

Prague in September 1993 makes substantially the same point with regard to Europe: "The curse of nationalism, which haunts Europe's past, resulted from the elevation of national identity into a false absolute."⁴¹

The idolatrous character of nationalism is perhaps most apparent in the case of great states with imperial ambitions and rich cultural heritages when these fall into the hands of leaders who will brook no criticism and who demand obedience in the pursuit of extreme ends. But it may also manifest itself in the very extremity of commitment to the cause of an oppressed people when it subordinates an otherwise-laudable devotion to the oppressed to a plan of action which rejects the duties implied by human rights and the moral bonds of the common humanity that is manifest both in the oppressed and the oppressors. In such an extreme commitment it is reasonable to think that there is also a rejection of God's sovereignty and God's creative will which rejoices in the many kinds of human diversity despite the problems they present to political leaders and to political theorists. The heart of a religious response to these problems, however, needs to be sought, as John Paul II urged in the sermon that he was unable to give in Sarajevo in September 1994, in seeing the power of God present in forgiveness and the nearness of God "to the refugees forced to leave their land and their homes" and "in solidarity with women humiliatingly violated."⁴² Such a realization breaks the cycle of violent retaliation, as the current examples of South Africa and the peacemaking process in the Middle East and the earlier example of the reconciliation of Germany with its Polish and French neighbors illustrate.⁴³

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ETHICAL ISSUES IN HEALTH-CARE RESTRUCTURING

The Republican landslide in the 1994 Congressional elections augurs the demise of sweeping, national legislative efforts to *reform* the American health-care system by guaranteeing universal access to a standard benefit package and instituting mechanisms to control the nation's swollen health-care budget.¹ Yet there is no end in sight to the furiously paced *restructuring* of the health-care industry, in which formerly autonomous health-care institutions affiliate with one another in order to provide a full spectrum of health care and compete for the

⁴¹ George Basil Cardinal Hume, "Tasks of the Church in the New Europe" (September 8, 1993), *Origins* 23 (Oct. 24, 1993) 341-48, at 342.

⁴² John Paul II's Sermon on the "Our Father," to be given at Mass in Sarajevo, Bosnia, September 8, 1994, in *Origins* 25 (Sept., 1994) 264-65, at 265.

⁴³ A great wealth of ideas for the practical resolution of the kinds of disputes that nationalism so powerfully exacerbates can be found in *Conflict and Peacemaking in Multiethnic Societies*, ed. Joseph Montville (New York: Lexington, 1991).

¹ President Clinton's *Health Security Act* was published with a useful summary by Commercial Clearing House, Chicago, in 1993.

business of third-party payors.² This note addresses the following challenges posed by such restructuring: (1) ethical issues generated by the shift from fee-for-service medicine to managed care, and (2) the newly revised *Ethical and Religious Directives for Health Care Facilities* promulgated by the National Conference of Catholic Bishops, in particular the principle of cooperation as applied to two case studies.

From Fee-for-Service to Managed Care

From the 1960s through the mid-1980s, the health-care industry was dominated by a fee-for-service reimbursement system, in which a health-care provider charged for each discrete service rendered. Apart from the relatively few health-maintenance organizations (HMOs), third-party payors exerted little control over the utilization of medical services. In fact, when the federal government reimbursed, it was extremely generous. Under the Medicare program, physicians were reimbursed at 80% of reasonable charges, and hospitals were reimbursed at 100% of the costs they incurred, including allowances for depreciation on assets.³

The incentives under this reimbursement system conspired to produce a rapid increase in both the number and technical sophistication of medical services. Hospitals and health-care providers were revenue centers; the more services each provided, the more money each made. Hospitals were prompted to introduce new services, knowing that the cost of doing so would be absorbed by private payors and the federal government. At the same time, patients had little or no financial incentive to refrain from medical treatment that had even the slightest hope of success. Third-party payors absorbed the lion's share of treatment costs. An employer's contribution to health insurance, no matter how exorbitant the coverage, was (and is) not counted as part of the employee's taxable income.⁴

Medical ethics in the late 1960s and early 1970s was shaped by the issues that emerged through this reimbursement system, in particular the need to curb unremitting incentives to continue treatment. In the world of secular bioethics, discussions of patient autonomy emphasized the patient's right to *refuse* medical interventions; in Catholic circles, moral theologians updated the distinction between ordinary and extraordinary medical treatment. Curiously, such discussions generally

² The Catholic Health Association (CHA) has prepared a series of invaluable workbooks on integrated delivery systems and managed care. See, e.g., CHA, *A Handbook for Planning and Developing Integrated Delivery (Working Draft)* (St. Louis: CHA, 1993); *A Workbook for Understanding Capitation* (St. Louis: CHA, 1994); and *A Workbook for Building Relationships with Physicians* (St. Louis: CHA, 1994).

³ For reimbursement history and reform, see Mark A. Hall and Ira Mark Ellman, *Health Care Law and Ethics* (St. Paul: West Publishing Co., 1990) 3–71.

⁴ To give Americans an incentive to make cost-conscious choices, President Clinton's reform proposal wanted to tax employees for most coverage exceeding the standard benefit package in the proposal (*Health Security Act*, Section 7201).

took place in a framework that did not integrate concerns about the social cost of such treatment.⁵ Even the most publicized question of microallocation of that era, the availability of dialysis, evaporated in 1972 when Congress decided to expand the Medicare program to fund such treatment.

"Managed care" is a reaction to the incentives to use health-care resources without heeding their costs and prospective benefits.⁶ Generally speaking, managed-care entities, like HMOs, diverge in three fundamental ways from fee-for-service medicine. First, they use some type of "gate-keeping" method, e.g. a referral from a general practitioner, to regulate access to more specialized medical services.

Second, they monitor and control the delivery of medical care to make it cost-effective. Such a process involves the development of practice guidelines or "clinical pathways" to describe the recommended treatment, "utilization review" to determine the optimal use of the HMO's resources, and quality-assessment-and-improvement protocols to gather information about treatment outcomes. For such procedures to be effective, the HMO must steer patients toward providers who are contractually committed to compliance.

Third, rather than being reimbursed for each episode of care, an HMO typically is paid on a "capitated" basis; it charges a fixed sum per month for each member enrolled, whether that person is sick or well. In return, the HMO must provide each enrollee with the care included in the benefit package. Like insurance companies, HMOs are thereby "at risk" for the cost of treatment exceeding the sum of the capitated payments collected. Consequently, unlike fee-for-service providers, HMOs consider hospitals to be "cost centers," not "revenue centers." They therefore have a greater incentive to provide preventive care and treatment in the least intensive setting possible.

Although HMOs are the purest case of "managed care," insurers and health-care providers have incorporated many of their incentives to control costs. For example, in 1983, the federal government restructured the cost-based payment Medicare reimbursement system for general, acute-care hospitals.⁷ Instead of paying for each discrete ser-

⁵ See the relatively brief treatments in, e.g., *Medical Ethics*, eds. Natalie Abrams and Michael D. Buckner (Cambridge: MIT, 1983), and *On Moral Medicine*, eds. Stephen E. Lammers and Allen Verhey (Grand Rapids: Eerdmans, 1987).

⁶ For a blueprint of the theory of managed competition, see Alain Enthoven and Richard Kronick, "A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy," *New England Journal of Medicine* 320 (1989) 29-37 and 94-101; see also Uwe E. Reinhardt, "Managed Competition in Health Care Reform: Just Another American Dream, or the Perfect Solution?" *Journal of Law, Medicine, and Ethics* 22 (1994) 106-20.

⁷ Effective January 1, 1992, Congress reformed the manner in which Medicare compensated physicians. They are now paid according to a fee schedule that reflects the medical resources consumed in furnishing a particular service relative to other physician services, as well as the cost of practicing in a particular geographic region.

vice provided, Medicare now pays a hospital a fixed, prospective amount based on that patient's diagnosis, thereby providing an incentive to discharge patients as soon as possible (and perhaps sooner).

Similarly, many third-party payors have developed loose networks of providers (preferred provider organizations or PPOs) which have agreed either to accept a specified payment per day for providing care to a covered individual, or to charge a discounted price. The provider offers its services at a discount in exchange for access to the payor's patient base. Finally, indemnity insurance plans now require prior approval for expensive medical treatment.

If a managed-care system fulfills its promise of controlling costs by eliminating useless treatment, providing early intervention, and standardizing good medical care, then it will contribute greatly to the common good.⁸ But, like any institutional framework, a managed-care system also offers opportunities to act unjustly or to violate the dignity of society's weaker members. These opportunities are different from those in a fee-for-service system. What follows is a short summary of the issues likely to preoccupy medical ethics for the next decade.⁹

The Purpose of Health Care

In order to know *how* to distribute health care resources, we need to understand *what* we hope to achieve in doing so. As Michael Walzer

⁸ On managed care's effectiveness, see Dana Gelb Safran et al., "Primary Care Performance in Fee-for-Service and Prepaid Health Care Systems," *Journal of the American Medical Association* 271 (1994) 1579–86; for the compatibility of insuring high-quality health care while controlling costs, see the symposium on "Quality of Care and Health Reform: Complementary or Conflicting," *American Journal of Law and Medicine* 20 (1994) 1–229, and E. Haavi Morreim, "Whodunit? Causal Responsibility of Utilization Review for Physicians' Decisions, Patients' Outcomes," *Law, Medicine, and Health Care* 20 (1992) 40–56.

⁹ On health reform and ethics, see, e.g., the symposia on "Health Care Priorities, Policies, and Practices," *Journal of Law, Medicine, and Ethics* 22 (1994) 104–78; "Implementing U.S. Health Care Reform," *American Journal of Law and Medicine* 19 (1993) 1–144; and "The Ethical Foundations of Health Care Reform: Clinton and Beyond," *Journal of Medicine and Philosophy* 19 (1994) 397–516. See also Donald M. Berwick, "Eleven Worthy Aims for Clinical Leadership of Health System Reform," *JAMA* 272 (1994) 797–802; Dan W. Brock and Norman Daniels, "Ethical Foundations of the Clinton Administration's Proposed Health Care System," *JAMA* 271 (1994) 1189–96; Howard Brody et al., "The Place of Ethics in Health Care Reform," *Hastings Center Report* 24/3 (1994) 7–13; Council on Ethical and Judicial Affairs, American Medical Association, "Ethical Issues in Health Care System Reform," *JAMA* 272 (1994) 1056–62; "Discussion of Values Reappear in Health Reform Debate," *Hospital Ethics* (July/August 1994) 14–15; Charles J. Dougherty, "Ethical Values at Stake in Health Care Reform," *JAMA* 268 (1992) 2409–12; and William F. May, "The Ethics of Health Care Reform," *Annual of the Society of Christian Ethics* (Washington: Georgetown University, 1994) 171–86. See also Philip S. Keane, *Health Care Reform: A Catholic View* (New York: Paulist, 1993). Dealing with important specific issues are Lawrence O. Gostin et al., "Privacy and Security of Personal Information in a New Health Care System," *JAMA* 270 (1993) 2487–93; and Susan M. Wolf, "Health Reform and the Future of Physician Ethics," *Hastings Center Report*, 24/2 (1994) 28–41.

has noted, "If we understand what [a good] is, what it means to those for whom it is a good, we understand how, by whom, and for what reasons it ought to be distributed."¹⁰ What is the purpose of "health care"?¹¹ For a long time, "health care" meant care for the afflicted, as James Burtchaell's description of Dutch physicians responding to Nazi policies captures: "They knew their job was not to produce a healthy, working population, nor to eliminate the stunted; it was their profession to heal whom they could, alleviate the affliction of those they could not and stand by all whom they served."¹² But emerging from our current debates is another view of health care, as an instrument to improve our collective physical well-being. Oregon governor John Kitzhaber, the principal architect of the Oregon Basic Health Services Act states: "Health care is but a means to an end—not an end in itself. And thus it is important only to the extent that it furthers the end of maintaining, restoring or improving [national] health."¹³ Most of us, of course, expect health care to serve both purposes. Yet in a cost-conscious world of scarce resources, the welfare of the weak will likely compete against the "wellness" of the majority.

The Contents of a Benefit Package

The contents of a benefit package is controlled by two forces. First, tensions between the differing purposes of health care underlie recent debates about whether a standard benefit package should include services such as preventive care, mental-health services, fertility services, or high-technology treatment.¹⁴ The second force derives from the shift to managed care. Here, an enrollee's access to benefits is not found in the plan itself, but in the payor's determination of what constitutes "medically necessary and appropriate care." This case-by-case assessment is based upon those practice guidelines, utilization-review protocols, and quality-control procedures outlined above. These two forces converge in the debate over the Oregon Plan.¹⁵ In brief, the

¹⁰ Michael Walzer, *Spheres of Justice* (New York: Basic Books, 1983) 9.

¹¹ See M. Cathleen Kaveny, "Distributive Justice in the Era of the Benefit Package: The Dispute over the Oregon Basic Health Services Act," forthcoming in *Critical Choices and Critical Care: Catholic Perspectives on Allocating Intensive Care Resources*, ed. Kevin Wm. Wildes (Dordrecht: Kluwer Academic Publishers, 1995).

¹² James Burtchaell, "How Much Should a Child Cost? A Response to Paul Johnson," in *On Moral Medicine* 508.

¹³ John Kitzhaber, "The Oregon Health Plan: Presentation to the Conference on Health Care," unpublished lecture given at a conference on "The Oregon Solution," Portland, Oregon (August 9, 1991) 5.

¹⁴ See Maura A. Ryan, "Particular Sorrows, Common Challenges: Specialized Infertility Treatment and the Common Good," *The 1994 Annual of the Society of Christian Ethics* 187–206.

¹⁵ On the Oregon Plan, see, e.g., a symposium devoted to that topic in *Journal of Medicine and Philosophy* 19 (August 1994) 301–88; Michael J. Garland, "Justice Politics, and Community: Expanding Access and Rationing Health Services in Oregon," *LMHC* 20 (1992) 67–81; Thomas M. Gill and Alvan R. Feinstein, "A Critical Appraisal

Oregon Basic Health Services Act expanded the population eligible for Medicaid by reducing the scope of covered services. To determine a revised Medicaid benefit package, the Oregon Health Services Commission developed a list of health-condition/treatment pairs, which were then ranked by their evident necessity and their distinctive value to society and to the particular patient. The plan's defenders stressed that it would provide basic, effective care to more persons; its major opponents claimed that its overall preference for cure would discriminate against the disabled.¹⁶

Providing Care to the Old, the Sick, and the Uninsured

Because they are paid on a capitated basis, managed-care providers have a strong financial incentive to search out young, healthy enrollees and to avoid populations likely to require expensive medical treatment.¹⁷ In addition to refusing coverage to, or imposing lengthy waiting periods on, persons with preexisting conditions,¹⁸ providers can employ a variety of subtle ways to discourage the elderly and chronically ill from enrolling.¹⁹

A closely related question is the fate of the uninsured and underin-

of the Quality of Quality-of-Life Measurements," *JAMA* 272 (1994) 619-626; John La Puma, "Quality-Adjusted Life Years: Ethical Implications and the Oregon Plan," *Issues in Law and Medicine* 7 (1992) 429-41; Eric Robinson, "The Oregon Basic Health Services Act: A Model for State Reform?" *Vanderbilt Law Review* 45 (1992) 977-1014; Sara Rosenbaum, "Mothers and Children Last: The Oregon Medicaid Experiment," *AJLM* 18 (1992) 97-126; and Kenneth K. Schmitt, "Waiver Quest: Oregon's Attempt to Re-Ration Health Care," *Saint Louis University Law Journal* 36 (1992) 947-83.

¹⁶ Dr. Louis Sullivan, secretary of the Department of Health and Human Services under President Bush, refused to grant Oregon the necessary Medicaid waiver because its prioritization of services violated the Americans with Disabilities Act by assuming that the life of a disabled person was less valuable than that of a person without disability. On March 19, 1993, Donna Shalala, secretary of the Department under the Clinton administration, granted the waiver, subject to certain restrictions. See, e.g., "Approval for Oregon Health Care Plan," *Chicago Tribune*, 19 March 1993, 1.

¹⁷ For an analysis of the utilization of health-care resources by persons with AIDS and HIV, see Dennis P. Andrus et al., "Comparison of Hospital Care for Patients with AIDS and Other HIV-Related Conditions," *JAMA* 267 (1992) 2482-86.

¹⁸ Without universal coverage, the success of the Human Genome Project may significantly affect access to health care because third-party payors might deny coverage to persons genetically predisposed to certain diseases on the basis of a "pre-existing condition."

¹⁹ See Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon & Schuster, 1987), and the symposium "Caring for an Aging World: Allocating Scarce Resources," *Hastings Center Report* 24/5 (1994) 3-41. See also *Law, Medicine, and Health Care* 18:3 (1990), which was devoted entirely to that topic. See also Dolores G. Clement et al., "Access and Outcomes of Elderly Patients Enrolled in Managed Care," *JAMA* 271 (1994) 1487-92; Nancy S. Jecker, "Age-Based Rationing and Women," *JAMA* 296 (1991) 3012-15; Frida Kerner Furman, "Women, Aging, and Ethics: Reflections on Bodily Experience," *The 1994 Annual of the Society of Christian Ethics* 229-54; and Sidney Dean Watson, "Minority Access and Health Reform: A Civil Right to Health Care," *JLME* (1994) 127-37.

sured in a restructured but not reformed health-care system.²⁰ Hospitals with high levels of uncompensated care (i.e. bad debt and charity care) will be less attractive partners in managed-care networks.²¹ At the same time, the increased pressure on providers to control costs may limit their ability to underwrite uncompensated care. Providing medical treatment to the poor is not only at the heart of the Catholic mission in health care; it also affects all not-for-profit health-care organizations.²² Their tax-exempt status is justified in terms of the "community benefit"²³ they provide, which has traditionally included some level of free care to the needy. In October 1994, the Catholic Health Association (CHA) limited its membership to nonprofit entities, reaffirming the nexus between a not-for-profit corporate structure and a mission to the poor.²⁴ While there has been significant debate about whether for-profit corporations provide charity care substantially equivalent to their nonprofit counterparts, the difference in their respective missions is clear: the ultimate obligation of the trustees and officers of a for-profit hospital is to maximize the dividends reaped by its shareholders, while the fiduciaries of a tax-exempt, not-for-profit hospital are ultimately obliged to fulfill its charitable purposes.²⁵ While not-for-profit status does not mean that a hospital can ignore the bottom line, it does provide more flexibility to consider the needs of society's vulnerable.

²⁰ Peter Franks et al., "Health Insurance and Mortality," *JAMA* 270 (1993) 737-41; Katherine Swartz, "Dynamics of People without Health Insurance: Don't Let the Numbers Fool You," *JAMA* 271 (1994) 64-66.

²¹ See Jim Montague, "The Big Question: Will High Levels of Uncompensated Care Make Some Providers Unattractive to Emerging Networks," *Hospitals and Health Networks*, (5 February 1994) 48-54; Elizabeth McMillan, "The Health Care Marketplace: Cost-Containment at the Price of Access," *Theology and Public Policy* (Fall 1989) 18-31; and Edward J. Mahoney, "Justice and Healthcare for the Poor," *Louvain Studies* 13 (1988) 232-51.

²² California became the first state to require not-for-profit hospitals to draft and implement community benefit plans; see David Burda, "California Gets Tougher on Charity Care," *Modern Healthcare* (10 October 1994).

²³ See CHA and Lewin/ICF, *Social Accountability Budget for Not-for-Profit Healthcare Organizations* (St. Louis: CHA, 1989); and CHA, *A Community Benefits Report on Catholic Healthcare Providers* (St. Louis: CHA, 1991).

²⁴ In so doing, CHA reversed its 1993 decision permitting for-profit entities to join, provided they promoted Roman Catholic values. For-profit health-care corporations are extremely interested in acquiring nonprofit hospitals, particularly Catholic hospitals. See Sandy Lutz, "Not-for-Profits Lure Investors," *Modern Healthcare* (26 July 1993) 49-54; and Sandy Lutz, "Industry Follows, Fears the Leader," *Modern Healthcare* (14 February 1994) 23-25, on Rick Scott, the chief executive officer of for-profit Columbia/HCA Healthcare Corporation, the nation's largest hospital system.

²⁵ See, e.g., Daniel W. Coyne and Kathleen Russell Kas, "The Not-for-Profit Hospital as a Charitable Trust: To Whom Does Its Value Belong?" *Journal of Health and Hospital Law* 24/2 (1991) 48-57; T. J. Sullivan and V. Moor, "A Critical Look at Recent Developments in Tax Exempt Hospitals," *Journal of Health and Hospital Law* 23/3 (1990) 65-83; Jay Wolfson and Scott L. Hopes, "What Makes Tax-Exempt Hospitals Special?" *Healthcare Financial Management* (July 1994) 56-60.

Incentives for Undertreatment

The financial structure of many managed-care providers militates against "taking a chance" and performing treatment that is expensive and of unproven benefit. Consequently the topic of "futile care" has received increased attention. Can a provider ethically refuse to furnish treatment desired by patients because *the provider* believes it is futile?²⁶ Ronald Cranford and Lawrence Gostin remind us that "futility" has been used in a variety of different value-laden ways. "Futile care" can refer to treatment unlikely to improve the quality or duration of the particular patient's life. "Futility" can also focus on the needs of society, by referring to resources that would be better directed to other patients.²⁷ As Cranford and Gostin suggest, the second use of the term surreptitiously incorporates normative claims of distributive justice. Questions of microallocation and macroallocation deserve more forthright consideration.²⁸

Measuring and Comparing the Effectiveness of Care

Managed care does not aim simply to control costs, it also strives to make health care more *cost-effective* by improving the quality of care. Accordingly, several health-reform proposals would require providers to furnish data concerning the "outcomes" of various procedures to potential enrollees, who would then be able to "comparison shop" for price and quality. Data concerning treatment outcomes may also have other uses, including weeding out "substandard" practitioners and developing "clinical-practice guidelines" or "critical paths" that correlate a diagnosis with a series of clinical interventions designed to bring improvement as quickly and inexpensively as possible.²⁹

Developing meaningful ways to measure and compare the effectiveness of various clinical interventions is clearly at the heart of managed

²⁶ Two of the more renowned cases involving the question of futile treatment are *In Re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct., Prob. Div., July 1, 1991) (hospital ordered to continue ventilator support for an 87-year-old woman in a persistent vegetative state, in accordance with her husband's wishes); and *In the Matter of Baby K*, 16 F.3d 590 (4th Cir. 1994) (holding that a hospital would violate the federal Emergency Medical Treatment and Active Labor Act by refusing ventilator support for an anencephalic child whose mother desired treatment).

²⁷ Ronald Cranford and Lawrence Gostin, "Futility: A Concept in Search of a Definition," *LMHC* 20 (1992) 307-9. See also Bethany Spielman, "Collective Decisions about Medical Futility," *JLME* 22 (1994) 152-60.

²⁸ See, e.g., the symposia "Rationing Health Care: Social, Political, and Legal Perspectives," in *AJLM* 18 (1992) 1-126; and "Meeting the Challenges of Justice and Rationing," in the *Hastings Center Report* 24/2 (1994) 27-42; Russell E. Smith, "Health Care Rationing: A Theologian's Perspective," *Linacre Quarterly* 60 (August 1993) 20-29; as well as several essays in K. Wildes, ed., *Critical Choices and Critical Care* (see n. 11 above).

²⁹ See Kevin Lumsdon and Mark Hagland, "Mapping Care," *Hospitals and Health Networks* (20 October 1993) 34-40.

care. Doing so, however, is not as simple as comparing automobiles in *Consumer Reports*. Two basic sets of issues are involved. First, how adequate are the specific indicators used to assess quality of care? For example, the Pennsylvania Health Care Cost Containment Council published a report comparing the mortality rates of the hospitals—and the individual physicians—who performed coronary-artery-bypass-graft surgery within that state.³⁰ Mortality rates are clearly one indication of quality. However, their correlation to other relevant measures of good care, such as rapid ability to return to work, is unclear. An equally important issue is how methods to compare treatment outcomes account for the fact that some patients are sicker than others at the outset. A number of different measures have been developed to adjust for the severity of illness in evaluating treatment effectiveness; unfortunately, they do not define severity uniformly. For example, in one system, the severity of a patient's illness is measured by risk of imminent death; in another, it is determined by the resources consumed by the patient.³¹

The measurement and comparison of outcomes raises a host of moral issues. Are patients sufficiently informed about the meaning and limitations of the comparative information provided them? If not, the information hinders rather than facilitates informed consent. Is outcomes data being conscripted for purposes beyond its intended use? For example, some systems for collecting outcomes data are designed to identify unusual cases that merit further consideration in the institution's quality-assurance committee. It would be unjust to discipline physicians responsible for the unusual cases solely on the basis of such uninterpreted data. Inappropriate use of information may also adversely affect quality of care. In their efforts to advertise a good "report card," some providers may focus disproportionately on improving isolated "indicators" of quality (e.g. mortality rates in bypass surgery), which do not encompass the totality of good medicine.

The Revised Ethical and Religious Directives

Institutional challenges are among the many matters addressed in the newly revised *Ethical and Religious Directives for Catholic Health Care Services*. The National Conference of Catholic Bishops' greatly expanded directives address a number of new issues, ranging from the nature of health care as a basic right to the legacy of Catholic (especially women religious) health-care providers. Moreover, in determin-

³⁰ *A Consumer Guide to Coronary Artery Bypass Surgery* (Harrisburg, Pa.: Health Care Cost Containment Council, 1991).

³¹ See Lisa I. Iezzoni, "Measuring the Severity of Illness and Case Mix," in *Providing Quality Care*, ed. Norbert Goldfield and David B. Nash (Philadelphia: American College of Physicians, 1989) 70–105; and Lisa I. Iezzoni, "Using Severity Information for Quality Assessment: A Review of Three Cases by Five Severity Measures," *Quality Review Bulletin* 15 (1989) 376–81.

ing a particular form of medical treatment when several options are available, the new directives replace an earlier "best interests" model with a "responsible patient's wishes" model. The *Directives* not only require a patient's consent, they also state that the patient must be provided "all reasonable information" so that the consent is free and informed.³² With this same respect for the patient, the bishops leave open the neuralgic debate on the morality of withdrawing artificial nutrition and hydration; though there is a clear presumption to maintain such support, it may be withdrawn when burdens outweigh benefits.³³

The bishops recognize not only the shift in patient decision making, but also the changes in the reimbursement system and the need for consolidation of health-care services.³⁴ While noting that "until recently most health-care providers enjoyed a degree of independence from one another," they offer in the final part of the *Directives* four particular directives for "forming new partnerships with health-care organizations and providers." The *Directives* stipulate "consultation" with the diocesan bishop when a facility's identity or reputation will be seriously affected, and they require "appropriate authorization" from the diocesan bishop when the "mission or religious and ethical identity" of the facility will be altered.³⁵ Moreover, when a partnership may "involve" a Catholic facility in activities judged morally wrong by the Church, the facility "should limit its involvement in accordance with the moral principles governing cooperation," always bearing in mind that cooperation "may be refused because of the scandal that would be caused in the circumstances."³⁶

The bishops' turn to the principle of cooperation is an important one.³⁷ Though the principle is sometimes used to help protect individ-

³² Compare directive 1 of *Ethical and Religious Directives for Catholic Health Facilities* (Washington: USCC, 1971) with directives 25, 26, 27, 28, 56, and 59 of *Ethical and Religious Directives for Catholic Health Care Services* (hereafter ERD) (Washington: USCC, 1994). The new document insists repeatedly that the patient's wishes must be respected so long as they do not violate Catholic moral principles.

³³ ERD, Part Five, and directive 58. See the varying viewpoints that bishops offer in James Keenan and Myles Sheehan, "Life Supports: Sorting Bishops' Views," *Church* 8 (1992) 10-17. See also Edwin Lisson, "Moral Repugnance as a Source in Moral Analysis," *Linacre Quarterly* 61 (1994) 53-65.

³⁴ In 1993, five of the ten largest health-care systems in the country (by net patient revenues) were Catholic. Apart from government-owned hospitals, Catholic hospitals are the single largest group of not-for-profit providers in the industry (Jay Greene and Sandy Lutz, "Systems Post 4th Straight Year of Income Growth," *Modern Healthcare* [23 May 1994] 36-62, at 37).

³⁵ ERD, directives 67 and 68 respectively.

³⁶ ERD, directives 69 and 70 respectively.

³⁷ Though Benedict Ashley and Kevin O'Rourke argue that cooperation is nothing more than an expression of double effect (*Healthcare Ethics* [St. Louis: CHA, 1989] 188-190), the hermeneutic function of the principle of double effect has been repudiated (see James Keenan, "The Function of the Principle of Double Effect" *TS* 54 [1993] 294-315;

ual subordinates in their employment,³⁸ it is also invoked frequently by persons in positions of authority (priests, judges, physicians) in order "to diminish the physically evil effects" of a wrongdoer's action.³⁹ The principle's utility in addressing questions related to the common good, then, has prompted many to recognize its institutional relevance. For instance, the Congregation for the Doctrine of the Faith⁴⁰ and the United States Catholic Conference⁴¹ have offered strict guidelines governing when a Catholic health-care facility, under duress, could materially cooperate in sterilization. Moral philosophers also concur about the principle's institutional import.⁴²

Cooperation is not primarily a permissive principle governing whether one may act, but rather a guiding principle illuminating *how* one should act.⁴³ It provides instructions for negotiating one's participation in work with another, some of whose actions are morally wrong.⁴⁴ Mindful of this fact, the bishops draw a firm line between abortion and other activities judged morally wrong, like sterilization and contraception. No amount of duress will justify the practice of abortion within a Catholic health-care institution.⁴⁵

Applying the principle of cooperation to contemporary cases is no

Joseph Selling, "The Problem of Reinterpreting the Principle of Double Effect," *Louvain Studies* 8 [1980] 47-62; Bruno Schüller, "The Double Effect in Catholic Thought: A Reevaluation," in *Doing Evil to Achieve Good*, ed. Richard McCormick and Paul Ramsey [Chicago: Loyola University, 1978] 165-91; Lucius Ugorji, *The Principle of Double Effect* [Frankfurt: Peter Lang, 1985]. For comparison of the two principles, see James Keenan and Thomas Kopfensteiner, "The Principle of Cooperation," forthcoming in *Health Progress*, March 1995.

³⁸ Anthony Fisher, "Cooperation in Evil," *Catholic Medical Quarterly* 44 (1994) 15-22, at 15.

³⁹ James Keenan, "Prophylactics, Toleration, and Cooperation: Contemporary Problems and Traditional Principles," *International Philosophical Quarterly* 29 (1989) 205-20, at 208-9.

⁴⁰ "Vatican Upholds Ban on Sterilization," *Origins* 6 (1976) 33, 35.

⁴¹ USCC, "Sterilization Policy for Catholic Hospitals," *Origins* 7 (1977) 399-400. See also the arguments in Gary Atkinson and Albert Moraczewski, *A Moral Evaluation of Contraception and Sterilization* (St. Louis: Pope John XXIII Center, 1979) 77-87.

⁴² See Joseph Boyle, "Radical Moral Disagreement," *JMP* 19 (1994) 183-200, at 197; John Finnis, Joseph Boyle, and Germain Grisez, *Nuclear Deterrence, Morality and Realism* (Oxford: Oxford University, 1987) 343-57.

⁴³ Cooperation concerns nearly every form of public activity. Without it, as Bernard Häring has noted, "the exercise of the lay apostolate" would be "totally impossible" (*The Law of Christ* [Westminster, Md.: Newman, 1963] 2.495-517, at 500).

⁴⁴ On moral diversity and compromise, see H. Tristram Engelhardt, Jr., "Health Care Reform: A Study in Moral Malfeasance," *JMP* 19 (1994) 501-16; Albert R. Jonsen, "Theological Ethics, Moral Philosophy, and Public Moral Discourse," *Kennedy Institute of Ethics Journal* 4 (1994) 1-12; Marian Gray Secundy, "Strategic Compromise: Real World Ethics," *JMP* 19 (1994) 407-18.

⁴⁵ ERD, directive 45; James T. McHugh, "Health Care Reform and Abortion: A Catholic Moral Perspective," *JMP* 19 (1994) 491-500. On whether fetal-tissue research leads to cooperation in abortion, see Andrew Shorr, "Moral Connections? The Relationship

easy matter. Henry Davis noted there is "no more difficult question than this in the whole range of moral theology."⁴⁶ Likewise, even its articulation is subject to debate. We invoke the principle, then, as it appears in the *Directives'* appendix, that is, as a distillation of the many distinctions made by moral theologians over the past three centuries. Afterwards, we apply that principle to two cases.

The principle of cooperation differentiates the action of the wrongdoer from the action of the cooperator through two major distinctions. The first is between formal and material cooperation. If the cooperator intends the object of the wrongdoer's activity, then the cooperation is formal and, therefore, morally wrong. Since intention is not simply an explicit act of the will, formal cooperation can also be implicit. Implicit formal cooperation is attributed when, even though the cooperator denies intending the wrongdoer's object, no other explanation can distinguish the cooperator's object from the wrongdoer's object. If the cooperator does not intend the object of the wrongdoer's activity, the cooperation is material and can be morally licit. The second distinction deals with the object of the action and is expressed by immediate and mediate material cooperation. Material cooperation is immediate when the object of the cooperator is the same as the object of the wrongdoer. Immediate material cooperation is wrong, except in some instances of duress. The matter of duress distinguishes immediate material cooperation from implicit formal cooperation. But immediate material cooperation—without any duress—is equivalent to implicit formal cooperation and, therefore, morally wrong. When the object of the cooperator's action remains distinguishable from that of the wrongdoer's object, material cooperation is mediate and can be morally licit.

Moral theologians recommend two other considerations for the proper evaluation of material cooperation. First, the object of material cooperation should be as distant as possible from the wrongdoer's act. Second, any act of material cooperation requires a proportionately grave reason. Prudence guides those involved in cooperation to estimate questions of intention, duress, distance, necessity and gravity. In making a judgment about cooperation, it is essential that the possibility of scandal should be eliminated. Appropriate consideration should be given to the Church's prophetic responsibility.⁴⁷

One Scenario, Two Cases

A Catholic health system (CHS) that includes one or more Catholic hospitals (CH) is considering an affiliation with a nonprofit secular system (SHS) operating its own secular hospitals (SH). The affiliation

Between Abortion and Fetal Tissue Research," *Linacre Quarterly* 61 (1994) 44–52; Russell E. Smith, "The Principles of Cooperation in Catholic Thought," in *The Fetal Tissue Issue*, ed. Peter Cataldo and Albert Moraczewski (Braintree, Mass.: The Pope John XXIII Center, 1994) 81–92; Carson Strong, "Fetal Tissue Transplantation: Can It Be Morally Insulated from Abortion?" *JMP* 17 (1991) 70–76. Likewise, euthanasia, another death-dealing action, will not be permitted in a Catholic health-care institution.

⁴⁶ Henry Davis, *Moral and Pastoral Theology* (London: Sheed and Ward, 1958) 342. Disagreement arises even among the most competent; see Hieronymus Noldin, *Summa Theologiae Moralis* (Innsbruck: F. Rauch, 1923) vol. 2, nos. 119, 121, pp. 134, 137.

⁴⁷ *Directives*, Appendix. Besides Fisher, Häring, and Keenan on cooperation, see Orville Griese, *Catholic Identity in Healthcare: Principles and Practices* (Braintree, Mass.: Pope John XXIII Center, 1987) 373–419.

would substantially enhance the long-term viability of each system, which otherwise would be threatened. Long discussions among the officers and boards of both systems have confirmed that their respective missions and management styles are substantially compatible.⁴⁸ CHS and SHS have reached agreement on many key operational issues with significant moral import, ranging from charity care to reductions in staff.⁴⁹

There is, however, a potential impediment to the affiliation: SH performs sterilizations. How should CHS view the potential affiliation in light of the revised Directives? As the foregoing section emphasizes, the details of each particular situation inform the appropriate response. CHS might be able to affiliate with another Catholic facility.⁵⁰ The sponsoring order might also decide to sell CHS, in the belief that its mission to provide health care would be better served by opening hospices for victims of AIDS.⁵¹ However, in order to isolate the issue of cooperation, the following two cases assume that other crucial moral and practical issues have been resolved.

Case 1: Catholic Hospital in a Secular System

For the first case study, suppose that the CHS and SHS have decided that CH should join SHS. Nonprofit corporation law offers a number of ways to implement this decision. SP, the parent company in SHS, might become the parent of CH, whose distinct corporate framework would remain intact. Alternatively, CH and SH might merge, with SH remaining as the surviving corporation operating at two campuses.

In evaluating this situation, it is important to resist the temptation to use the terms "corporation" and "institution" interchangeably.

⁴⁸ See, e.g., Annelle Fitzpatrick and Christine C. Gaylor, "Mission Statements: Politically Correct or Countercultural," *Health Progress* (March 1994) 70–72; John Larrere and David McClland, "Leadership for the Catholic Healing Ministry," *Health Progress* (June 1994) 28–51; "Future in Focus: A Trustee's Guide to Changing Times," *Health Progress* (May 1994) 45–54; and "How to Approach Catholic Identity in Changing Times," *Health Progress* (April 1994) 22–51.

⁴⁹ See, e.g., David Burda, "Cutting Down: Hospitals' Labor Costs are Top Target, Annual Human Resources Survey Shows," *Modern Healthcare* (December 20–27, 1993) 49–58; Joanne Lappetito, "An Ethical Analysis of Human Resource Issues," *Health Progress* (May 1994) 66–67, 75; Leonard J. Weber, "Ethical Downsizing: Managers Must Focus on Justice and Human Dignity," *Health Progress* (July–August 1994) 24–26; and "Administrative Ethics in the 1990s: CEOs Confront Payment, Access Dilemmas," *Hospitals* (January 5, 1992) 20–28.

⁵⁰ In the fall of 1994, Cardinal Joseph Bernardin of Chicago issued new guidelines for Catholic health-care facilities, urging them to give preference to affiliations involving other Catholic organizations and to avoid affiliating with for-profit institutions ("Cardinal's Rules Limit Hospitals' Plans to Merge," *Chicago Sun-Times*, 9 September 1994, 1; and "Catholic Group to End For-Profit Membership," *Modern Healthcare*, 3 October 1994, 28).

⁵¹ Whether shrinking religious orders can best fulfill their mission through continued sponsorship of acute-care health systems merits significant discussion. However, given the recent failure of health-care reform, such institutions will play an important role in caring for those abandoned by society for the foreseeable future.

Some institutions never acquire a distinct corporate status, while others use multiple corporations as the vehicle for their work. While distinct corporate identity is one factor in defining an institution, equally important considerations are the personnel who carry on its tasks, the site from which it operates, the traditions it carries forward, and the values it offers to the community. Provided that appropriate steps are taken to preserve its identity with respect to these other factors, CH may remain a Catholic institution despite its secular corporate parent, and even despite its lack of distinct corporate identity after a merger with SH. However, precisely because an institution's identity is inseparable from its social role, CH must demonstrate to the community and to the Church that its new corporate structure adequately protects its institutional integrity.

By providing tools that enable institutions to endure and evolve over time, corporate law enables Catholic institutions corporately to implement the principles of cooperation. Creating a series of "default presumptions" about who controls a corporation and how decisions are made, corporate law also gives the parties embarking upon an affiliation sufficient flexibility to alter many of these presumptions. In this case, CHS and SHS might decide that SP would not be authorized to amend the purposes of CH, although parent corporations generally have such power over their subsidiaries. If the parties choose to merge CH with and into SH, they might stipulate that activities prohibited by the Directives would never take place at the CH site.⁵² In addition, CHS might be granted the right to fill a certain percentage of the seats on the SP board of trustees. After the affiliation, these CHS trustees would constitute a self-perpetuating subcommittee of the SP board, charged with insuring that CH (or the former CH site) operates in a way that is consistent with Catholic values. These and other provisions designed to preserve the integrity of a Catholic institution can be and are built into the memoranda of understanding, articles of organization, and bylaws that structure affiliations. It is important to consider the details set forth in these documents, rather than judging on the basis of a deceptively simple corporate chart.⁵³

Case II: Secular Hospital in a Catholic System

The second case is the mirror image of the first. SH joins CHS, with the result that a Catholic parent corporation (CP) serves as the sole member or stockholder of a nonprofit, secular facility. Just as CH was able to protect its religious identity while belonging to SHS, so here

⁵² As the USCC's "Sterilization Policy for Catholic Hospitals" makes clear, sterilizations cannot take place at the CH site, except under grave duress. As ERD 45 stated, no abortions can ever take place at the CH site; in addition, CH needs "to be concerned about the danger of scandal in any association with abortion providers."

⁵³ See Adam J. Maida and Nicholas P. Cafardi, *Church Property, Church Finances, and Church-Related Corporations* (St. Louis: CHA, 1984) for a helpful discussion of how civil law can be used to protect Catholic institutions, as well as canon-law requirements pertaining to affiliations involving Catholic health-care providers.

the parties can preserve SH's status as a secular institution. The question facing CHS is not whether SH should become a Catholic facility, since SH likely would not agree to join CHS unless it could preserve its secular identity after the affiliation. Rather, the question is whether and how CHS should agree to exercise limited authority over a non-Catholic health-care institution.

The response cannot be divorced from the conditions prompting the affiliation. Suppose that a payor offers to contract with CHS on a capitated basis to provide its enrollees with a benefits package that includes sterilization. In return, CHS could request the payor to "carve out" objectionable services from its contract with CHS, thereby requiring the payor to contract separately for sterilization services. Alternatively, CHS might accept the full capitated payment. In this case, CHS would either need to offer sterilization services to enrollees through a "subcontract" with an unrelated facility or to provide such services within its own system through SH.

This example demonstrates the unavoidable tension between distancing oneself from morally prohibited activity and maintaining sufficient power to act on behalf of the good, which lies at the heart of the principle of cooperation. In this case, the power at stake would enable CHS to insure that even prohibited medical services are provided in accordance with appropriate medical standards. The first option, the "carve-out," allows CHS the most distance from the prohibited activity. However, it also confers upon CHS virtually no control over the quality of the services provided to enrollees for whose health CHS is otherwise entirely responsible. By providing the services in a non-Catholic institution over which CHS has real, but limited authority, the third option gives CHS the most influence over the medical care provided to its patients.

Conclusion

While preserving institutional integrity is important, in the end, only human persons are moral agents accountable before God. A more subtle and difficult moral issue is how affiliations will enhance or impede the vocations of individual health-care providers. Drawing upon Oregon's recent decision to legalize assisted suicide, suppose a Catholic hospital prohibits the procedure, but that it is available at another facility in the network. Will physicians with privileges at both hospitals be able to perceive the roots of the prohibition against euthanasia in a wider respect for the sanctity of all life, or will they increasingly view it as an arcane rule applicable only in "sectarian" facilities? In the end, no matter how effectively such prohibitions are enforced, the fate of Catholic health care will depend upon our ability to communicate the positive theological vision undergirding the corporal works of mercy.

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