August 1998

In Answer to Critics: The Revised, Final Version of a Difficult Moral Question About Cooperation by Catholic Hospitals

Germain Grisez

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

Recommended Citation

Grisez, Germain (1998) "In Answer to Critics: The Revised, Final Version of a Difficult Moral Question About Cooperation by Catholic Hospitals," *The Linacre Quarterly*: Vol. 65: No. 3, Article 7.
Available at: <http://epublications.marquette.edu/lnq/vol65/iss3/7>

In Answer to Critics: The Revised, Final Version of a Difficult Moral Question About Cooperation by Catholic Hospitals

by

Professor Germain Grisez

The author, who serves on the Linacre Quarterly editorial advisory board, is on the faculty of Mount Saint Mary's College, Emmitsburg, MD 21727.

In the November 1995 issue of this journal (62:4), I published an early draft of a moral theological treatment of a question then formulated: "How far may Catholic hospitals cooperate with non-Catholic providers?" I invited readers to send criticisms and suggestions for improvement. Taking into account the many thoughtful comments I received, I greatly revised that draft before publishing (In *The Way of the Lord Jesus, Vol. III, Difficult Moral Questions*, Quincy, IL: Quincy University, 1997, pp 391-402.) the treatment of that question – along with forty-nine others on various health care issues and one hundred and fifty more on other matters.*

Meanwhile, however, several publications on the same or closely related topics have included criticisms of some statements in the tentative draft. Most of those criticisms have been based on misinterpretations of my views. In part, the misinterpretations were due to critics' overlooking vital parts of my argument in their efforts to show the moral acceptability of certain sorts of cooperation I regard as immoral. But in part, the trouble was due to various defects in that early draft.

So, I doubt it would be helpful to respond in detail to

published criticism of that draft. Rather, since the issues are very important and probably will remain so for many years, I think it will be more helpful simply to replace the early draft with the following revised, final version.

How far may Catholic hospitals cooperate with providers of immoral services?

Statement of the Question:

As you may know, the religious institute of women to which I belong always has been committed to health care. We regard it as an apostolate that continues in our day an essential part of Jesus' own ministry during his earthly life. At present, our various provinces operate hospitals in many communities and several states.

In times past, we carried on our work autonomously, ignoring most other health care providers while allowing some non-Catholics to work in our hospitals under conditions we set. Today, however, mutually agreeable cooperative relationships with those who do not share our faith and ethical views are becoming increasingly vital. There are four reasons: the increasing complexity of health care, which requires many forms of cooperation to meet the needs of the people we serve; the need to eliminate duplication in order to limit escalating costs; the demands of payers (the government and insurance companies) that we meet their conditions with respect to benefits and adapt to their arrangements for financing them; and the resistance of non-Catholics (and also of Catholics who do not agree with some of the Church's teachings) to the U.S. bishops' *Ethical and Religious Directives*. Given the trends of the time, our hospitals either will participate in various sorts of cooperative relationships or will become increasingly marginalized and ultimately financially nonviable.

Recognizing this dilemma, our superiors have established an interprovincial committee, of which I am a member, to develop guidelines for various types of cooperative arrangements. While difficult to sort out and classify, these appear to fall into four broad groups, though with some overlap: (1) simple contractual arrangements with other hospitals, diagnostic facilities, individual

physicians, and so forth; (2) integrated delivery networks, that is, broad affiliations with other institutions and providers to deliver the complete spectrum of health care in a particular locality; (3) cosponsored health maintenance organizations or similar deliverers of health care to certain groups of insured people; and (4) arrangements assuming responsibility for a purchased portion of the practices of a group of physicians and/or other providers who, at the same time, will remain free to offer the same or other clientele services in which we feel we cannot participate.

The recently revised *Ethical and Religious Directives* and the committee's initial discussions seem to indicate that, where the ethical aspects are concerned, two matters will be central.

First, while our commitment to the health care apostolate requires that we do whatever is necessary under rapidly changing conditions to continue delivering quality services, we must find ways to maintain our institutions' Catholic identity even as we surrender some of our traditional autonomy and legal control.

Second, though we will not sponsor any forbidden procedures (such as sterilizations and abortions) in our own hospitals, we necessarily will cooperate with those who perform them; therefore, we must clarify the ways in which formal cooperation might arise in the delivery of services under various arrangements, and try to limit our hospitals' involvement to material cooperation.

Though I know you probably will not be able to say much on the basis of such a general description of the problems we face, I will be grateful for any suggestions you can offer regarding their ethical aspects.

Analysis:

The questioner seeks fuller answers to two closely related questions touched on briefly in the 1994 revision of the *Ethical and Religious Directives*. The first question concerns the Catholic identity of Catholic hospitals, and calls for a clarification of the concept of the health care apostolate and the likely impact on it of entering into and carrying on the sorts of arrangements described. The second question concerns formal and material cooperation. An adequate response must explain two things. (1) Formal cooperation

can occur not only in carrying on a cooperative arrangement but also, and even especially, in setting it up. (2) Material cooperation also can be wrong, and a Catholic hospital's material cooperation with the provision of morally unacceptable services is likely to be wrong. Catholic hospitals that avoid all wrongful cooperation and maintain their identity may not be economically viable. Therefore, Catholics committed to health care as an apostolate may have to look for other, better ways of carrying it on.¹

The reply could be along the following lines:

As you say, I cannot provide specific moral advice in response to a general question. However, I will sketch out some considerations that I think the administrators of your hospitals should keep in mind as they deliberate about entering into any cooperative arrangement with other providers.

First, because Catholic identity is maintained by living up to the moral requirements of faith and is obscured, and ultimately abandoned, by living as nonbelievers do, the questions about Catholic identity and the moral limits of cooperation are not separable. Clarifying the concept of the apostolate of health care and its roots in Jesus' ministry will help answer both questions.

Since death is humankind's last enemy (see 1 Cor 15:26) and is part of the punishment for sin (see DS 1511/788), Jesus' redemptive mission was to overcome not only sin but death by making available resurrection and everlasting life. As health perfects life, disease detracts from it and ends in death. Thus, Jesus raised the dead and cured people of diseases. Yet, though these miracles no doubt were motivated partly by compassion for the suffering individuals he helped, Jesus' principal intention in healing people was to provide signs and foretastes of the coming of God's kingdom. Had he been committed to providing health care, having the power to cure everyone and raise all the dead, he would have done so. This consideration makes it clear that simply delivering quality health care services, as even some nonbelievers do, does not carry on an essential part of Jesus' ministry.

In commending the health care service of consecrated persons, John Paul II clarifies what is required if such work is to be a

genuine apostolate:

The church looks with admiration and gratitude upon the many consecrated persons who, by caring for the sick and the suffering, contribute in a significant way to her mission. They carry on the ministry of mercy of Christ, who "went about doing good and healing all (who were oppressed by the devil)" (Acts 10:38). In the footsteps of the Divine Samaritan, physician of souls and bodies, and following the example of their respective founders and foundresses, those consecrated persons committed to this ministry by the charism of their Institute should persevere in their witness of love towards the sick, devoting themselves to them with profound understanding and compassion. They should give a special place in their ministry to the poorest and most abandoned of the sick, such as the elderly, and those who are terminally ill, and to the victims of drug abuse and the new contagious diseases. Consecrated persons should encourage the sick themselves to offer their sufferings in Communion with Christ, crucified and glorified for the salvation of all. Indeed they should strengthen in the sick the awareness of being able to *carry out a pastoral ministry of their own* through the specific charism of the Cross, by means of their prayer and their testimony in word and deed.

Moreover, the Church reminds consecrated men and women that a part of their mission is to *evangelize the health care centers* in which they work, striving to spread the light of Gospel values to the way of living, suffering and dying of the people of our day. They should endeavor to make the practice of medicine more human, and increase their knowledge of bioethics at the service of the Gospel of life. Above all, therefore, they should foster respect for the person and for human life from conception to its natural end, in full conformity with the moral teaching of the Church. For this purpose, they should set up centers of formation and cooperate closely with those ecclesial bodies entrusted with the pastoral ministry of health care.²

Thus, to be an apostolate that carries on Jesus' ministry of mercy, Catholic hospitals must not only deliver quality health care but provide service to "the poorest and most abandoned of the sick", give religious instruction and encouragement along with health care, explicitly evangelize, strive to humanize medical practice, fully conform to the Church's moral teaching, and supply sound formation in that teaching. Of course, even isolated individuals' work in the field of health care can qualify as a lay apostolate, in the same way as

other morally acceptable occupations Christians might undertake, if carried out in a way that struggles against the evils that afflict such work and restores it in the light of the gospel, manifests Christian mercy, and bears clear witness to faith (see AA 5-7; *Living a Christian Life*, 102-13). However, Catholic hospitals will have lost their identity unless they meet all the conditions for carrying on Jesus' mission of mercy.³

The challenge they face must not be underestimated. A hospital is not simply a formal, institutional structure; it is a community whose corporate identity and character depend on the people who make it up. Thus, a Catholic hospital's special apostolate requires that the critical mass of participants be not only practicing Catholics but people whose professional work is permeated by faith and Christian mercy. However, most religious institutes operating hospitals have experienced a decline in the new members, and now can staff only a few positions in their hospitals while filling a few others with Catholics who have the necessary characteristics. Hence, even if Catholic hospitals could retain the autonomy they formerly enjoyed, their ability to carry on their special apostolate, and so their very Catholic identity, would be in question.

Second, those entering into cooperative arrangements should not take too narrow a view of the actual and potential problem areas. These are by no means limited to sterilization and abortion. Prescribing contraceptives and helping people use them normally involve formal cooperation with contraception, and even material cooperation, especially with forms of contraception whose mode of action sometimes is abortifacient, can be gravely wrong. Genetic counseling to assist deliberation about contraception, sterilization, and abortion normally involves formal cooperation in those immoral activities. The treatment of sterility often involves formal cooperation in masturbation. In vitro fertilization is morally unacceptable in itself, and procedures such as TOT and GIFT are questionable.⁴ While treatment often can be rightly limited or withdrawn, either can be a method of suicide or homicide, and both are likely to be abused by coming attempts to ration care on the basis of so-called quality of life, with the result that the elderly, the severely retarded, and others will be unjustly discriminated against and many of them will be victims of homicide by nontreatment and

neglect. Active euthanasia also is likely to be legalized, at first by permitting assisted suicide, but eventually by authorizing euthanasia for many people, including some incapable of consent, whose lives others do not consider worth living.

Third, you realize you must "try to limit" your hospitals' involvement in "forbidden procedures" to material cooperation, and say: "We will not sponsor any forbidden procedures (such as sterilizations and abortions) in our own hospitals." You rightly note the importance of clarifying "the ways in which formal cooperation might arise in the delivery of services under various arrangements." But you also say that "our commitment to the health care apostolate requires that we do whatever is necessary under rapidly changing conditions to continue delivering quality services." This way of putting the matter suggests that you consider continuing to operate your hospitals as the essential objective and consider avoiding wrongdoing as an incidental, though important, concern. Firmly committed to continuing to deliver quality services, you will try to avoid formal cooperation in sterilization and abortion.⁵ However, doing God's will and entirely avoiding wrongdoing are at the heart of anything that can be called an apostolate. Do not regard actions such as sterilization and abortion merely as forbidden procedures and do not think of wrongful cooperation with them merely as rule breaking, to be avoided if possible. Recognize such acts as grave injuries to persons or their very destruction, and thus contrary to Christian love and entirely incompatible with your apostolate.

Someone might argue that you can easily avoid formal cooperation if you reluctantly work with non-Catholic providers only insofar as you must in order to continue operating your hospitals. Acting under duress, it might be argued, your participation in necessary cooperative arrangements will not be formal cooperation, it will be like the submission of a woman threatened with death by a would-be rapist: in order to save her life, the woman obeys his orders to undress and assume a certain position. Plainly such a woman chooses only to do things morally acceptable in themselves for the good end of saving her life, and she neither intends sexual intercourse with the rapist as an end nor chooses it as a means. So, the argument could conclude, your hospitals need neither intend nor choose any forbidden procedure. They need only choose to take the

morally acceptable steps they must take to survive.

True, duress can lead one to choose to carry out another's orders by doing things that, though not wrong in themselves, ordinarily would be chosen only if one wished to cooperate in a wrongful common action. But duress also can lead one to choose reluctantly to adopt an immoral way of life and cooperate in common actions. The desperate woman who reluctantly chooses to become a prostitute as a way of earning her living formally cooperates in immoral acts, though with considerably mitigated guilt. Unlike the rape victim, who chooses to submit passively to violence, and like the desperate woman who chooses prostitution, your hospitals, though under duress, may well come to cooperate formally in the immoral activities of other parties to the complex arrangements into which the hospitals are constrained to enter.

Since sponsoring acts of mutilation and killing in your own hospitals plainly would be formal cooperation with those evils, you rightly reject doing so. But even without sponsoring immoral procedures carried out in a hospital, those responsible for the hospital can formally cooperate with such procedures. Indeed, if a hospital is involved in a cooperative arrangement with providers who do immoral procedures, its administrators can formally cooperate in those procedures even if they are done elsewhere and without using any of their hospital's facilities.

Unlike people who manage a hotel, the administrators of a hospital ordinarily do sponsor the things done in it. Since a hospital exists to provide health care services, administrators ordinarily intend each and every procedure carried out using its facilities. Of course, if a hospital's administrators were blamelessly unaware of wrong things done in it, they would not cooperate with them, and they might avoid formally cooperating even with certain wrongful activities done in the hospital they knew about but neither initiated nor facilitated. However, administrators hardly can avoid cooperating formally with procedures such as sterilization and abortion done using their hospital's facilities. They must ensure that patients, having been adequately informed, genuinely consent, and must see to it that the procedures are carried out correctly. Therefore, when such a procedure is done in a hospital, even if its administrators not only avoid sponsoring it but are very displeased

about its being done, they are likely to cooperate formally in it.

Formal cooperation also can occur without a hospital's facilities being used when the hospital is involved in a cooperative arrangement with providers of sterilization, abortion, and other evils.

Suppose that the arrangement to provide the complete spectrum of health care in a locality or all services for participants in a health maintenance organization includes some immoral activity of at least one of the other providers involved in this joint enterprise. In that case, all who share responsibility for managing the enterprise will formally cooperate in that activity insofar as they must ensure that patients give informed consent and that those directly involved meet professional standards. Therefore, if your hospitals enter an arrangement with providers of any evil, they either must avoid all responsibility for managing the joint enterprise or entirely exclude from it the evils other parties provide.

Moreover, your hospitals will be involved not just in delivering services after an arrangement has been made but in making the arrangement.⁶ Moral norms can be violated at this stage.

Suppose, for instance, a governmental agency, insurer, or non-Catholic health care provider sought to create an entity to provide the full range of services that at least some of the prospective clientele and parties to the cooperative arrangement think pertain to health care. Suppose a Catholic hospital was a potential party to the prospective arrangement. The negotiators might agree that nothing contrary to the *Ethical and Religious Directives* would be done in the Catholic hospital or sponsored by it; they might even arrange that providers working in the Catholic hospital would never be called on to refer for excluded services or follow up on them. To ensure that the Catholic hospital would be able to avoid such unacceptable cooperation, they also would agree that one of the other parties to the arrangement would provide the excluded services for clients who wanted them. This arrangement seemingly would neatly divide responsibility, isolating the Catholic hospital from immoral activities.

In making the arrangement, however, the Catholic negotiators, intending to avoid providing the immoral services in their hospital, would have intended that another party supply them. So, making the arrangement would be formal cooperation in the

other party's supplying them. Moreover, when those authorized to act on behalf of the Catholic hospital signed the contract, the hospital would be agreeing to all its provisions and intending its doing so to motivate the other parties to agree to the contract and do as they agreed. So, since one of the other contracting parties would have undertaken to provide immoral services, the hospital would be formally cooperating in that undertaking and its execution as long as the contract remained in force.

Someone might object that nothing the Catholic hospital did would bring about anything immoral. The governmental agency, insurer, or non-Catholic health care provider initiating negotiations might well have decided beforehand that certain services, such as sterilization, would be provided, "either because the market 'necessitates' this or because the government will mandate a basic benefits package which will require provision of all services." And, indeed, the immoral services would be provided even if the Catholic hospital did not participate – the arrangement "designed this way will neither increase nor decrease the number of prohibited procedures." Moreover, the objection will continue: "The 'moral object' of the Catholic provider is the provision of health care as a Gospel mission." So: "The moral object of creating [the entity] is precisely *not* to provide prohibited procedures." Therefore, the objection will conclude: "Since our intention is *not* to provide services we deem immoral, cooperation seems to be *material*."⁷

The problem with this argument is that it treats the Catholic hospital's intended end – providing health care as an apostolate without being involved in immoral procedures – as the moral object of its choice to participate in the arrangement. But the object of that choice precisely is to make an arrangement for "provision of all services", and in choosing to make this arrangement, each contracting party intends the others to make and carry out the undertakings required of them by the arrangement. Therefore, to achieve its good end the Catholic hospital chooses a bad means: to have the immoral procedures provided by another party to the arrangement. Even if no more immoral procedures are done than would have been done in the absence of the arrangement, the Catholic hospital will have intended to arrange that the immoral procedures be done as a necessary means to "the provision of health

care as a Gospel mission."

But, it might be argued, this formal cooperation could be avoided. Your hospitals could refuse to agree to anything more than this: "We are only going to do together what all partners agree is appropriate and anything deemed inappropriate must be the private project of that proponent."⁸ Thus, the contract would omit all reference to immoral activities except to make it clear that the Catholic provider would not provide them and that the cooperative arrangement in no way concerned them. The Catholic negotiators could require that the contract not specify that any party to it would provide any immoral service. They could even require that the contract's effectiveness not be contingent on any agreement between the other parties for the provision of any immoral service.

One can imagine making agreements with provisions of that sort, and such agreements could be made and carried out without formally cooperating in another party's immoral procedures. But an agreement with such provisions hardly would satisfy those who "mandate a basic benefits package which will require provision of all services." To satisfy them, negotiators might work out an arrangement to provide all services but agree to formalize it in two or more legal documents so that the Catholic party would not be required to sign any contract that made reference to immoral procedures except in specifying that the Catholic party would not provide them. However, if the set of documents gave effect to the whole arrangement, the choices of all parties in signing any of them would depend on one another's undertakings in the same way as they would if a single contract straightforwardly implemented the agreement to provide all services, and the Catholic hospital would formally cooperate in providing all of them.

In sum, entirely avoiding formal cooperation in immoral practices will be difficult indeed. It can arise in ways that are not obvious and it seems unavoidable in any arrangement that would satisfy a mandate to provide all services. Though I have pointed out some of the problems, there might well be others.

Fourth, avoiding formal cooperation in wrongdoing is not enough. Even if it can be avoided, your hospitals will materially cooperate with all the services by other providers in any way facilitated by a cooperative arrangement. Such material cooperation

can be morally unacceptable for several reasons. It can occasion a sin of formal cooperation; it can be scandalous; materially cooperating with wrongdoing can impair the capacity to give credible witness against it; and it can be unfair to those injured by the wrongdoing.

In providing health care, one who materially cooperates in wrongdoing often will be tempted to cooperate formally for three closely related reasons. Health care providers ordinarily share the intentions of those they serve; particular services ordinarily must be integrated into a comprehensive pattern of care; and the problem with morally excluded services very often is that a bad means is chosen to attain an appropriate end. For example, if a woman's or family's physical and/or psychological health calls for birth regulation and the woman refuses morally acceptable means, any health care provider sharing responsibility for her care will be tempted not only to refer her to someone who will prescribe other means but to try to ensure that she uses her chosen means regularly and effectively. Even if a Catholic hospital's policy excludes such formal cooperation, members of its staff and some other personnel – some and perhaps many of whom do not accept the truth the Church teaches on such matters – almost certainly will be drawn into it.

If a Catholic hospital is to carry on its work as an apostolate, its board members and administrators should deal with formal cooperation in various evils by its personnel. If those responsible instead studiously avoid noticing such formal cooperation or decide to tolerate it, they at least materially cooperate in it in a way that hardly can be justified. As a community committed to an apostolate, the hospital will have betrayed itself even if its board members and administrators manage to stop just short of letting its own complicity in evil become formal cooperation.

Material cooperation with wrongdoing can be scandalous in the strict sense: It can lead people to sin by encouraging them in rationalization and self-deception (which do not free them of guilt) regarding the wrongdoing. The scandal would not be prevented by a Catholic institution's prohibition of morally unacceptable procedures within the domain remaining to it, even if that policy is well publicized. For, to most non-Catholics and many Catholics that material cooperation would seem to imply that those procedures are

not wrong in themselves but merely forbidden to Catholics, as eating meat on Friday used to be. Moreover, other things being equal, a Catholic institution's material cooperation is much more likely to be scandalous than an individual Catholic's. The institution's acts are presumed to be fully deliberate and free, not the product of ignorance or weakness, as an individual's might be. And since the institution claims to be distinguished from others by being Catholic, whatever it does is taken by many non-Catholics and even unsophisticated Catholics to be the Church's own act.

In various ways, a Catholic institution's significant, obvious, voluntary cooperation in wrongdoing inevitably will impair and probably even negate its capacity to provide credible witness. For example, commingled with the service of secularized providers, its activities will become less identifiable and less distinctively Catholic. Again, the closer association with health care providers whose practice violates moral norms taught by the Church often will make it harder for a Catholic institution's administrators and staff to speak out for the truth of those norms and work against their violation. Its partnership in an integrated delivery network or cosponsorship of an HMO providing sterilization, abortion, or euthanasia will strongly suggest that the Catholic Church does not really and firmly reject these evils but only maintains an insincere official opposition. For those engaged in health care as an apostolate to impair their witness in these and other ways would be utterly self-defeating, since, to repeat, the essence of apostolate is not only to promote a human good such as health but to practice Christian love and bear witness to the gospels' truth, including love for the tiniest and the most debilitated of Jesus' sisters and brothers, and the moral truths regarding how they are to be dealt with.

The material cooperation itself, together with the scandal and impairment of witness, will have consequences. Some individuals will die or suffer lesser injuries that might have been prevented if those who profess the sacredness of life and the dignity of persons consistently avoided complicity in wrongful behavior. Accepting these bad consequences is likely to be unfair unless the victims themselves freely consent to what they suffer. Like individuals, institutions should be prepared to make great sacrifices rather than allow anything they do to bring about the death of – or grave injury

to – an innocent person.

Someone might argue that many health care providers who do not accept Catholic moral teaching are convinced that what they are doing is right, and if those with whom a Catholic hospital cooperates act out of sincere consciences, their good faith calls for respect that can justify otherwise excluded material cooperation. But Catholic hospital administrators are responsible for their own acts. The apparent sincerity of conscience of others – their actual consciences are unavailable to us – does call for respect and sometimes justifies toleration of objective wrongdoing. But their apparent good faith may even increase the temptation to cooperate formally with them by making such cooperation seem less repugnant. And if some who appear to be acting in good faith actually are rationalizing and deceiving themselves, cooperating with them can give very serious scandal by making it more difficult for them to acknowledge the truth and repent. Similarly, cooperating with others presumed to be in good faith makes it not easier but in some ways more difficult to bear clear witness to the truth about what they are doing. And even real good faith cannot reduce the unfairness to third parties involved in helping bring about effects injurious or destructive to them.

In view of these considerations, it seems to me that limited material cooperation with non-Catholic providers is least likely to be morally excluded from the first and fourth of the types of cooperative arrangements you mention: specific forms of cooperation with other providers, and purchasing and administering the morally acceptable services of other providers. As for the second and third types of cooperative arrangements, even if a Catholic hospital can participate in an integrated delivery network or cooperatively operated health maintenance organization with others who provide immoral procedures while avoiding formal cooperation in them, I doubt that it can justifiably engage in the material cooperation that any such arrangement would require of it. Moreover, operating within the cooperative arrangement, the Catholic hospital's distinctive characteristics and practices would be likely to be marginalized or even completely suppressed, so that even if it maintained its juridical ties with the Church, it will no longer carry on Jesus' ministry of mercy and will have lost its Catholic identity.

Fifth, the preceding considerations make it clear that you cannot assume that you always will be able to enter into the arrangements necessary to keep a hospital financially viable while entirely avoiding wrongful cooperation. Therefore, you ought to be prepared to give up at least some – and eventually, perhaps all – of your hospitals. In bearing witness, individual Christians are expected to sacrifice even life itself when that is necessary. Should not your institute be ready to bear witness by giving up its hospitals and finding other ways of carrying on its apostolate under today's changing conditions?

Many dedicated and generous women and men put their money and effort into building the system of Catholic hospitals founded and operated by your institute and others. Health care fully integrated with Catholic faith, moral teaching, and pastoral care would otherwise have been unavailable; some cities and towns would have lacked hospitals; and many poor people would have been deprived of hospital care. Without Catholic teaching hospitals, Catholics would not have had the opportunity to be trained as physicians and nurses in full harmony with their faith and in a way that helped many of them carry on their professional work as a true apostolate.

Since Catholic hospital administrators today are, as it were, trustees for those who built the system, your superiors rightly wish to adapt to the changed situation and carry on the apostolate, if possible. But they would betray their trust in saving their hospitals by changing them in ways their founders and supporters would not approve. Institutions, like hospitals, are only means for carrying out a health care apostolate. Like other means, their usefulness is limited. Remaining attached to them as their usefulness diminishes will entail infidelity to the good they formerly served.

Many of the benefits that flowed in the past from operating Catholic hospitals will no longer be realized if they are merged into the secularized health care system, and some of those benefits could be realized even without Catholic hospitals. To provide health care fully integrated with Catholic faith, moral teaching, and pastoral care surely is a noble ideal. But how likely is it to be realized by a Catholic hospital whose services are merged into an integrated delivery network or HMO cosponsored by secularized providers?

Catholic teaching hospitals offer a valuable opportunity for Catholics to be trained in full accord with their faith only if their programs are consistently Catholic, and if nurses and doctors completing those programs will be able to practice without moral compromise in the fields for which they trained. But where such principled practice remains possible, the technical training for it is likely to be available outside Catholic teaching hospitals, and individuals can acquire their indispensable moral and spiritual formation by private study and from faithful Catholic mentors whose concerns extend to health care.

Finally, just as individuals maintain their Christian identity by constantly seeking, accepting, and faithfully fulfilling their personal vocations, so groups of Christians who make up associations maintain their identity as Christian communities only by fidelity to their proper missions. Fidelity precludes questioning basic commitments, such as the vows by which you and other members of your institute have consecrated your lives. But it also calls for periodic reconsideration of all projects undertaken to implement those basic commitments. Like discernment pertaining to vocation, this reconsideration should seek to match gifts and resources with the opportunities to serve others by meeting their genuine needs, not only for temporal goods but for spiritual ones. In carrying on such reconsideration, members of your institute might ask: What health care needs are now unmet and likely to remain unmet by others? And what gifts equip us for meeting some of those needs?

Today, I believe, clearheaded and courageous reflection may well point toward refusing to accept a subordinate role for your hospitals in a secularized health care system and instead adopting more suitable means of serving people most in need and least served by the secularized system. Candidates for your service include the terminally ill who need appropriate care to die with true dignity rather than by the indignity of suicide or homicide,⁹ handicapped individuals whose quality of life falls below some arbitrarily set limit, unborn babies whose abortions the system would provide and whose mothers need help to choose an alternative, couples who need instruction in natural family planning, the working poor who lack health insurance, people too disorganized to make use of the health care system, the mentally ill who have been "freed" from institutions to wander in the streets, and other victims of selfishness and

ideological fashions. By serving these "poorest and most abandoned" and joining explicit catechesis and evangelization to that service, your institute could in truth continue to carry on Jesus' ministry of mercy.

* In *The Way of the Lord Jesus*, volume three, *Difficult Moral Questions* (Quincy, IL: Quincy University, 1997) 391-402.

References

1. Appendix 2 of *Difficult Moral Questions* is especially relevant to this question; its last two sections comment on the appendix on formal and material cooperation in the 1994 revision of the ERDs and the moral significance of various sorts of pressure – "duress" in a wide sense.
2. John Paul II, *Vita Consecrata*, 83 (notes omitted), AAS 88 (1996) 460-61, OR, 3 Apr. 1996, xvi.
3. Richard McCormick, S.J., "The Catholic Hospital Today: Mission Impossible?" *Origins*, 24 (1995): 648-53, proposes several characteristics of the context in which health care is now being delivered as grounds for suggesting (though he does not firmly assert) that "the heart of the Catholic health care culture is gone. The mission has become impossible" (649). An illustration of the tension between mission and financial viability for one (unnamed) Catholic hospital: Marie Wolff, "No Margin, No Mission: Challenge to Institutional Ethics," *Business and Professional Ethics Journal*, 12:2 (Summer, 1993): 39-50.
4. In my judgment, they are morally similar to the "simple case" of in vitro fertilization.
5. Patricia A. Cahill, "Response to 'The Principles of Cooperation and Their Application to the Present States of Health Care Evolution'," in *The Splendor of Truth and Health Care*, Proceedings of the Fourteenth Workshop for Bishops, ed. Russell E. Smith (Braintree, MA: The Pope John Center, 1995), 238-42, makes the point (239): "The majority of joint ventures, networks, mergers and affiliations which have occurred and which are on the drawing board are, from my observation, driven from a business or economic perspective. The leaders responsible for consummating these arrangements understand the business world well. They also understand and support fully the fact that no proscribed services may be offered by their own Catholic institution. However, when the transaction under consideration is between the Catholic provider and a non-Catholic provider and its consummation promises improved fiscal well-being for the Catholic

partner, attention sometimes shifts from strict adherence to the *Ethical and Religious Directives* to a tone of compromise which recognizes the ethical perspective of the non-Catholic provider and softens the principle to achieve the desired outcome. These are not people who intend to do wrong but they are people who have not necessarily had the theological and philosophical preparation to address appropriately the material cooperation questions before them. They hear the term 'material cooperation' but do not understand its philosophical underpinnings and rationale and thus, in my opinion, are ill equipped to apply the principle to the matter at hand."

6. William B. Smith, "Cooperation in Health Care", *Homiletic and Pastoral Review*, 96:9 (July 1996): 70-72, agrees in questioning the possibility of avoiding formal cooperation with other parties' wrongdoing when setting up the joint arrangement.

7. The quotations in the argument are from Russell E. Smith, "The Principles of Cooperation and Their Application to the Present State of Health Care Evolution", in *The Splendor of Truth and Health Care*, 228-29.

8. Russell E. Smith, "Ethical Quandary: Forming Hospital Partnerships", *The Linacre Quarterly*, 63:2 (May 1996): 90.

9. Sheila Cassidy, *Sharing the Darkness: The Spirituality of Caring* (Maryknoll, NY: Orbis Books, 1991), shows both how providing hospice care can be a true apostolate and how great the need is for such care; as the culture of death intensifies, the need and apostolic potential of such work will increase. For a fuller understanding of hospices and how they differ from hospitals, see Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying*, rev. ed. (New York: Vintage Books, 1992)