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A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

AN INTRODUCTION TO THE SIXTH EDITION OF THE *ERDS*

Ethicists of the NCBC

In July 2018, the United States Conference of Catholic Bishops published the sixth edition of the *Ethical and Religious Directives for Catholic Health Care Services*.[1] While only part 6 of the *ERDs* was revised, the revisions were substantial. These revisions strengthen the role of the local bishop, provide new guidance for assessing collaborative arrangements, and introduce a new consideration for assessment beyond the principles of cooperation and theological scandal—the witness of the Church. This article provides an initial overview of the revisions and some brief commentary on their significance.

Background

One event contributing to the revision of part 6 of the *ERDs* was the 2012 transformation of Catholic Health West into Dignity Health. CHW was a Catholic health care system that owned and operated both Catholic and former community hospitals before being converted to Dignity Health, a secular system owning and operating community and Catholic hospitals. The Congregation for the Doctrine of the Faith (CDF) replied to a *dubium* of the US bishops about this transaction in February 2014 with a four-page document, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services."[2] This document provided introductory reflections and seventeen numbered paragraphs of principled guidance on collaborative arrangements. The CDF Principles went beyond the assessment of any particular transaction to address larger concerns about the size, scope, and complexity of collaborative arrangements among contemporary Catholic health care organizations in the United States.

Soon after receiving the CDF Principles, the US bishops decided to update the *ERDs* rather than append the CDF Principles to the existing, fifth edition. The 2018 update to the *ERDs* includes an expansion of the introduction to part 6, six new directives, and the reorganization of existing content. While not everything from the CDF Principles was incorporated, the CDF's guidance as a whole was incorporated by reference, via an endnote citation in the title of the new part 6.

The New Introduction to Part 6

The new introduction to part 6 is similar in organization and topics to the corresponding introduction in the fifth edition; however, it is significantly longer and introduces some noticeable changes in tone, terminology, and substantive content.[3]

Much like the fifth edition, the sixth edition introduces the topic of collaboration between Catholic and non-Catholic institutional partners in part 6 with a brief description of the opportunities and challenges posed by collaborative arrangements. Here a change in tone can be detected. Unlike the fifth edition, in which equal numbers of opportunities and challenges of partnerships in health care were listed, the sixth edition describes five positive opportunities made possible through collaborative arrangements and lists only one particular challenge. This more positive tone can be traced to the prologue of the CDF Principles, which states that "effective engagement in health care often calls for collaboration with non-Catholic health care institutions" and that "in itself, collaboration in good works is, of course, a good thing."[4]

The new introduction to part 6 then explains, more completely than in the past, the moral framework for collaboration, with short summaries of formal and material cooperation and of theological scandal. The inclusion of this material accounts for the expanded length of the introduction. Beyond inserting important guidance into the fabric of the *ERDs*, these summaries provide a context for expressing concerns about the challenges posed by collaborative arrangements. For example, two entire paragraphs are now devoted to theological scandal. The first paragraph brings into the introduction materials previously covered only in the fifth edition's directive 71 and its endnote. The second paragraph adds additional cautions about ongoing association with wrongdoing as well as a concern that the integrity of the Church's witness not be adversely affected.

This latter paragraph provides an opportunity to note some changes in terminology and content in the new part 6. The first change is minor—the term "collaborative arrangements" is employed in place of the fifth edition's "partnerships." The introduction of two other terms is more significant. First, references to canon law are made for the first time in part 6, two in the introduction and a third in

directive 72. Second, there is a change in the frequency and content of the term "witness."

The impetus for introducing the term "witness" can be traced to the CDF Principles, which used it four times. The new part 6 of the *ERDs* employs "witness" eight times, four times in the introduction and four more times in the directives. The frequency of use alone suggests that this is no mere rhetorical flourish. The NCBC believes that the expanded use of "witness" in the *ERDs* serves in part to counterbalance the positive tone regarding collaborative arrangements noted above. In addition, as will be explained below in the discussion of directive 67, use of the term "witness" introduces a new consideration for the assessment of collaborative arrangements.

The final paragraph of the introduction is unique for two reasons. First, it removes any references to historical issues and actions (such as the creation of an ad hoc committee on health care issues and the elimination of a flawed appendix) that were present in both the fourth and fifth editions of the *ERDs*. The absence of such historical references may reflect an emerging stability in the theological stance of the US bishops. Second, the paragraph contains a strong statement on the authority of the diocesan bishop ("the ultimate responsibility for the interpretation and application of the directives rests with the diocesan bishop"). While the authority of the diocesan bishop over ministries in the local church is well recognized in canon law, and while the teaching authority of bishops has been referenced in the seventh paragraph of the general introduction to the *ERDs* since 1994, this strong statement is a notable addition in the new edition.

Commentary on the Part 6 Directives

The directives in the revised part 6 underwent significant changes. Six new directives were introduced, and every directive except one was modified in some respect. The eleven directives in the new part 6 can be organized into three broad categories: directives 67 to 69 address the role of the diocesan bishop in establishing collaborative arrangements; directives 70 to 72 address traditional parameters for establishing or monitoring collaborative arrangements; and directives 73 to 77 contain most of the new guidance from the CDF Principles regarding the creation, maintenance, or dissolution of major collaborative arrangements.

Directive 67 contains language adopted from the fifth edition's directive 71 concerning theological scandal. What is notably new here is the list of *three* considerations that a diocesan bishop has the ultimate responsibility to assess regarding new collaborative arrangements. The first two considerations are standard—the principles of cooperation and theological scandal. The third is new—to assess whether the proposed arrangement might undermine "the Church's witness." This is the first of four references to "witness" in the directives section. While all three considerations appear together only in directive 67, the term "witness" is added to the consideration of theological scandal three more times, twice in directive 71 and once in directive 76, identifying "witness" as a distinctive, significant consideration to address.

Directive 68 contains material drawn from the fifth edition's directives 67 and 68 about the need to consult the bishop in a timely manner when a proposed collaborative arrangement might negatively affect a Catholic health care ministry's operations or identity. Given that collaborative arrangements can be complex to form and to finalize, and given that diocesan bishops are busy, the NCBC believes it is necessary to find a virtuous mean in the timing of consulting the bishop—between when the terms of the proposed collaborative arrangement are well-enough defined and when the bishop's concerns and input can best be addressed. Beyond consulting, the approval of the diocesan bishop is required. The second sentence in this paragraph covers what form of approval is required from a diocesan bishop. Overall, this revised directive recognizes that many Catholic health care institutions are no longer canonically organized as ministries sponsored by religious institutes of diocesan or pontifical right but rather as public juridic persons. The level of approval for both kinds of canonical entities (*nihil obstat*) is the same.

The content of **directive 69** is entirely new, having been raised for the first time in CDF principle 17. Over the past few decades, once relatively independent Catholic hospitals were consolidated into systems; subsequently, sizable Catholic health care systems merged with one another and now extend across multiple states and dioceses. As collaborative arrangements affecting local hospitals are established at system headquarters far from local hospitals and dioceses, the question increasingly arises, Whose approval is required—that of the local bishops in whose dioceses a system's facilities are operative or that of the bishop of the diocese in which the system headquarters is located, or all of them?

Directive 69 specifies and adds significant content to CDF principle 17, which states, in relevant part, that "the bishop of the diocese in which the [Catholic] system's headquarters are located must collaborate with the bishops of the other dioceses in which the member institutions are located." Now, directive 69 makes three important points: First, each bishop in whose diocese a Catholic health system facility is located must give appropriate approval to the terms of a collaborative arrangement that is operative in his diocese. Second, directive 69 stipulates that the role of the "headquarters bishop" is to lead a collaborative effort to assess and approve a collaborative arrangement. Third, directive 69 calls on all of the bishops involved to strive for consensus. What comes through most clearly in the end is an emphasis on respecting the authority of the local bishop, while also doing justice to the need for collaboration in addressing matters of organizational complexity.

Directive 70 is the only directive left unchanged in number and content from the fifth edition of the *ERDs*. Given the major changes made to the rest of part 6, the significance of this retention should not be underestimated. The text and endnote of directive 70 were added to the *ERDs*

in 2001 to address confusion about immediate material cooperation that had been introduced in a flawed appendix in the fourth edition of the *ERDs*. Directive 70 reaffirms the traditional proscription against immediate material cooperation with intrinsically evil actions in spite of organizational duress and lists those actions most likely to arise in collaborative arrangements: abortion, euthanasia, assisted suicide, and direct sterilization. Endnote 48 in directive 70 contains three important resources: (1) the source for the list of intrinsically evil actions (a 1998 *ad limina* address of Pope St. John Paul II); (2) a quotation from the 1975 CDF *responsum* known as *Quaecumque sterilizatio*, proscribing immediate material cooperation with direct sterilization; and (3) a short statement explaining that a 1977 commentary by the National Conference of Catholic Bishops on *Quaecumque* is no longer valid. Given these substantive teachings and authoritative sources, the NCBC believes that properly applying directive 70 and its endnote should be a high priority in assessing any collaborative arrangement.

Directive 71 incorporates the subject matter and text from the fifth edition's directive 71. While this revised directive is much shorter, because one of its sentences was moved to the new directive 68, it contains a significant addition—a twofold reference to the effect that collaborative arrangements might have on the witness of the Church beyond the considerations posed by theological scandal.

Directive 72 is also similar in subject matter and text to the fifth edition's directive 72, and it too contains a significant addition. The standard for periodic reassessment of collaborative arrangements (consistency with Catholic teaching) is supplemented with explicit references to "the natural moral law" and "canon law." The NCBC believes these additions are intended to strengthen the standards for faithful implementation of Church teachings as the size and complexity of Catholic health care organizations grow.

The final five directives in part 6 derive from guidance in the CDF Principles and address issues in forming, operating, and potentially dissolving collaborative relationships.

Directive 73 rephrases but retains the guidance of CDF principle 9 regarding the process of forming or beginning a new collaborative arrangement. The directive requires a morally sufficient separation between a Catholic institution and any immoral activities of a non-Catholic partner. The areas and activities to be separated—performing, assisting in, managing, and benefitting financially from immoral procedures—are traditional considerations in the analysis of cooperation and collaborative arrangements.[5]

Like directive 73, **directive 74** references the terms of morally sufficient separation in collaborative arrangements, but this time from the perspective of the organizations themselves. CDF principle 6, from which this directive is drawn, articulates a principle long observed in responsible moral analysis of collaborative arrangements, namely, that any collaborative organization or program established by Catholic and non-Catholic partners may not perform any (immoral) actions that the Catholic institution may not perform itself. The application of this directive will require particular care in moral analysis taken together with the guidance of directive 75.

Moving beyond the traditional guidance found in directives 70 and 71, **directive 75** establishes clear limits on the *process* of establishing a collaborative arrangement if such a process would entail creating or helping to create alternative institutions to engage in activities proscribed for Catholic health care institutions. This revised directive combines into one paragraph the guidance of CDF principles 13 and 14, namely, that Catholic partners cannot contribute to the establishment of organizations that would be responsible for immoral procedures. The NCBC believes that the actions listed (drawing up civil bylaws, policies, or procedures) should be taken as an illustrative, not exhaustive, list of prohibited actions. A Catholic institution should not provide any specific assistance to establish the means for immoral activities.

In some cases, when a Catholic institution or system engages in a significant collaborative arrangement with a non-Catholic partner (such as joining a system as a constitutive member), the Catholic institution is accorded a seat on the board of the non-Catholic partner or of the collaborative organization created. This role may allow the Catholic partner to articulate and defend its interests. However, the authority that such representation provides also can carry with it some level of responsibility for the actions of that governing board, including responsibility for immoral activities over which the board exercises governance. **Directive 76** directs any such Catholic representatives not merely to recuse themselves or remain passive in board deliberations over such activities, but rather to make their opposition known and to withhold their consent from any decisions relating thereto. At the end of this directive there is a fourth and final reference to not undermining the witness of the Church.

Directive 77 provides guidance about what should be done if a Catholic institution, despite exercising due diligence in creating and monitoring a collaborative arrangement, discovers at some point that it is engaged in an arrangement that does not respect the moral teachings of the Church or the content of directives 70 through 76. The Catholic institution should first inform the diocesan bishop. This duty can be viewed as analogous to the civil duty that organizations already have to report evidence of fraud or abuse in their operations. Second, leaders of the Catholic institution should resolve the situation as soon as reasonably possible. Third, while the legal, financial, and operational issues involved in resolving a problematic situation can be complex, the Catholic health care institution should apprise the diocesan bishop of progress and consult with him about proposals to resolve the situation, particularly when these might involve new conditions to an ongoing collaborative relationship or alienation of Church property. As in directive 68, Catholic health care institutions must find the most appropriate time to meet with the bishop—that is, when the bishop has the best opportunity to give meaningful input on the potential solutions.

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The Witness of the Church

No area of the *ERDs* has been as significantly amended as part 6. No doubt this reflects the complexity of both contemporary health care delivery and application of the principle of cooperation to collaborative arrangements. The sixth edition's more positive approach to collaborative arrangements, coupled with the absence of any reference to historical issues and actions found in part 6 in past editions, seems to reflect an emerging stability in the approach of the bishops toward collaborative arrangements. Nevertheless, significant concerns remain. These concerns are reflected in the addition of explicit instruction about the principles of cooperation and theological scandal, in new references to canon law and the natural moral law, and in the introduction of a new consideration—the "witness" of the Church. Two brief observations about the content and application of "witness" can be made at this time.

First, beyond the greater number of times it is used, the term "witness" has been invested with significant content. This content emerges in the first sentence of the CDF Principles, which use the term "witness" in reference to the Catholic faith and to a distinctive approach to caring for the sick. The CDF cites as examples of witness the martyrs SS. Cosmas and Damien, connoting the need for courage in testifying to the truth of Christ and offering authentic charitable care. In the new introduction to part 6, "witness" consistently references something distinctive and ultimate—"the Gospel of Jesus Christ," "the Catholic faith," and "the Church's witness to Christ and His saving message." These affirmations contrast noticeably with the two referents of "witness" in part 6 of prior editions of the *ERDs*—that is, (1) to the "religious and ethical commitments" of Catholic institutions and (2) to "a responsible stewardship of limited health care resources." The NCBC believes that the strengthened content given to "witness" expresses a concern about maintaining the fullness and the distinctiveness of the Catholic faith in the increasingly integrated and secularized fields of health care financing and delivery.

Second, when applying the new consideration of the "witness of the Church" to the assessment of collaborative arrangements, the NCBC believes it will be necessary to go beyond traditional concerns about theological scandal to identify the new challenges posed if Catholic health care were to be delivered increasingly in large, integrated systems and complex collaborative arrangements. The more Catholic health care institutions are integrated into large, complex, standardized, and interwoven programs of care, the harder they could find it to offer distinctive programs of care, such as fertility or hospice services, and the harder they, or the Church as a whole, could find it to prophetically proclaim the truth about the human person and authentic respect for human dignity.

Implementing the new part 6 and, in particular, addressing the exigencies of "witness" will require careful analysis in scholarly articles and discernment in assessing and approving new collaborative arrangements. The National Catholic Bioethics Center looks forward to assisting in these endeavors.

Notes

1. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018).
2. Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services" (March 2014), reprinted in *National Catholic Bioethics Quarterly* 14.2 (Summer 2014): 337–340. Hereafter, CDF Principles.
3. Both editions of the *ERDs* are available online, at http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf (5th ed.) and at http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf (6th ed.).
4. CDF Principles, 337 (prologue).
5. See, for example, Michael Place, "CDF Principles for Collaboration with Non-Catholic Health Care Entities: Ministry Perspectives," *Health Care Ethics USA* 22.3 (Summer 2014): 31.

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