SPECIAL  SECTION

PART SIX OF THE *DIRECTIVES*

Preserving Integrity in Partnerships Directives Requires an Objective Moral Analysis of Cooperative Arrangements

BY RON HAMEL, PHD

Part Six of the *Ethical and Religious Directives for Catholic Health Care Services* addresses the issue of ethical integrity in the formation of arrangements with other-than-Catholic organizations. This section was added in the 1994 revision because of the new situation in health care—a dramatic increase in mergers, acquisitions, joint operating agreements, and various other affiliations between and among hospitals and health care systems as well as physician groups and health plans.

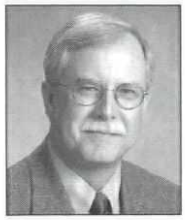
The drafters of the *Directives* and the bishops view these arrangements as both opportunities and challenges. On the one hand, the *Directives* give Catholic health care organizations an opportunity to witness to their religious and ethical commitments, provide a more extensive continuum of care to the community, witness to stewardship of limited resources, and provide more equitable access to basic care for the poor and vulnerable. On the other hand, such arrangements can be a challenge to the identity of Catholic organizations as well as to their ability to live out the *Directives*. This is especially true when the Catholic organization partners with an organization that does not share its moral convictions.

Part Six does not preclude such arrangements. The bishops recognize that there are various market, economic, demographic, and geographic pressures that might diminish a Catholic organization's options (e.g., partnering with another Catholic-sponsored health care facility or system) and require it to partner with an other-than-Catholic organization. However, because of the potential dangers, Part Six does call for a systematic and objective moral analysis of all such arrangements. The six directives in the section are offered to assist Catholic health care organizations, as well as bishops, in this analysis.

Until June 2001, Part Six contained four directives and an Appendix that explained the principle of cooperation. The latter is the principle employed to assess the moral justifiability of the Catholic organization's cooperation with what the church judges to be the wrongdoing of the other-than-Catholic organization.

In the spring of 2000, the Congregation for the Doctrine of the Faith (CDF) instructed the National Conference of Catholic Bishops (now known as the U.S. Conference of Catholic Bishops [USCCB]) to revise Part Six of the *Directives*, including the Appendix. In the judgment of the Holy See, the Appendix (in conjunction with the USCCB's Commentary on the CDF's 1975 document, *Quaecumque Sterilizatio*) had given rise to misinterpretations and misapplications of the principle of cooperation, as evidenced in three arrangements in the United States that had been brought to the Holy See's attention. The CDF had several specific concerns it wanted addressed.

- First, it sought a clarification of the distinction between material and formal cooperation so as to exclude any possibility of proportionalist*



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* Generally speaking, proportionalism is a method of moral analysis that maintains that the moral rightness or wrongness of an act can be determined only when all

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interpretations of the principle.

- Second, it was concerned about the application of the principle of cooperation to institutions and how that application differs from its application to individuals.
- Third, it wanted a complete review of the category of "duress." The CDF believed that the presentation of duress in the Appendix led to the conclusion that actions that are intrinsically evil could be considered licit because of duress. This, the CDF believes, is incompatible with the teaching of *Evangelium Vitae* (para. 74) and *Veritatis Splendor* (paras. 71-83). After more than a year of consultation and several drafts, the USCCB voted to approve the present text at its June 2001 meeting.

With the exception of its last paragraph, the text of the Introduction to Part Six was left intact. In the 2001 revision, the Appendix was deleted rather than revised. The final paragraph in the Introduction explains the reason for the deletion of the Appendix and serves as an implicit caution against appealing to the Appendix for guidance. In place of the Appendix, the Introduction exhorts the use of reliable theological experts to interpret and apply the principle of cooperation. This assumes, of course, that those experts will take account of the new directives in this section, as well as the specific concerns of the Holy See over the Appendix. The final phrase of the Introduction is quite important and, in a sense, establishes a basic assumption when considering arrangements, namely, that Catholic health care providers, as a rule, should avoid partnering with other providers that would involve them in cooperation with the other providers' wrongdoing. The stated presumption then is against cooperating with others involved in wrongdoing. Any licit cooperation must be for serious reasons and when there are no better options.

The 1994 Appendix has been deleted from the 2001 *Directives.*

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dimensions of the act are considered—the proportion between premoral values and disvalues associated with the action, the agent's intention, foreseeable consequences, and the morally relevant circumstances. This approach calls into question the assessment of the moral rightness or wrongness of an action on the basis of the moral object (the act itself), as well as the notion of intrinsic evil and exceptionless behavioral moral norms. For example, a proportionalist might say that sterilization involves a premoral disvalue (loss of the capacity to procreate), but that this disvalue might be morally justified depending on the circumstances and intention. It is the total meaning of the action that determines its moral rightness or wrongness. Pope John Paul II rejected proportionalism in his encyclical *Veritatis Splendor* (1993).

Directives 67 and 68

Directives 67 and 68 remain unchanged from the 1994 version. They exhort health care leaders and others to consult with the diocesan bishop or his health care liaison when there is the possibility that a decision about a particular arrangement could lead to scandal or harm the reputation or identity of the Catholic health care organization. Experience has shown that it is generally more helpful and effective if the diocesan bishop is brought into the process sooner rather than later. The bishop must give his approval to any arrangement involving a Catholic health care organization that falls under his jurisdiction or his *nihil obstat* (his judgment that nothing morally objectionable stands in the way of the finalization of the arrangement) if the organization is sponsored by religious institutes of pontifical right. In addition, Directive 68 specifies that arrangements that affect the mission or identity of the Catholic partner must be consistent with church teaching and discipline.

Directive 69

The substance of Directive 69 remains unchanged from the 1994 version. There have been some wording changes for the sake of precision. This directive cautions a Catholic organization that is considering entering into an arrangement with an other-than-Catholic organization that is involved in wrongdoing to structure the arrangement in such a way that any participation in or cooperation with the wrongdoing is limited to what is permitted by the principle of cooperation (i.e., mediate material cooperation).

Directive 70

This directive was inserted in the 2001 revision to address explicitly one of the CDF's primary concerns, namely, Catholic health care facilities engaging in immediate material cooperation (i.e., participating in the act itself or contributing to its performance in some essential way) in intrinsically evil actions. The Appendix in the 1994 version interpreted the principle of cooperation as permitting this type of cooperation when duress was present. The text read: "Immediate material cooperation is wrong, except in some instances of duress. The matter of duress distinguishes immediate material cooperation from implicit formal cooperation. But immediate material cooperation—without duress—is equivalent to implicit formal cooperation and, therefore, is morally wrong."

The CDF has rejected this interpretation, claiming that it is inconsistent with the teaching of *Evangelium Vitae* (para. 74) and *Veritatis Splendor* (paras. 71-83). Some theologians maintain that

such cooperation for reasons of duress is reflected in parts of the tradition. Although this directive may not resolve the larger theological debate, it does resolve the practice of Catholic health care institutions—they may not enter into any arrangement that involves immediate material cooperation in the wrongdoing of others when that wrongdoing consists in intrinsically evil actions.

Immediate material cooperation would likely include such things as ownership, governance, or management of the entity that offers prohibited procedures; financial benefit derived from the provision of the procedures; supplying elements essential to the provision of the services such as medical or support staff or supplies; or performing or having an essential role in the procedure.

An Important Footnote

Directive 70 is followed by an important footnote (n. 44). The first part of this footnote acknowledges differences in moral gravity among intrinsically evil actions. Direct sterilization, for example, while judged to be intrinsically evil, is not as morally grave as abortion or euthanasia.

A second part of the footnote appeals to Pope John Paul II's June 27, 1998, *Ad Limina* address to the bishops of Texas, Oklahoma, and Arkansas and to a quotation from the CDF's *Quaecumque Sterilizatio* in support of the CDF's prohibition of immediate material cooperation in intrinsically evil actions. In his address, John Paul II reiterates the "absolute prohibition" against abortion, direct sterilization, and euthanasia in Catholic health care facilities (*Origins*, vol. 28, no. 16, 1998, p. 283).

The quotation from *Quecumque Sterilizatio* reads: "Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . is absolutely forbidden. For the official approbation of direct sterilization and, a fortiori, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil." This quote, which addressed direct sterilization in Catholic hospitals (rather than in partnerships), is used here to underscore the prohibition of formal and immediate material cooperation.

The final part of footnote 44 is very important. It states that Directive 70 supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops (September 15, 1977). The CDF believes that the Commentary (in addition to the former Appendix) led to misapplications of the principle of cooperation by suggesting that direct sterilizations could be performed for reasons of duress. The practical effect of this directive superseding the Commentary is that the theological reasoning of the Commentary no longer can be used in evaluating the liceity of arrangements with other-than-Catholic health care facilities.

An important footnote in the 2001 revision clarifies the meaning of "scandal."

Directive 71

This is Directive 70 from the 1994 version with some modifications. The directive as a whole deals with the nature of scandal, the role that scandal can play in assessing the moral liceity of arrangements, and the role of the diocesan bishop in assessing the presence and potential impact of scandal.

The possibility of scandal is a critical factor in judging the moral acceptability of any arrangement with an other-than-Catholic partner; it is an essential element of the principle of cooperation. In fact, it is possible that a particular arrangement cannot be pursued precisely because of scandal, even though the arrangement reflects a morally justifiable form of mediate material cooperation (i.e., contributing to the performance of an action in a nonessential way or mere association with those performing the action). Scandal can be a decisive consideration. Ultimately, the diocesan bishop has responsibility for assessing the threat of scandal and dealing with issues surrounding possible scandal. He should do so in a way that is sensitive to the potential effects of his decision on other dioceses both in his own region and nationally.

An important footnote (n. 45) was added in the 2001 revision that clarifies the meaning of "scandal." The footnote introduces the technical theological definition of the term from the *Catechism of the Catholic Church*: "Scandal is an attitude or behavior which leads another to do evil" (no. 2,284). This footnote was added not only to underscore the gravity of scandal but also to distinguish it from other reactions by the faithful that are often taken to be scandal (e.g., disagreement, consternation, emotional upset).

As Directive 71 notes, true scandal (and even what portends to be scandal) can often be avoided by clear explanations of precisely what is being done, why it is being done, and how it is consistent with church teaching. Appropriate education for clergy and laity alike is a critical element to the success of an arrangement between a Catholic entity and an other-than-Catholic partner when there is morally licit cooperation with evil involved.

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DIRECTIVE 72

Directive 72 was added in the 2001 revision. In arrangements with other-than-Catholic partners, it is essential for the Catholic organization to ensure that what was agreed to, especially with regard to cooperation with the partner's wrongdoing as well as overall consistency with Catholic moral teaching, is being observed. The directive calls for a periodic assessment of the implementation of the agreement (not of the agreement itself), assuming that the original agreement was consistent with Catholic moral teaching.

The 2001 revisions of Part Six of the *Directives* will directly affect the structuring of new arrangements with other-than-Catholic partners that are involved in wrongdoing. Considerable moral distance will need to be established and maintained between the Catholic entity and the provision of prohibited services, such that the arrangement constitutes mediate material cooperation. This may be particularly difficult when the Catholic hospital would become the sole provider in the community.

What is at issue here is the integrity of the Catholic organization. How do Catholic health care facilities remain true to their identity—their beliefs and commitments—in the complex, secular, and pluralistic world of health care while meeting the needs of the communities they serve? The goal of any moral assessment of a possible arrangement with an other-than-Catholic partner—whether that assessment is conducted by Catholic health care providers, diocesan bishops and their consultants, theologians, or ethicists—is to ensure the identity and integrity of the Catholic organization, taking into account the uniqueness and complexities of each situation. The principle of cooperation—one of the most difficult moral principles to apply—is a tool in that process. □

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eration will lead to scandal. Institutional applications of the principle will be more susceptible to scandal because of the public nature of institutions. Scandal is most likely to be an issue when "partnerships are not built upon common values and moral principles" (*Ethical and Religious Directives*, Introduction to Part Six). Obviously, the more divergent the values of the partners, the higher the risk of scandal.

The traditional definition of scandal is "leading another person into sin." Scandal is of such importance in the application of the principle that "cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused" (Directive 71). Keeping the issue of scandal in mind will ensure that institutional survival does not depend upon sacrificing Catholic identity through wholesale accommodation or through dilution of one's sense of wrongdoing. At the same time, the ambiguity often caused by partnering must not be exaggerated to preclude legitimate forms of cooperation. "Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the health care facility under Catholic auspices" (Directive 71). So although the bishops rightly encourage "an increased collaboration among Catholic-sponsored health care institutions" we should resist the temptation to fall into a ghetto-like mentality in Catholic health care.

The assessment of the possibility of scandal will build on a nuanced consideration of the kinds of evil that may be involved in the cooperation in wrongdoing. Abortion and assisted suicide are, for example, graver evils than reproductive technologies or sterilization. To attack and destroy human life is a graver evil than bringing life about or suppressing the reproductive function. One can formulate an axiom: The graver the evil, the higher the risk of scandal; the higher the risk of scandal, the more distant the Catholic partner must be from the wrongdoing. □

LEADERSHIP DEVELOPMENT

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lowship through 60 colleges and universities with MHA programs as well as 14 professional organizations of minorities and women in health care, among them the National Association of Health Service Executives (NAHSE).

CHI has a strong relationship with NAHSE, an organization for African-Americans in health care leadership. Lofton is a past president. "We learned through NAHSE that members of racial and ethnic minority groups really thrive in mentorship relationships," Black said. "That's why we built the program this way."

About 100 inquiries and 20 formal applications resulted from CHI's communications about the fellowship. "The challenge has not been in recruitment or in program development," Fordyce said. "The challenge will be insuring that at the end of the fellowship, we have good spots to place these people in." To that end, he added, CHI is taking a longer-range approach to filling vacancies in the vice president of operations role. "Six months into the program, we are going to start identifying the jobs for these fellows."

The fellowship represents a sizeable investment for CHI: approximately half a million dollars in direct costs, according to Fordyce. Included in the costs are executive salaries for the fellows. "Most programs offer a modest stipend," Black said. "We are paying the fellows a starting salary for the target position—vice president of operations—for the fellowship year. Because this program targets high-potential leaders, we feel we need to pay them accordingly."

Fordyce said that CHI's board—briefed on the fellowship program during the leadership conference—is very supportive. Cahill told me that she is "enormously excited and proud" of this effort to ensure leadership that matches the increasingly diverse populations CHI serves. With success in the fellowship, there will be some new faces and more diverse representation at CHI's next national leadership conference in 2004. □