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Partnering for More Than the Survival of a Catholic Presence in Healthcare

One of the contributions to the Catholic healthcare ministry made by the late Cardinal Bernardin is a set of criteria for Catholic healthcare systems to use in choosing partners for joint ventures and affiliations (Bernardin, 1994). He based his criteria on the premise that appropriate partners are those who will ultimately strengthen and enhance the Catholic presence in healthcare in general, and the Catholic identity of the Catholic facility in particular. Hence, the preferred partner is another Catholic party. A second option is another not-for-profit system or facility that shares "in a substantive way our Catholic vision and values." This choice of partner can be problematic in that, even if common vision and values are affirmed, the Catholic identity of the Catholic partner may be diluted. This situation could occur, for example, as a result of the shift from an exclusive Catholic sponsorship to an arrangement of *co*-sponsorship. It could also result from the need, in some cases at least, for material cooperation by the Catholic system in some prohibited procedures. The growing reluctance in some quarters to approve material cooperation even for the sake of a continued Catholic presence in healthcare (e.g., Smith, 1996) makes such partnerships especially troublesome. In addition to diluting the identity of the Catholic partner, choosing non-Catholic partners may, in some instances, damage the presence of Catholic healthcare by putting other Catholic facilities in the same service area at financial risk. A third partner option is a for-profit system. For-profit healthcare had been judged by the Cardinal to be inimical to Catholic identity, and is ruled out (Bernardin, 1995; Place, 1998).

These criteria have proven to be helpful. They are helpful, however, only within the limited context of their grounding premise: the need to preserve and promote Catholic healthcare's ministry. The "healthcare" ministry is not the only public ministry of the Church. Nor does the healing ministry of the Church need to be viewed solely as an end, sought for its own sake. It is also possible and legitimate to view the healthcare ministry as a vehicle through which to pursue or fulfill another Church ministry. The criteria for choosing partners in healthcare can also be premised on a desire to strengthen and preserve a different public ministry of the Church. At the very least, this could allow choices of partners being made with more enthusiasm and creativity

than can be engendered when the primary motivation is survival. More importantly, material cooperation may be embraced with greater justification.

Rather than being viewed as diluting Catholic identity in healthcare as the Bernardin criteria presumes, partnerships with some non-Catholic facilities and systems can strengthen the Catholic identity of the broader ministry. Further, rather than seeing such partnerships as regrettably requiring appeal to material cooperation for the sake of survival, it might be possible to see this principle as a useful and welcome tool that enables the pursuit of some broader ministerial good. This may be the case when the healthcare ministry of the Church is understood as a means for the pursuit of the Church's ministry to effect ecumenical and interreligious unity.

PARTNERING IN HEALTHCARE FOR ECUMENICAL AND INTERRELIGIOUS UNITY

When there is a strong faith tradition shared among possible partners in healthcare, the opportunity exists for the cosponsoring of more than the healthcare ministry in fidelity to the healing ministry of Christ. There is also the as-yet-undervalued opportunity for the cosponsorship of ecumenical and interreligious unity through collaboration in healthcare. Catholic healthcare providers should not shrink from sponsoring this broader mission of the Church. The importance of sponsoring such collaboration is clear in the remarks of Archbishop Brunett of Seattle, Chair of the NCCB Committee for Ecumenical and Inter-religious Affairs. Inspired by John Paul II in *Ut Unum Sint*, the archbishop stated, "Ecumenism is not merely an addendum to the church's traditional activities. Promoting unity is an organic part of our life and work, and must pervade all that we do" (Brunett, 1998). Pope John Paul II himself describes the pursuit of unity as a "pastoral priority" (*Ut Unum Sint*, no. 98). If the fundamental task of all Christians is evangelization, then "evangelization and ecumenism are indissolubly linked with each other" (John Paul II, 1996, no. 5). Ecumenical and interreligious collaboration is fundamental to the mission of the Church (*Unitatis Redintegratio*, no. 5). The lack of unity among Christians "contradicts the truth which Christians have the mission to spread" (*Ut Unum Sint*, no. 98; *Evangelii Nuntiandi*, no. 77). By choosing faith based partners, Catholic healthcare in the United States can concretely and creatively engage in the essential task of achieving the ecumenical and interreligious mission of the Church.

Practical efforts to achieve unity, defined in the *Catechism* as "collaboration in providing human service" (no. 821), are envisioned in various church documents. These include Vatican II's *Unitatis Redintegratio*, nos. 4, 12; *The Catechism of the Catholic Church*, no. 281; John Paul

II's *Ut Unum Sint*, no. 74; and especially the Pontifical Council for Promoting Christian Unity's *Directory for the Application of the Principles and Norms of Ecumenism*, no. 216. The strong faith heritage that inspires and informs healthcare by another institution may make that institution an attractive partner for a Catholic system not only for healthcare, but for the Catholic response to the faith challenge to "collaboration with other Christians in the areas of common work for social justice, economic development, progress in health and education" (*Directory*, no. 9). Doing so can ensure not only the continuation of the healthcare ministry of the Church, but also and equally important the ecumenical/interreligious ministry of the Church. Because the pursuit of unity is a constitutive element of the ministry of the Church, such partnerships, properly formed, cannot but enhance and promote the Catholic identity of the Catholic partner, and may be sought, dare I say should be sought, even when there are no other compelling circumstances.

COMMITMENT TO DIALOGUE AND COLLABORATION

The urgency of this collaboration is particularly acute among Christians. The Christian heritage shared by many healthcare providers is one within which, "from the beginning, there arose certain rifts. . . . These, the ecumenical movement is striving to overcome" (*Unitatis Redintegratio*, no. 3). Healthcare is a proper domain of the ecumenical movement (e.g., *Unitatis Redintegratio*, no. 12;¹ *Ut Unum Sint*, no. 75). Collaboration amongst different ecclesial communities in healthcare delivery is as central to the task of unity as is dialogue and consensus on matters of doctrine, for "through such collaboration, all believers in Christ are able to learn easily how they can understand each other better and esteem each other more, and how the road to the unity of Christians may be made smooth" (*Unitatis Redintegratio*, no. 12; *Ut Unum Sint*, no. 75). This remains true even as disagreements place limits on collaboration (*Ut Unum Sint*, no. 75).

Among those disagreements that will place limits on collaborative efforts are differing moral positions on clinical issues that are faced in healthcare. These differences are rooted in part in the manner in which each tradition appeals to the Scriptures and other common resources, as well as the manner in which data from the empirical sciences are used in moral decision making. There is, in cosponsorship of an ecumenical/interreligious healthcare venture, the potential for ethical di-

¹ Collaboration among all Christians "should contribute to a just appreciation of the dignity of the human person, the promotion of the blessings of peace, the application of gospel principles to social life, and the advancement of the arts and sciences in a Christian spirit. Christians should also work together in the use of every possible means to relieve the afflictions of our times."

vergence rooted in medical, philosophical, and religious differences. This cannot be avoided. To prohibit all procedures in ecumenical/inter-religious collaboration in healthcare that are not allowed by one party as a condition for partnership makes the very collaboration envisioned by the Church effectively impossible, and undermines the ultimate goal of unity. There will be nothing about which to dialogue, and collaboration will become merely participation in someone else's ministry.

If there is to be collaboration in the midst of moral disagreement, two points must be kept in mind by the Catholic party. First, "the doctrinal stand of the Catholic Church has to be made clear and the difficulties that this can raise for ecumenical collaboration faced honestly and with loyalty to Catholic teaching" (*Directory*, no. 216). Second, the principle of mediate material cooperation may be used as a tool to give practical moral guidance for the prudent collaboration in efforts that may entail collaboration in the provision of prohibited procedures (*Ethical and Religious Directives*, 1994, no. 69).

MATERIAL COOPERATION AS A VEHICLE FOR COLLABORATION

Although most often cited as a principle to be used for the prevention of harm that cannot otherwise be readily avoided, the principle has also been used in the tradition to enable the pursuit of some good that cannot otherwise be readily achieved (Keenan, 1997). As such, it is an indispensable tool in ecumenical/interreligious collaboration. When there are disagreements between the sponsors of a ministry directed toward unity regarding the ethical status of a particular procedure, the principle of material cooperation could provide prudent guidance for discerning the limits of legitimate collaboration.

In order for the principle to be of use, there must be some element of duress. Duress need not be understood solely within the context of such dire circumstances as the threat to the continuing of a Catholic presence in healthcare. Duress refers to those circumstances that make an end that ought to be pursued reasonably impossible to pursue except through mediate material cooperation in a prohibited act. This is seen in the NCCB's 1983 *Commentary*, which states: "material cooperation will be justified only in situations where the hospital because of some kind of duress or pressure cannot reasonably exercise the autonomy that it has" (NCCB, 1983, p. 7). Duress may be understood to be the absence of some ready way to achieve a good end. In such a case, mediate material cooperation in some wrong is permissible if there is a just cause ("*et quando adest justa causa*"—"and when there is just cause," Ligouri, 1905, 357).

It is clear from the above discussion that unity, as a proper mission of the Church, is a good that ought to, indeed must, be pursued. There can be no question that, as a pastoral priority, there is a just cause regardless of whatever other circumstances may or may not be prompting the partnership. *There is no ready way for true ecumenical/interreligious collaboration in healthcare to take place if all ethical divergence is eliminated as an a priori condition for coming together. The principle of mediate material cooperation can be used as a mechanism by which clinical, philosophical, and religiously rooted divergence in the understanding of first-order principles may be resolved and the work of unity made possible.* By making the doctrinal stand of the Church clear, and with loyalty to the Catholic teaching, the Catholic party may use the principle of mediate material cooperation as a vehicle through which to “participate skillfully in the work of ecumenism” (*Unitatis Redintegratio*, no. 4). All the partners involved must be committed to be “ever alert to affirm whatever is shared in common, and to admit where there are serious divergence, even contrary stances.” Still, they can agree that “the communion of faith which already exists between Christians provides a solid foundation for their joining action . . . in the social field” (*Ut Unum Sint*, no. 75). By seeking to foster a greater understanding and collaborative effort among people of faith through the promotion of fitting ecumenical/interreligious initiatives, the Church’s pursuit of unity is promoted and the common good enhanced (*Tertio Millennio Adveniente*, no. 34).

COSPONSORING ECUMENICAL/INTERRELIGIOUS UNITY THROUGH HEALTHCARE

To accomplish this “joining action,” the partners might establish a center for ecumenical/interreligious dialogue and collaboration as a formal part of the new corporate structure. This might entail the establishment of some type of ecumenical/interreligious ethics committee. Such a committee should, to be effective in the pursuit of unity, consist of representatives from the various hospital ethics committees, areas of mission and clinical practice, and representatives from the ecumenical and interreligious offices of the traditions represented. Some of the ongoing tasks of this committee might be to identify those values that are integral to the life of faith (*Directory*, no. 216; *Unitatis Redintegratio*, no. 4) and establish a common ethical foundation as a reference in resolving the dilemmas posed by ethical divergence on clinical issues that may arise. In doing so, it could use the principle of material cooperation to define the boundaries for collaboration by all partners. It would also create a formal collaborative program that might include ecumenical/interreligious ethics grand rounds, and the endowment of a visiting scholar position filled each year by a scholar

representing one of the faith traditions that make up the partnership. Public education concerning ecumenical/interreligious collaboration in healthcare would also be necessary, in part to preclude the possibility of scandal among any of the participating faith communities.

Collaboration necessarily begins with the acknowledgment of the value that the different traditions bring to each other. It is important that we not forget that whatever is wrought by the grace of the Holy Spirit in the hearts of our separated brethren can contribute to our own edification. Whatever is truly Christian never conflicts with the genuine interests of the faith; indeed, "it can always result in a more ample realization of the very mystery of Christ and the Church" (*Unitatis Redintegratio*, no. 4). In most instances, the commitment of both traditions to ethical excellence in clinical, business, organizational, and social practices will be enhanced. In but a few instances, clinical ethical traditions may be challenged. An ecumenical/interreligious committee could review each of these procedures. In the light of this review, and with neither party demanding that those "with whom we disagree compromise their integrity and convictions" (Joint Working Group, 1995, Guidelines), a judgment could be made about the appropriateness of the procedure within the context of a commitment to ecumenical/interreligious unity. This judgment might reflect a common commitment that no facility will perform any procedure in which its partners in sponsoring ecumenical and interreligious unity cannot legitimately cooperate even as dialogue continues. Among these would no doubt be the transplantation of aborted human fetal tissue, some reproductive programs, euthanasia, and medically assisted suicide. Further, it might be understood that no facility would provide any procedure that would, through mediate material cooperation in it, cause the ethical integrity of any partner to be called into question by its own faith community. Structures common in partnerships today to minimize this final possibility, such as funds related to a prohibited procedure being kept separate from funds that are commingled, can be used although this is probably not necessary (e.g., McCarthy, 1955; Connery, 1955).

CONCLUSION

In approaching other faith based healthcare facilities and systems, or being approached by them, Catholic healthcare has a unique opportunity not addressed, but perhaps not unforeseen, by Cardinal Bernardin in his 1994 protocol. Catholic providers seeking partners in healthcare need not choose solely or even primarily those who can strengthen the Catholic healing identity. Partners may also be chosen to seize an opportunity to pursue the goal of ecumenical/interreligious dialogue to promote "visible unity in common life and service in order

that the world may believe" (Joint Working Group, 1995, Guidelines). In pursuing this ministry, it is possible to "skillfully participate" in the urgent task of "overcoming the divisions of the second millennium" (*Tertio Millennio Adveniente*, no. 34).

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