SPECIAL SECTION

RESPONSIBILITY AND COOPERATION

Evaluating Partnerships among Health Care Providers

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New partnerships among health care providers have been common phenomena over the past several years. Catholic providers have created partnerships among themselves and had strategic opportunities to enter relationships with other-than-Catholic providers. These latter partnerships have been the subject of scrutiny and, in some cases, occasions for serious reservations on the part of theologians and church leaders. In fact, last year the U.S. Conference of Catholic Bishops revised the *Ethical and Religious Directives for Catholic Health Care Services* in light of recent observations by the Holy See that found certain partnerships to be illicit applications of the principle of cooperation with regard to the provision of sterilization. To be sure, one advantage of the current climate in health care has been renewed discussion of the principle of cooperation and, more precisely, of the ways its internal logic is linked to an ethic of responsibility concerning a social good such as health care.

This article will examine the various phases that are entailed in analyzing potential partnerships between Catholic and other-than-Catholic providers. Successful partnerships reveal a five-fold process at work:

- Identification of a common ground between the partners
- Recognition of the duty to avoid wrongdoing
- Careful review of the partnership to safeguard the integrity of the moral tradition
- Analysis of duress as one of the factors to be taken into consideration with prudence in assessing whether to enter into a partnership
- Consideration of the scandal that might preclude an otherwise legitimate partnership

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Sharing Responsibility for Health Care

From a ministerial perspective, partnerships with other-than-Catholic providers begin with an ethics baseline that specifies the values and goals held in common. Catholic providers find more in common with other faith-based providers than with community hospitals, and more in common with community hospitals than with for-profit institutions. A wide range of moral interests usually unite such partners: a concern to protect and improve community health, a desire to provide or expand services to the underserved, a commitment to respect a person's physical and spiritual well-being, and a belief that one can be a better steward of resources through a spirit of collaboration rather than through competition.

Working from a shared ethics baseline is important for at least three reasons. First, it ensures that Catholic identity in health care is not reduced to what the Catholic partner does *not* do. Second, it establishes a foundation for future discussions between the partners, as well as a context in which the Catholic partner can engage other providers in ventures that might emerge at some future date. Finally, and most significant, working from a shared ethics baseline offers a new context for understanding the traditional principle of cooperation.

The moral tradition presented the principle of cooperation in the language of wrongdoing. With an ethics baseline, the grammar of wrongdoing is completed by a grammar of responsibility. A grammar of responsibility focuses on the

shared sense of the good life held in common with all members of the community. This is particularly important when a public good such as health care is at stake. Focusing on our responsibility to work with others is not meant to compromise our moral integrity; rather, it advances a more adequate context in which to weigh the goods and evils that any decision to partner with other providers will entail. A grammar of responsibility offers the proper perspective in which to consider the long-term effects of our decision to partner or not, to calculate the harms that we might bring about, and to realize the importance of the goods that are in danger of being lost.

The Duty to Avoid Wrongdoing

Nevertheless, partnerships can pose serious challenges to the identity of Catholic health care institutions and their ability to implement the *Ethical and Religious Directives*, especially when partnerships are formed with those who do not share Catholic moral principles. When a partner is involved in services judged morally wrong by the church, the partnership must be evaluated by the categories provided by the principle of cooperation.

Traditionally, the principle of cooperation discerned and measured the moral distance between two agents. In the manuals, for instance, the principle was used in reference to the cooperation with wrongdoing of, for example, a mail carrier, a pharmacist, or a newsstand owner. Moral agency can extend to institutions also. A nation's armed forces can be a wrongdoer; a political party that is opposed to Catholic teaching can be identified as a wrongdoer; a quasi-religious sect can be a wrongdoer. Given that a "wrongdoer" can be an institution, it is fair to assume that a "cooperator" in wrongdoing can also be an institutional agent.

The principle is applied to institutions by analogy. Analogy allows us to extend to institutions moral attributes that belong most properly to persons. For instance, analogy is used when we attribute a "conscience" to an institution in order to protect our religious commitments in health care. Similarly, we conceive of the institution as a cooperating agent in order to hold the institution responsible for the moral parameters of the partnership.

What is precluded absolutely is formal cooperation in situations in which one shares in the intention of the wrongdoer. Sharing in the wrong intention corrupts the act. By sharing in the wrong intention, one shares in the sin of the other. What might be allowed, however, is material cooperation in which one's action can be set apart from the wrongdoer's, creating coherence between intention and action. That is, when we neither intend the wrongdoing nor act as the primary agent of the wrongdoing, our cooperation is licit. To maintain this coherence institutionally, all proscribed procedures must be "carved out" of the partnership. A "carve-out" is a legal mechanism ensuring that the Catholic partner does not share in the governance, management, performance, or financial benefit of the wrongdoing.

The adequacy of these mechanisms was the focus of observations of the Holy See in a case in which Seton Medical Center, Austin, TX, which is sponsored by the Daughters of Charity, assumed responsibility for Brackenridge Hospital, a community hospital in that city. The operating agreement between Seton and the city allowed for the continued provision of sterilizations. The carve-outs were needed to guarantee that the sterilizations would be the responsibility of the city alone. Without them, Seton would have become the *principal* agent of the wrongdoing, which would have made the partnership an illicit form of cooperation.

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Accurate Moral Description

The case of St. Vincent's Doctors Hospital in Little Rock, AR, is another example of illicit cooperation. In this case, the Holy See's observations were based on the distinction between explicit and implicit formal cooperation found in the Appendix to the 1994 *Directives*.

A traditional example illustrates the meaning of implicit formal cooperation. Imagine that one person hoists another through a window in order to rob the house. Helping someone through a window is not in itself wrong and, under some circumstances, might be virtuous. In this case, the cooperator might not explicitly cooperate in the wrongdoing; in fact he may explicitly try to dissuade his friend from robbing the house. But because he cannot reasonably abstract himself from the action as a whole, his cooperation in the wrongdoing is implicitly formal.

St. Vincent's, sponsored by Catholic Health Initiatives, Denver, entered a partnership with the Arkansas Women's Health Center. The women's health center, however, would not have existed had St. Vincent's not shared in its establishment. It was established for the *sole* purpose of providing sterilizations within the hospital. Even though St. Vincent's leaders publicly deplored the wrongdoing, their involvement was an indispensable and essential condition for its occurrence.

According to the Holy See's observations, the category of implicit formal cooperation prevents a truncated analysis of moral action that artificially tries to isolate the agent or institution from what

is happening from a moral point of view. Try as one may to describe it otherwise, the action of the cooperator can have no other reasonable explanation than sharing in the wrongdoing of another. The category, then, is accusatory in that it calls for an honest assessment and description of what is taking place. In this way, the category of implicit formal cooperation prevents an abuse of casuistry.

A word of caution is appropriate for those considering the category of implicit formal cooperation. If each and every circumstance of wrongdoing, or even knowledge that wrongdoing was to occur, were to be exaggerated into implicit formal cooperation, then all distinctions between material and formal cooperation would collapse.

Institutional Cooperation and Duress

The articulation of the principle of cooperation in the 1994 directives was in line with the U.S. bishops' Commentary (*Origins,* no. 11, 1977, pp. 399-400) on the Congregation for the Defense of the Faith's statement on sterilization, *Quaecumque Sterilizatio* (*Origins*, no. 10, 1975, pp. 33-35). The Commentary had been used to allow for the direct participation of Catholic facilities in sterilization, the rationale for it being that such participation would preclude greater harms from occurring—the closing of hospitals, for example. In the newly revised directives, however, the Commentary has been superseded by Directive 70, which says, "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization."

An intractable dilemma is created, however, when these acts are distinguished by their varying degrees of moral gravity, as the bishops do in a note. A situation can be imagined in which an institution would have to directly participate in the wrongdoing of sterilization in order to prevent greater and irreparable harms from occurring. There is no consensus on this issue in the theological community, and it presents a most difficult pastoral challenge.

To be sure, the Commentary provided a valid insight into the moral tradition of the church. The element of duress has always been a morally relevant factor in the application of the principle. Even the Holy See's observations on Brackenridge, sent to the bishop of the Diocese of Austin, admit that duress can justify a direct participation in wrongdoing: "A locksmith forced at gunpoint to open a safe is not required to sacrifice his life to protect money." The legitimating argument is that one's direct participation in the wrongdoing is done to prevent harms that cannot be repaired or to protect goods that cannot otherwise be preserved.

In the case of institutional cooperation, the element of duress would refer to factors that go beyond any medical indications for the sterilization to be performed. Medical indications are necessary but not sufficient criteria for cooperating in a sterilization at a Catholic health care institution. To perform a sterilization for medical indications alone cannot be justified by Catholic moral theology; earlier attempts to justify a sterilization on the basis of the principle of totality do not meet the more stringent evidentiary threshold of the principle of cooperation. Invoking the principle of totality fails to account for the legitimate ways of avoiding pregnancy available to the patient, including abstinence.

The argument from duress is that external factors—mandated benefits or imposed standards of care, for instance—may so diminish an institution's autonomy that there is no feasible alternative but to cooperate in order to avoid greater or irreparable harm from occurring—for example, the forfeiture of an obstetrics unit that handles high-risk pregnancies in a way that is consistent with Catholic moral teaching. Or our unwillingness to cooperate in such strictly circumscribed cases may lead to the closing of a facility and, not only the subsequent loss of a Catholic institutional presence in health care but, perhaps, the complete loss of health care services in a community.

The provision of health care is a vehicle of evangelization.

From a pastoral point of view, when dealing with cases of institutional duress, the principle of cooperation will account for the evil that is done and the good that is achieved. Is the good valued highly enough, or is there a sufficient sense of urgency to protect it, to outweigh the evil caused by cooperation? Moreover, when dealing with such cases, the principle of cooperation can be coupled with the law of graduality that is constitutive of all the church's evangelization efforts. The provision of health care is a vehicle of evangelization; as with other vehicles, not all of its teachings can be accepted at once or with the same conviction. This calls for a strategy of action that recognizes that the church is part of a pluralistic society, even while it hopes to effectively shape and influence society. That is, even though the wrongdoing cannot be abolished now, one can aim to contain and limit it as much as possible in the present, hoping to build a consensus that will diminish it further in the future.

Avoiding Scandal

A prudential application of the principle will also consider the possibility that an institution's coop-

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PART SIX OF THE *DIRECTIVES*

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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. □