be performed in Catholic healthcare facilities as free-standing institutions.

The bishops maintain that, through such prohibitions, "Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church." The implication is that persons desiring the prohibited procedures may utilize other healthcare facilities, those that do not judge these procedures to be morally wrong. The bishops' statement is true, but it meets consistent opposition from some in our pluralistic society.

There are, for example, lawsuits now in the courts challenging joint ventures involving Catholic hospitals. The suits maintain that these partnerships reduce the opportunities for women to obtain legal medical procedures such as abortions or contraceptive sterilizations.⁷ Those defending the presence of Catholic institutions in the nation's healthcare system often mention the "conscience clause" that allows Church facilities to exclude certain procedures. Indeed, a conscience clause is often set forth as the main defense of Catholic participation in the nation's healthcare system. But this seems shortsighted. The Church has a right to participate in the system because of its commitment to provide good care. Some maintain that good healthcare is measured by the law or by the autonomous demands of patients. But both legal rights and autonomy are insufficient measures of good care. The best measure is the integrated well-being of the person.

COMMENTARY ON INDIVIDUAL DIRECTIVES

We assume that readers are familiar with the directives and will not repeat them here. We will

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examine only those directives which seem to require further explanation, or which will be difficult to apply.

Directive 2 The call for "a spirit of mutual respect among caregivers" as the basis of compassionate healthcare is noteworthy. It indicates, first, that effective care in the spirit of Christ requires a coordinated team effort. Second, it subtly calls attention to one of the more critical eth-

ical issues in healthcare: Some healthcare workers are treated like second-class citizens.

Much decision making in medicine is, it is true, hierarchical in nature. Although an attending physician may need to consult with many others in making a diagnosis and prognosis, for example, the attending physician alone must decide whether a pathological condition exists and, if it does, how to treat it. Such power, wielded by a few decision makers, can help set a pattern in which highly unethical class distinctions are created among healthcare workers. Anyone who has worked with professionals engaged in a clinical situation knows that one of the most serious ethical issues in healthcare is the manner in which such professionals treat one another.

Many healthcare facilities have made efforts to improve quality through programs such as total quality management. These programs tend to emphasize the manner in which the "customer" is treated by healthcare personnel. But Directive 2 indicates that, in a healthcare service being offered in the spirit of Christ, the manner in which personnel treat one another is of utmost importance in creating a compassionate care giving community.

Directive 3 Catholic healthcare, to be faithful to its mission, should care for people "at the margins of society." Many of the healthcare needs of the people mentioned in the directive—for example, children, those with incurable diseases, persons with physical and mental disabilities—are now more adequately filled outside healthcare facilities. In 1989 the Catholic Health Association (CHA) published its *Social Accountability Budget*, a needs assessment document. The task force that composed this document realized that providing healthcare for people "at the margins of

society" is not the responsibility of healthcare institutions alone. Following the recommendations of the U.S. bishops' 1981 pastoral letter, *Health and Health Care*, the task force suggested that some healthcare be carried out at the parish level and through volunteer activity in community settings. Although Catholic healthcare institutions should indeed seek to promote "an option for the poor," they need not be the exclusive agent in this endeavor, according to enlightened social teaching.⁸

Directive 4 Research carried out in Catholic healthcare institutions should be done in accord with Catholic moral principles. Research is performed in hospitals affiliated with Catholic medical schools, and also in the many Catholic hospitals that have residency programs.

For the most part, the ethical norms for research in Catholic healthcare facilities are similar to those of other institutions. Thus informed consent on the part of patients or their proxies is a very important ethical norm (see Directives 26-28, 31). However, Directive 66 specifically prohibits the use in Catholic facilities of human tissue obtained from direct abortion, even for research and therapeutic purposes.

Directives 5 and 9 Adherence to the *ERD* is required in a Catholic institution as a condition for medical privileges and employment. These nuanced directives do not require that Catholic healthcare facilities deny staff privileges to physicians who perform abortions at other facilities. Denying privileges for this reason could result in a discrimination lawsuit against the institution. However Catholic facilities have often been embarrassed by procedures some of their physicians have performed at other facilities. Hence, caution is advised before allowing physicians admitting privileges to Catholic institutions.

A Catholic healthcare facility should offer appropriate instruction regarding the *ERD* to all its members. The facility will usually need to establish no specific procedures to ensure adherence to the *ERD*. Catholic healthcare facilities are most likely to help physicians and employees identify with their mission by offering them the opportunity to provide and practice medicine in a compassionate and patient-centered manner. If they are true to their mission, Catholic facilities will be concerned about holistic healing rather than profit. No healthcare facility can escape the real world of financial concern, of course. Still, the vital question is: Which objectives will dominate the atmosphere of Catholic healthcare facilities? Setting meaningful objectives and making an intense cooperative effort to achieve them seems

to be the best way to perpetuate Catholic identity.

Directive 7 This directive mandates that Catholic healthcare institutions treat employees respectfully and justly. The meaning of the statement is illustrated by several examples, the last being the requirement to recognize "the rights of employees to organize and bargain collectively without prejudice to the common good." This right is an eminent part of Catholic social teaching.

However, when employees try to organize unions in Catholic health facilities, union proponents or the media often speak as though management is acting contrary to Church teaching if it opposes the formation of unions. Managers of Catholic healthcare facilities do have a moral and legal right to resist the formation of unions in their facilities if forming those unions seems likely to hinder patient care.⁹ This seems to be the meaning of the phrase, "without prejudice to the common good." Catholic healthcare facilities should be willing to have a board of neutral observers, appointed perhaps by the local bishop, offer advice concerning the effect of union organizations on the common good of the facility. Above all, as Pope John XXIII observed, an adversarial spirit must be avoided. "Finally, both workers and employers should regulate their mutual relations in a spirit of human solidarity and Christian brotherhood."¹⁰

Directive 8 This directive states that the relevant requirements of Church (canon) law must be observed in founding a new Catholic healthcare institution; revising an institution's mission; or selling, closing, or transferring the sponsorship of an existing institution. In canon law, the general right of local bishops to direct and coordinate the apostolic endeavors of the Church is acknowledged (see cc. 394, 678).

These rights are made more explicit in regard to starting new apostolic ventures, such as healthcare facilities, whether they are founded by laypeople or religious (cc. 216, 300, 323, 394, 678, 680, 683). It follows that closing a Catholic healthcare facility or changing its mission or sponsorship would also be done under the bishop's direction and coordination. Finally, if a Catholic healthcare facility is under the sponsorship of religious, the canons on alienation or sale of property apply (c. 1291).

In brief, the canons on alienation or sale of property require a religious congregation of diocesan stature to seek approval of a sale of property from the local bishop. If the religious congregation is of pontifical stature, as are most of the larger religious congregations in the United States, approval of the sale must be grant-



ed by the Congregation for Religious and Secular Institutes in Rome. In such a case the Roman officials usually ask the local bishop for his opinion, so that they can clearly understand how the desired sale might affect the diocese's apostolate. An affirmative opinion on the sale by a local bishop is known as a *nihil obstat* (nothing stands in the way).

As we noted, Part 6 of the *ERD* is an application of the teaching of the Church on social justice. After affirming the need for new partnerships, the bishops suggest a process for doing so in cases where the Catholic identity of the Catholic healthcare facilities might be endangered or the new association might entail the risk of scandal. In addition, this section encourages Catholic healthcare institutions to collaborate—indeed to merge—with other Catholic institutions if it is at all possible.

These forms of joint venture do not appear to require the approval of the diocesan bishop, because they would endanger neither the identity nor the reputation of the Catholic institutions involved.

Directive 68 If a proposed partnership potentially infringes on Catholic identity, the diocesan bishop should be involved in the discussions. And before partnership plans are completed, the bishop should give the proper authorization (see c. 394). If the bishop were to be involved from the beginning of discussions, difficulties could clearly be avoided. Because such partnerships will affect the apostolate of the diocese, we believe that authorization of the diocesan bishop amounts to full canonical approval even if a religious congregation of pontifical stature is involved (see the commentary on Directive 8).

Hence it seems the reference in Directive 68 to a *nihil obstat* is out of place, because the *nihil obstat* is applicable primarily in a case of alienation, not in matters affecting the well-being of the diocesan apostolate. Many types of new associations can be formed without an alienation of property.

Directive 70 This directive says that scandal is to be avoided in forming new partnerships. "Scandal" implies more than mere surprise or bad

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publicity. Scandal is an attitude or behavior that leads another to do evil, which is a grave offense.¹¹ Scandal would appear to be possible "in any association with abortion providers" (Directive 45). At times, a Catholic facility can overcome a potential for scandal by explaining the need to cooperate with an institution performing some activity not approved by Church teaching. For

example, a Catholic facility's need to cooperate with an institution performing contraceptive sterilization or reproductive technologies could probably be explained satisfactorily. Explaining cooperation with an abortion provider would be much more difficult.

Directive 69 But some forms of cooperation are unethical even if scandal is not present. "When a Catholic health care institution is participating in a partnership which may be involved in activities judged morally wrong by the Church, the Catholic institution should limit its involvement in accord with moral principles governing cooperation." To help trustees and administrators make correct ethical decisions when forming partnerships with those who engage in activities "judged morally wrong by the Church," a section concerning the principles of cooperation is appended to the document. (An explanation of this appendix appeared in the April issue of *Health Progress*.¹²)

To offer additional assistance in analyzing the moral implications of new partnerships, the National Conference of Catholic Bishops has established an Ad Hoc Committee on Health Care Issues. As a means of providing such assistance, the committee asked the National Coalition on Catholic Health Ministry, a group composed of representatives from the Leadership Conference of Women Religious, the Bishop's Ad Hoc Committee, the CHA, and others, to produce a handbook that would offer guidelines for evaluating proposed partnerships. In the handbook, which will be published by the coalition in June, bishops, sponsors, and executive leaders will find a section which addresses the application of the principle of cooperation in concrete situations. However, as

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ARRANGED MARRIAGES

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My second reservation concerns the stability of the religiously based partner. For the negotiations I have outlined to succeed, it is essential that this partner be a continuing presence in healthcare. Unfortunately, such stability cannot be assumed when Catholic partners are involved, given the extreme vulnerability of Catholic congregations as sponsors of healthcare institutions. Sadly, all reasonable signs point to the inability of most—if not all—Catholic religious congregations to continue as owners-sponsors much beyond another decade, if indeed that long.

What then will replace that source of influence? Who will exercise the necessary authority on behalf of the offspring of the "marriages" now being consummated? Only two options realistically exist: Either the Church will provide such direction and influence directly; or lay associations, empowered by the Church, will replace the religious congregations as cosponsors with secular partners dedicated to service to the community.

I see no perceptible movement in either of these two directions at present. I fear that denial, inaction, and failure to take the long view dominate many Catholic settings today. Non-Catholic religious partners appear to have more freedom and fewer constraints.

The bottom line is to make every effort to preserve a religious presence for our offspring, both human and institutional. The stakes are very high and the outcome very uncertain. As we forge the deals and work through the challenges of change, let us make Mark's wise counsel the guidepost for our negotiations: "Anyone among you who aspires to greatness must serve the rest. Anyone who wants to rank first among you must serve the needs of all" (Mk 10:42). □

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noted in the *ERD*, appropriate application of the principle must take into consideration the circumstances in a particular diocese. □

NOTES

1. "Justice in the World: The Synod of Bishops," in Vincent Mainelli, ed., *Social Justice: The Catholic Position*, Consortium Press, Washington, DC, 1975, para. 1042.
2. National Council of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," *Origins*, December 15, 1994, pp. 449, 451-462. Unless otherwise noted, passages quoted here are from this document.
3. "Documents on the Laity," in Austin Flannery, ed., *Vatican Council II: The Conciliar and Post Conciliar Documents*, Liturgical Press, Collegeville, MN, 1975, pp. 775, 786.
4. Edmund Pellegrino and David Thomasma, *For the Patient's Good*, Oxford University Press, New York City, 1988, pp. 80-83.
5. Jefferson to Sr. Therese de S. Xavier Tarzon, May 15, 1804, Washington, DC.
6. Ten years later, the U.S. Department of the Treasury issued regulations clearly rejecting the notion that Catholic hospitals were an "integrated auxiliary." See *Hospital Progress*, February 1977, p. 18.
7. Tamar Lewin, "As Health Mergers Rise, Standards of Catholics Face a New Challenge," *New York Times*, March 8, 1995, p. 12.
8. For information about successful cooperative efforts to break through the old parameters of providing access to healthcare for the poor, debilitated, and disabled, contact the director, Archbishop's Commission on Community Health, St. Louis, MO.
9. Eugene Lauer, *Human Services Strikes: A Contemporary Ethical Dilemma*, Catholic Health Association, St. Louis, 1987, pp. 123-153.
10. *Mater et Magistra*, 1961, para. 23.
11. *Catechism of the Catholic Church*, U.S. Catholic Conference, Washington, DC, 1994, p. 550, no. 2284, p. 558, no. 2326.
12. James F. Keenan and Thomas R. Kopfensteiner, "The Principle of Cooperation," *Health Progress*, April 1995, pp. 24-27.

COMMUNICATION STRATEGIES

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Teach staff how ideas become bills and laws.


offices. Meet lawmakers and staff members. Send them your publications. Thank them for good votes and note bad ones."

STAFF INVOLVEMENT

Although members of your healthcare organization may want to help with legislative affairs, the process intimidates many people who have had little occasion to work with it. Peters suggests conducting staff training sessions about the mechanics of legislation and how ideas become bills and laws. Staff should also receive reading materials that outline and analyze legislative developments. On the other hand, Peters insists that the CEO must personally endorse and spend time on legislative affairs. The public relations professional may implement much of the program, but only the CEO, along with the board, has authority to define the organization's position on an issue or bill.

CHOOSE YOUR BATTLES WISELY

Peters's final advice is, "You'll never win 'em all." He adds, "Sometimes your favored bill will pass, and your work will have demonstrably influenced key votes. But your organization won't always get its way. Making every bill a do-or-die struggle is a risky strategy. Advocating strongly for your position, seeking compromise where possible, and maintaining relationships even when you lose makes far more sense. Focus on the bills that matter most and do what you can to influence their outcome." □

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