A Venue for Theological/Ethical Issues

BY FR. MICHAEL D. PLACE, STD

This issue's column will be a series of reflections on some of the theological/ethical issues that have been discussed in recent issues of *Health Progress.*

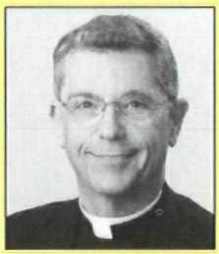
Principle of Cooperation

The November-December 2002 issue included several articles on the principle of cooperation. Discussion of the principle contributes to the realization of one measure of success of our current strategic plan: "Our voice has contributed proactively and positively to church positions on one or more key ethical issues."

As we know, application of the principle has not always been easy. However, we have learned much. We also have recognized the need to clarify our understanding and to evaluate how we have applied it. The revisions, in 2001, of Part Six of the *Ethical and Religious Directives for Catholic Health Care Services* were part of that process.

Last February, the biannual workshop for bishops sponsored by the National Catholic Bioethics Center (NCBC), Boston, provided the bishops an opportunity to reflect on the principle and its application. I was invited to welcome the bishops. My remarks follow:

> It is an honor to extend to you tonight the greetings of the Catholic health care ministry in the United States; a ministry that our Holy Father in Phoenix in 1987 described as being "one of the most vital apostolates of the ecclesial community and one of the most significant services the Catholic Church offers society in the United States in the name of Jesus Christ."
>
> Ours is a vibrant ministry that includes over 600 hospitals and over 1,300 continuum-of-care services, facilities, and programs in all 50 states and the District of Columbia. There is at least one facility in 173 of 176 dioceses.



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Ours is a time of great opportunity. Externally we are experiencing new forms of collaboration under the New Covenant initiative. For example, last August we jointly celebrated 275 years of Catholic social services and health care in what today is the United States. Internally, we have new opportunities to strengthen our identity as a ministry of the church and to ensure that our commitments are reflected in all we do. Clearly we can be proud of our incredible service to the poor and the vulnerable, in particular, women and children. Supporting the prolife cause from conception to natural death is an integral dimension of who we are.

But today also is a time of challenge. State reductions in Medicaid funding are affecting Catholic health care and Catholic Charities. It is likely that similar challenges will emerge from the new federal budget. There also have been other changes and pressures that have made it difficult to operate in isolation. Though the number of new joint ventures and collaborative arrangements with other-than-Catholic partners has decreased, the need to explore such possibilities remains a reality.

As we do so, however, the first priority must be remaining faithful to who we are as disciples of the Lord Jesus and as a ministry of the church. We are fortunate that our theological heritage has provided us with tools to guide us, such as the principles of cooperation and double effect, as we labor to craft morally correct "business" arrangements. We also have the guidance offered by you, our bishops, through the *Ethical and Religious Directives for Catholic Health Care Services* and your pastoral leadership within your particular churches.

Despite these remarkable resources, the path is not always easy. Prudential reasoning, though well intended, might err. It is

imperative that we remain open to new insights and to developing our skills of ethical discernment in complex situations. Clearly, we learned a great deal as we responded to the concerns of the Apostolic See that resulted in the most recent revisions of the *Ethical and Religious Directives*. The health care ministry remains indebted in a very special way to the thoughtful and patient leadership of Archbishop Pilarczyk and Bishop Wuerl as those revisions were developed. It is our hope that your participation in this time of study will allow us to further that spirit of solidarity. We look forward to continued collaboration with Dr. Haas and his colleagues. Know of my prayers for you and your ministry in these complex times even as I ask for yours for the ministry of Catholic health care.

Recently a letter about the utilization of the principle of cooperation was sent to the bishops of the United States by Bishop Robert C. Morlino, Helena, MT, in his capacity as chair of the United States Conference of Catholic Bishops (USCCB) Ad Hoc Committee on Health Care Issues and the Church, and Bishop Donald W. Trautman, Erie, PA, chair of the Committee on Doctrine. For Catholic health care the letter is, in effect, another component in our ongoing learning about how to apply the principle of cooperation. The letter points out that the Congregation for the Doctrine of the Faith considers the revised arrangement of the relationship between Seton Healthcare Network (part of Ascension Health, St. Louis) and Austin, TX, with regard to that city's Brackenridge Hospital, to be "minimally acceptable." In other words, it should not be considered an acceptable model or template for other applications of the principle of cooperation. When this letter is read in light of other Vatican interventions, it would seem that the "condominium" approach, involving the isolation of prohibited services in a separate entity *within* a Catholic institution, is problematic. Clearly, this communication invites further theological reflections.

It should be noted, however, that it was possible for the local Catholic provider to revise an existing arrangement in a manner that addressed the practicalities of the local situation so that it would be ethically acceptable to the Holy See, albeit minimally so. For the ministry, this means that a process of careful ethical analysis involving the diocesan bishop and ministry leaders can have a successful outcome even in quite challenging situations.

All of the above points out the continuing importance of the dialogue on the principle of cooperation that is being sponsored by CHA. It is critically important that we truly become a "learning community" concerning how we can act with integrity in complex and challenging markets. *Health Progress* will continue to serve the ministry in that process.

Rape Treatment

In the September-October 2002 issue of *Health Progress*, we had articles on the ethical issues associated with providing compassionate and appropriate service to women who have been victims of sexual assault. Within the ministry, several understandings have emerged as to how to interpret and apply Directive 36, which reads:

> Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.

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*Archbishop Daniel E. Pilarczyk, is archbishop of Cincinnati; Bishop Donald W. Wuerl is bishop of Pittsburgh; John M. Haas, PhD, STL, is president of the NCBC.

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Seton Hall College of Medicine and Dentistry Records (www.umdnj.edu/librweb/speccoll /SHC MD.htm); Marquette Medical Alumni Association (www.mcw.edu /alumni/history.html).

4. For an interesting history of how this happened, see Darrell Amundsen, "Medieval Canon Law on Medical and Surgical Practice by the Clergy," *Bulletin of the History of Medicine*, 1978, vol. 52, pp. 22-44.
5. Mark Sargent, "Catholic Social Thought and Professional Education," a paper read at the Commonweal Winter 2002 Colloquium, Malibu, CA, February 24, 2002, and available at: www.catholicsinpublicsquare.org/papers/winter2002commonweal/sargent/sargentpaper.htm.
6. Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*, 1910, reprinted by the Heritage Press, Buffalo, NY, 1973.
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8. Jack Hadley, Jean M. Mitchell, Daniel P. Sulmasy, and M. Gregg Bloche, "Perceived Financial Incentives, HMO Market Penetration, and Physicians' Practice Styles and Satisfaction," *Health Services Research*, 1999, vol. 34, pp. 307-321.
9. Daniel P. Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*, Paulist Press, Mahwah, NJ, 1997.
10. See, for example, The ABIM Foundation, American Board of Internal Medicine, ACP-ASIM Foundation, American College of Physicians-American Society of Internal Medicine, and the European Federation of Internal Medicine, "Medical Professionalism in the New Millennium: A Physician Charter," *Annals of Internal Medicine 2002*, vol. 136, pp. 243-266.
11. Richard P. Sloan, Emilia Bagiella, T. Powell, "Religion, Spirituality, and Medicine," *Lancet*, 1999, vol. 353, pp. 664-667; see also Relman's commentary in Arnold S. Relman and Andrew Weil, "Is Integrative Medicine the Medicine of the Future?" *Archives of Internal Medicine*, 1999, vol. 159, pp. 2,122-2,126.
12. Daniel P. Sulmasy, "The Fullness of Life: Integrating Patient Care, Teaching, and Research," *Health Progress*, January 1993, vol. 74, pp. 76-78.
13. Daniel P. Sulmasy, "Catholic Health Care: Not Dead Yet," *The National Catholic Bioethics Quarterly*, 2001, vol. 1, pp. 41-50.

REFLECTIONS

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The USCCB Committee on Doctrine sponsored a study day on rape treatment.

Recently, the USCCB Committee on Doctrine sponsored a study day on the many aspects of this issue: the nature of the reproductive process, how various available pharmacological agents work, the experience of emergency room clinicians, and the theological principles. After reflecting on the results of the dialogue, the Committee on Doctrine concluded that testing only for a pregnancy unrelated to the sexual assault is not inconsistent with Directive 36.

Let me offer several observations on this carefully worded statement. First, it is based on "the present state of scientific and medical research." In other words, additional evidence could change the understanding of what constitutes appropriate testing. Second, the committee's decision does not indicate a preference for any particular approach. Rather, its members have said that protocols that do not include testing for ovulation are not in violation of Directive 36. Finally, diocesan bishops are left free, if they choose to offer pastoral guidance, to determine the approach they deem to be in accord with the directive.

From the perspective of the ministry, the process that led to this determination was a good one. *Health Progress* played a critical role in outlining the various approaches. The ministry also was involved in the study day. There is, however, more to be done. Continued research and scholarly discussions on the part of moral theologians and medical researchers are critically important. As a ministry gathered and engaged, we will be involved in both. Hopefully, *Health Progress* will be a forum for sharing the results of that research and thus contribute to resolving some of the remaining ambiguity.

SPONSORSHIP

The July-August 2001 and January-February 2002 issues of *Health Progress* highlighted the critically important issue of sponsorship. One of our measures of success relates to sponsorship. It reads: "Ministry-wide understanding of sponsorship has deepened, and alternative models of sponsorship—in addition to the 'Public Juridic Person' model—have been articulated."

As part of our efforts to meet this measure of success, a group of theologians has been working over the course of the last year to develop a draft of a theology of sponsorship. This document has as its foundation the earlier CHA work that had developed an initial definition of sponsorship and its theological components. When the internal dialogue about the text is completed, it will be shared with the ministry as a study document that will serve as a basis for reflection and dialogue within the ministry. *Health Progress* will be one of many venues in which that dialogue takes place. □

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